Inpatient Psychiatric Facility Prospective Payment System

2005 OVERVIEW

FACT Sheet

This Fact Sheet highlights significant policy changes and subsequent CRs relevant to the November 15, 2004 Final Rule for Inpatient Psychiatric Facilities (IPFs).

Background

A per diem Prospective Payment System (PPS) for Inpatient Psychiatric Facilities (IPFs) has been implemented based on Section 124(c) of Public Law 106-113, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). This law directed the Centers for Medicare & Medicaid Services (CMS) to implement a per diem PPS for psychiatric hospitals and units in acute care hospitals and critical access hospitals (CAHs).

How Will Medicare Pay IPFs For Their Services Under PPS?

Payments to IPFs under the IPF PPS are based on a single 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, direct graduate medical education, and blood clotting factors). The standardized Federal per diem base rate, adjusted for budget neutrality (behavioral offset, outlier payments and stop-loss payments) is $575.95.

Federal Per Diem Base Rate	$575.95
Labor Share (0.72247)	*$416.11*
Non-Labor Share (0.27753)	*$159.84*

Facility-Level Payment Adjustments

There are several facility-level payment adjustments to the Federal per diem base rate. They include:

- A hospital wage index to adjust for geographic differences in labor costs and wage levels;
- A 17 percent payment adjustment to rural facilities because of their higher costs;
- An emergency department (ED) adjustment for IPFs maintaining a qualifying ED that will be incorporated into the variable per diem adjustment for the first day of each stay;
- A teaching adjustment because teaching facilities' costs are higher. The adjuster is based on a capped ratio of interns and residents to occupied beds (average daily census); and
- A cost of living adjustment (COLA) for Alaska and Hawaii.

ALSO IN THIS ISSUE:

Patient-Level Payment Adjustments

In addition to facility-level payment adjustments, there are several patient-level payment adjustments to the Federal per diem base rate. These adjustments are based on:

- **Age** – There are nine adjustment factors for age. The age adjustment has nine age categories: under age 45, over age 80, and categories in five year groupings in between the ages of 45 and 80;
- **Diagnosis Related-Group (DRG)** – There are 15 diagnosis-related group (DRG) adjustment factors. IPF claims with a psychiatric principal diagnosis included in one of the 15 DRGs will receive a DRG adjustment and all other applicable adjustments throughout the patient stay. Psychiatric principal diagnoses that do not group to one of the DRGs will receive the Federal per diem base rate and all other applicable adjustments, but the payment will lack a DRG adjustment for the stay;
- **Comorbidities** – There are 17 comorbidity categories identified by diagnosis codes that generate payment adjustments for conditions requiring comparatively more costly treatment during an IPF stay; and
- **Day-of-Stay** – The variable per diem adjustment is added to the Federal per diem rate to account for ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. These variable adjustments will begin on day one and decline at fixed intervals until day 21 of a patient's stay. Beginning on day 22, the variable per diem adjustment remains the same each day for the remainder of a patient's stay.

Electroconvulsive Therapy (ECT) Adjustment

IPFs receive an adjustment for each ECT treatment furnished during the IPF stay. The ECT payment is $247.96 which is then adjusted by the wage index and any applicable COLA. In order to report an ECT treatment and to receive the payment adjustment, IPFs must use revenue code 0901 and procedure code 94.27 to report the ECT along with the appropriate number of units.

DID YOU KNOW?

IPFs must report revenue code 0901 and ICD-9-CM procedure code 94.27 for an ECT.

"Code First"

The principal diagnosis is the condition chiefly responsible for the patient's admission to the IPF even though another diagnosis may be more severe.

"Code first" rule applies when a condition has both an underlying etiology and a manifestation due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. Whenever such a combination exists, there is a "use additional code" note at the etiology code and a "code first" not at the manifestation code.

