2005 Conference

IPF PPS and ESRD Contractor Training

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

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CMS
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Medicare Learning Network

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Introduction

- **Training Guide**
  - IPF PPS Overview
  - Payment
  - Billing
- **Acronyms**
- **Definitions**

Resources

- **CR 3541**
  - http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf
- **CR 3678**
  - http://www.cms.hhs.gov/manuals/pm_trans/R444CP.pdf
- **Federal Register**
  - Proposed Rule November 28, 2003
  - Final Rule November 15, 2004
- **IPF web page**
  - http://www.cms.hhs.gov/providers/ipfpps/

IPF PPS Overview

Highlights of the IPF PPS

IPF PPS Overview

- **Participants will learn the following information in the course of this chapter:**
  - Statutory basis for the IPF PPS
  - IPFs impacted and not impacted
  - Implementation guidelines for the transition
  - Overview of changes

Legislation and Final Rule

- **Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)**
  - Per Diem Prospective Payment System
  - Budget Neutral
  - Adequate patient classification system
  - Require IPFs to submit necessary information to develop PPS
  - Report to Congress
- Final Rule Published November 15, 2004

IPFs Affected by IPF PPS

- **IPF PPS is applicable to:**
  - Freestanding psychiatric hospitals
  - Distinct part psychiatric units of general acute care hospitals
  - Distinct part psychiatric units of critical access hospitals (CAHs)

IPFs Affected by IPF PPS

- **Psychiatric Unit**
  - Separately certified from inpatient hospital
    - §412.22
    - §412.23
    - §412.25
    - §412.27
  - Not currently paid under IPPS

IPFs Affected By IPF PPS

- **IPFs should primarily**
  - Provide psychiatric services for the diagnosis and treatment of mentally ill patients
    - By or under the supervision of a physician
  - Maintain clinical records
    - Necessary to determine the degree and intensity of the treatment provided to the mentally ill patient
  - Meet staffing requirements
    - Sufficient to carry out active programs of treatment for individuals who are furnished care in the institution

IPFs Not Affected by IPF PPS

- **IPF PPS Exclusions**
  - Veterans Administration (VA) Hospitals
  - Hospitals reimbursed under state cost control systems
  - Hospitals reimbursed in demonstration projects
  - Non-participating hospitals furnishing emergency services
- **Maryland**
  - IPFs as distinct units are waived from IPF PPS

Transition and Effective Date

- **Start Date**
  - Beginning on or after January 1, 2005
    - Based on IPF's cost reporting period
- **3-Year Phase-In Period**
  - Payment blended
    - Decreasing percentage of TEFRA payment
    - Increasing percentage of PPS payment

Transition and Effective Date

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

Transition and Effective Date (con't)

- **Important Transition Issue**
  - Cost reporting periods beginning on or after January 1, 2005, but before April 1, 2005
    - TEFRA payments initially issued
    - Blended-PPS payments issued after reconciliation

Transition and Effective Date (con't)

- **Existing IPFs**
  - Transition period is mandatory
- **New IPFs**
  - Paid the full PPS Federal per diem amount

Definition of New IPF

- A new IPF is a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs set forth in CFR §§412.22, 412.23, 412.25, and 412.27 which under current ownership, previous ownership, or both, has not received payment under TEFRA for the delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005.

New IPFs

- To be considered new, an IPF must have never been paid under TEFRA
- It is not necessary that the IPF be in continuous operation until implementation of the IPF PPS
- CHOW has no effect on IPF status as a "new" IPF provider

Per Diem Base Rate

- **Included**
  - Operating costs
  - Ancillary costs
  - Capital costs
- **Not Included**
  - Physician/other professional costs
  - Bad debts
  - Direct medical education
  - Nursing education programs
  - Allied Health

Per Diem Base Rate

- **Payment Adjustments**
  - Facility
    - Wage index adjustment
    - Rural location adjustment
    - A teaching status adjustment
    - A COLA adjustment for IPFs in Alaska and Hawaii
    - Emergency Department (ED) adjustment

