

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1256	Date: MAY 25, 2007
	Change Request 5619

SUBJECT: Update Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for Rate Year (RY) 2008

I. SUMMARY OF CHANGES: This change request (CR) indicates changes that are required as part of the annual IPF PPS update for RY 2008. These include: the market basket update, Federal per diem base rate update, electroconvulsive therapy update, Pricer updates, and other policy updates.

NEW / REVISED MATERIAL

EFFECTIVE DATE: * Discharges on or after July 1, 2007

IMPLEMENTATION DATE: July 2, 2007

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/revise 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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1256	Date: May 25, 2007	Change Request: 5619
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SUBJECT: Update Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for Rate Year (RY) 2008

Effective Date: Discharges on or after July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: On November 15, 2004, we published in the Federal Register a final rule that established the prospective payment system for Inpatient Psychiatric Facilities (IPF) under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a Federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). We are required to make updates to this prospective payment system annually. The RY update is effective July 1- June 30 of each year and the DRGs and ICD-9-CM codes are updated on October 1 of each year.

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update from the RY 2008 IPF PPS update notice, published on May 4 ,2007. These changes are applicable to IPF discharges occurring during the rate year beginning on July 1, 2007, through June 30, 2008.

B. Policy:

1. Market Basket Update:

We use the **Rehabilitation/Psychiatric/Long-Term Care (RPL)** market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate). The fiscal year (FY) 2002 excluded hospital market basket is used to update the cost-based portion (Tax Equity and Fiscal Responsibility Act of 1982-(TEFRA)), effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

2. PRICER Updates:

- The Federal per diem base rate is \$614.99.
- The fixed dollar loss threshold amount is \$6,488.00.
- The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is 75 percent PPS and 25 percent TEFRA. The transition blend percentage for cost reporting periods beginning on or after January 1, 2008 is 100 percent PPS.
- The IPF PPS uses the FY 2007 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 75.788 percent.
- The non-labor related share is 24.212 percent.
- The electroconvulsive therapy (ECT) rate is \$264.77.

3. Payment Rate:

Federal Per Diem Base Rate	\$614.99
Labor Share (0.75788)	\$466.09
Non-Labor Share (0.24212)	\$148.90

The rates for RY 2008 were published in a Federal Register notice and can also be found on the IPF PPS Web site at <http://www.cms.hhs.gov/InpatientPsychFacilPPS>

4. ECT Update:

The update methodology for the ECT rate is to update the previous rate year's amount by the market basket increase and wage index budget neutrality factor. The ECT adjustment per treatment is \$264.77 for RY 2008.

5. DRG Adjustment Update:

There are no changes to the DRG adjustment factors for RY 2008.

6. Comorbidity Adjustment Update:

There are no changes to the Comorbidity adjustment factors for RY 2008.

7. The National Urban and Rural Cost to Charge Ratios (CCR) for the IPF PPS RY 2008:

Cost to Charge Ratio	Median	Ceiling
Urban	0.55	1.7947
Rural	0.71	1.7255

We are applying the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, we are using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost reporting period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

8. Updated Methodology for computing CCRs for the IPF PPS RY 2008:

For IPFs that are distinct part psychiatric units, total Medicare inpatient routine and ancillary charges will be obtained from Worksheet D-4, column 2, line 31 (or appropriate subscript), plus line 103. 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	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	described in policy section 8, effective for cost reporting periods beginning on or after July 1, 2007.											
5619.3	Contractors shall update the provider specific file (PSF) with the new COLA values effective July 1, 2007.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
5619.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Policy: Matthew Quarrick, email:
Matthew.Quarrick@cms.hhs.gov Claims Processing/Pricer: Valeri Ritter, email:
Valeri.Ritter@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC), use the following statement:

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

B. For Medicare Administrative Contractors (MAC), use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.