"Code First" Example

Diagnosis code 294.1, "Dementia in Conditions Classified Elsewhere," is designated as "code first," indicating that all 5 digit diagnosis codes that fall under 294.1 (codes 294.10 and 294.11) must follow the "code first" rule. According to the "code first" requirements, a provider would code the appropriate physical condition first. For example, 333.4, "Huntington's chorea," as the primary diagnosis and 294.11 as the secondary diagnosis. The submitted claim will go through the CMS processing system, which will assign a DRG based on the primary diagnosis code. If the assigned DRG is non-psychiatric, the system will search the secondary diagnosis code for a psychiatric code to assign a DRG for payment adjustment.

Outlier Adjustment

There is an outlier policy to promote access to IPFs for patients who require expensive care and to limit the financial risk of IPFs. A case will fall into this category if the estimated cost of the case exceeds an outlier threshold amount of $5,700 plus the Federal per diem payment. If the cost of the case is greater than this adjusted threshold amount, an additional payment will be added to the IPF PPS payment amount. Once the threshold amount is met, CMS will share a declining percentage of the losses for a high cost case. For days one through nine, the risk-sharing is 80 percent of the difference between the cost for the case minus payment and the adjusted threshold. For day 10 and thereafter, the risk sharing percentage is 60 percent.

Outliers are not paid on interim bills, but on the final discharge bill.

DID YOU KNOW?

The outlier threshold amount is $5,700.

Interrupted Stays

There is an interrupted stay policy in IPF PPS to eliminate inappropriate Medicare payments to IPFs that prematurely discharge patients after receiving the higher variable per diem adjustments and then readmit the same patient to receive the higher variable per diem adjustments again. Under IPF PPS, if a patient is discharged from an IPF and returns to any IPF before midnight on the third consecutive day following discharge, the case is considered continuous for applying the variable per diem adjustment and any applicable outlier payment.

Transition and Phase-In Implementation

The IPF PPS began on January 1, 2005, via a 3-year phased-in period. IPFs will transition from the current cost-based reimbursement to the Federal prospective payment system. During the transition period, payment will be based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPF's cost-based reimbursement rate.

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

New IPF providers will not participate in the 3-year transition from cost-based reimbursement to a PPS payment since they do not have an established TEFRA amount. Instead, they will be paid 100 percent of the IPF PPS Federal rate from the start.

Stop-Loss Provision

The IPF PPS includes a stop-loss provision during the 3-year transition to PPS that will reduce the financial risk for IPFs experiencing substantial reductions in Medicare payments during the transition period. The stop-loss provision is 70 percent, and it will be calculated at the time of cost report settlement for each IPF. The stop-loss provision ensures that during the transition, each facility's average payment per case under IPF PPS is no less than a minimum proportion of its average payment under the TEFRA. The combined effects of the transition and the stop-loss policies ensure that the total estimated IPF PPS payments will be no less than 92.5 percent in year one, 85 percent in year two, and 77.5 percent in year three.

Helpful IPF PPS Resources

Centers for Medicare & Medicaid Services
Inpatient Psychiatric Facility PPS Information Resource Page
http://www.cms.hhs.gov/providers/ipfpps/

Centers for Medicare & Medicaid Services
Medicare Learning Network IPF PPS web page
http://www.cms.hhs.gov/medlearn/ipfpps.asp

IPF PPS Press Release announcing the new IPF PPS
http://www.cms.hhs.gov/media/press/release.asp?Counter=1252

Centers for Medicare & Medicaid Services
IPF PPS Program Transmittal
Transmittal 384
http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf

Federal Register
Prospective Payment System for Inpatient Psychiatric Facilities Final Rule
Vol. 69, No. 219, November 15, 2004
http://www.cms.hhs.gov/providerupdate/regs/cms1213f.pdf

Section 124(c) of BBRA - Pub.L. 106-113
http://www.cms.hhs.gov/providers/ipfpps/section124bbra.pdf

ICD-9-CM Official Guidelines for Coding and Reporting
www.cdc.gov/nchs/data/icd9/icdguide.pdf

Questions regarding the IPF PPS Final Rule and the IPF PPS can be emailed to IPFPPS@cms.hhs.gov