- **Payment Adjustments**
  - Patient
    - DRG adjustment
    - Comorbidity adjustment
    - Age adjustment
    - Variable per diem adjustment
    - ECT

Overview

- **Other Policies**
  - Interrupted stays
  - Outlier adjustments
  - Stop-loss payments

Overview (con't)

- **Billing Changes**
- **Correct Coding**
- **Processing Bills**
  - January 1, 2005 – April 4, 2005
    - Fiscal Intermediary Shared System (FISS)
    - TEFRA rules
    - Claim adjustments

Reminders

- **Inpatient Hospital Lifetime Reserve Days**
  - 90 benefit days
  - 60 inpatient lifetime reserve days
- **Inpatient Psychiatric Benefit Days**
  - Lifetime limitation
    - 190 days

Reminders (con't)

- **Beneficiary Liability**
  - **No change**
    - **Charge beneficiaries for:**
      - Deductible
      - Coinsurance
      - Noncovered service
      - Noncovered days

Q/A Session

IPF PPS Payment

Payment Concepts and Examples

IPF PPS Payment

- **Participants Will Learn:**
  - Calculation of the standardized Federal per diem base rate
  - Facility-level adjustments to the standardized Federal per diem base rate
  - Patient-level adjustments to the standardized Federal per diem base rate
  - Outlier policy
  - Stop-Loss policy
  - Cost-to-charge ratio methodology
  - Periodic interim payment (PIP)

Budget-Neutral Federal Per Diem (con't)

- Federal Per Diem Base Rate Is $575.95

Labor Share of the Per Diem	0.72247	$416.11
Non-Labor Share of the Per Diem	0.27753	$159.84

Per Diem Adjustments

- **Facility Adjustments**
  - Hospital wage index adjustment
  - Rural location adjustment
  - Teaching status adjustment
  - COLA adjustment
  - Emergency Department (ED) adjustment
- **Patient Adjustments**
  - DRG adjustment
  - Comorbidity adjustment
  - Age adjustment
  - Variable per diem adjustment
  - ECT adjustment

Facility-Level Adjustments

- **Facility-Level Adjustments**
  - Hospital wage index adjustment
  - Rural location adjustment
  - Teaching status adjustment
  - COLA adjustment
  - Emergency Department (ED) adjustment

Facility-Level Adjustments (con't)

- **Hospital Wage Index Adjustment**
  - Labor portion of Federal per diem
    - FY 2005 unadjusted, pre-reclassified hospital wage index
- **Rural Location Adjustment**
  - 17 percent adjustment

Facility-Level Adjustments (con't)

- **Teaching Adjustment**
  - Ratio of interns and residents to average daily census plus 1 raised to power of 0.5150
    - Number of interns and residents capped
      - Level of latest cost report prior to November 15, 2004

Facility-Level Adjustments (con't)

- **Teaching Adjustment Example**
  - Step 1: Add 1 to the interns and residents to ADC ratio
    - **IPF A: 1 + .1 = 1.1**
    - **IPF B: 1 + .2 = 1.2**
  - Step 2: Raise the factors in Step 1 to the power of .5150
    - **IPF A: 1.1 x exp (.5150) = 1.050**
    - **IPF B: 1.2 x exp (.5150) = 1.098**

Facility-Level Adjustments (con't)

- **Teaching Adjustment Example (con't)**
  - Step 3: Multiply the Step 2 factors by the appropriate adjusted Federal per diem payment amount
    - **IPF A: $625 x 1.050 = $656.25**
    - **IPF B: $625 x 1.098 = $686.25**

Facility-Level Adjustments (con't)

COLA by State	Adjustment Amount
Alaska	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

Facility-Level Adjustments (con't)

- **Emergency Department (ED) Adjustment**
  - 1.31 adjustment factor for first day
  - Qualifying ED
    - Dedicated ED
    - Provider-based status

Facility-Level Adjustments (con't)

- **ED Adjustment**
  - Dedicated ED meeting one of the following criteria
    - Licensed by the state
    - Advertised to the public
    - One-third of all outpatients sought urgent treatment for emergency conditions
      - Not required to have previously scheduled appointment

Facility-Level Adjustments (con't)

- **IMPORTANT NOTE**
  - When a patient is discharged from an acute care hospital and admitted to a distinct IPF unit
    - No ED adjustment
      - 1.19 adjustment

Facility-Level Adjustments (con't)

- **ED Adjustment**
  - An IPF with a qualifying ED must supply documentation to its FI
    - Qualifying ED
      - Dedicated ED
      - Provider-based entity
  - ED adjustments for IPFs that transition to IPF PPS on January 1st

Patient-Level Adjustments

- DRG Adjustment
- Comorbidity Adjustment
- Age Adjustment
- Variable Per Diem Adjustment
- ECT Adjustment

Patient-Level Adjustments (con't)

- **15 DRG Categories**
  - Expressed relative to most frequent DRG (DRG 430)
  - Based on principal diagnosis
  - Classified based on 3M's Grouper 22
  - If a psychiatric code does not group to one of the 15 DRGs, a DRG adjustment will not be received.
    - Remain eligible for all other applicable adjustments

Patient-Level Adjustments (con't)

DRG Description	DRG	Adjustment Factor
Procedure with principal diagnosis of mental illness	DRG 424	1.22
Acute adjustment reaction	DRG 425	1.05
Depressive neurosis	DRG 426	0.99
Neurosis, except depressive	DRG 427	1.02
Disorders of personality	DRG 428	1.02
Organic disturbances	DRG 429	1.03
Psychosis	DRG 430	1.00
Childhood disorders	DRG 431	0.99
Other mental disorders	DRG 432	0.92
Alcohol/Drug use Leave Against Medical Advice (LAMA)	DRG 433	0.97
Alcohol/Drug use with comorbid conditions	DRG 521	1.02
Alcohol/Drug use without comorbid conditions	DRG 522	0.98
Alcohol/Drug use without rehabilitation	DRG 523	0.88
Degenerative nervous system disorders	DRG 012	1.05
Non-traumatic stupor & coma	DRG 023	1.07

Patient-Level Adjustments (con't)

- **Comorbidity Adjustment**
  - 17 groups
    - ICD-9-CM
  - Conditions
    - Coexist at time of admission
    - Develop subsequently, OR
    - Affect treatment and/or length of stay

Patient-Level Adjustments (con't)

Description of Comorbidities	Adjustment Factor
Developmental Disabilities	1.04
Coagulation Factor Deficit	1.13
Tracheostomy	1.06
Eating and Conduct Disorders	1.12
Infectious Diseases	1.07
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.13
Drug/Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings – Digestive & Urinary	1.08
Musculoskeletal & Connective Tissue Diseases	1.09
Poisoning	1.11

Patient-Level Adjustments (con't)

Age	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

Patient-Level Adjustments (con't)

Variable Per Diem Adjustment

Day 1 -- Facility Without Full-service Emergency Department	1.19
Day 1 -- Facility With a Full-service Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
Day 22 and thereafter	0.92

Payment Example

- **68-Year-Old Female Presented At A Qualified ED**
  - Not recently discharged after an IPPS stay
  - Primary diagnosis of Dysthymic Disorder (ICD-9-CM code 3004), which groups to DRG 426 – "Depressive Neuroses"
  - Her comorbid conditions included:
    - ICD-9-CM code 491.20 – "Obstructive Chronic Bronchitis Without Exacerbation"
    - ICD-9-CM code 519.02 – "Mechanical Complication of Tracheostomy"
    - ICD-9-CM code 250.53 – "Diabetes with Ophthalmic Manifestations"
    - ICD-9-CM code 250.73 – "Diabetes with Peripheral Circulatory Disorders"
  - IPF length of stay was 10 days
  - No ECT during the inpatient stay

Payment Example (con't)

- **Calculate Total Wage Adjusted Rate**
  - **Step 1**
    - Multiply the Wage Index Factor by the Labor Portion of the Federal base rate
      - Gives the Adjusted Labor Portion of the Federal per diem base rate
        = (0.7743 x $416.11= $322.19)
  - **Step 2**
    - Add the Adjusted Labor Portion of the Federal Base Rate to the Non-Labor Portion of the Federal per diem base rate
      - Gives the Total Wage Adjusted Rate
        = (322.19 + 159.84 = $482.03).

Payment Example (con't)

- **Apply Facility-Level and Patient-Level Adjusters**
  - **Step 1**
    - Determine which facility-level and patient-level adjustment factors are applicable

      1. Teaching adjustment: None.

      2. Rural adjustment: North Dakota
      - Adjustment Factor 1.17.

      3. COLA: None.

      4. DRG adjustment: DRG 426
      - Depressive Neuroses – Adjustment Factor 0.99

      5. Age adjustment: Age 68
      - Adjustment Factor 1.10

Payment Example (con't)

- **Apply Facility-Level and Patient-Level Adjusters**
  - **6. Comorbidity**
    - ICD-9-CM code 491.20 – "Obstructive Chronic Bronchitis Without Exacerbation"
      - No comorbidity adjustment
    - ICD-9-CM code 519.02 – "Mechanical Complication of Tracheostomy"
      - Adjustment Factor 1.06
    - ICD-9-CM code 250.53 – "Diabetes with Ophthalmic Manifestations"
      - Adjustment Factor 1.05
    - ICD-9-CM code 250.73 – "Diabetes with Peripheral Circulatory Manifestations"
    - No comorbidity adjustment
  - **7. ECT treatments**
    - None

Payment Example (con't)

- **Apply Facility-Level and Patient-Level Adjusters**
  - **Step 2**
    - Multiply the applicable adjustment factors
      - Determines the PPS Adjustment Factor
        = (1.17 x 0.99 x 1.10 x 1.06 x 1.05 = 1.4181).
  - **Step 3**
    - Calculate the adjusted per diem
      - Multiply the total wage adjusted rate by the PPS adjustment factor
        = $482.03 x 1.4181 = $683.57

Payment Example (con't)

- **Calculate The Variable Per Diem Adjustment**
  - **Step 1**
    - Determine the number of days in the stay
      - Length of Stay: 10 days and the facility has a qualifying ED
        - Day 1 adjustment factor 1.31
        - Day 2 adjustment factor 1.12
        - Day 3 adjustment factor 1.08
        - Day 4 adjustment factor 1.05
        - Day 5 adjustment factor 1.04
        - Day 6 adjustment factor 1.02
        - Day 7 adjustment factor 1.01
        - Day 8 adjustment factor 1.01
        - Day 9 adjustment factor 1.00
        - Day 10 adjustment factor 1.00

Payment Example (con't)

- **Calculate The Variable Per Diem Adjustment**
  - **Step 2**
    - Multiply the variable per diem adjustment factors by the total wage and PPS-adjusted per diem for each day of the stay
      - Gives the total variable per diem amounts for each day of the stay

Payment Example (con't)

- **Step 2 continued…**
  - Day 1 (adjustment factor 1.31) x $683.57 = $895.48
  - Day 2 (adjustment factor 1.12) x $683.57 = $765.60
  - Day 3 (adjustment factor 1.08) x $683.57 = $738.26
  - Day 4 (adjustment factor 1.05) x $683.57 = $717.75
  - Day 5 (adjustment factor 1.04) x $683.57 = $710.91
  - Day 6 (adjustment factor 1.02) x $683.57 = $697.24
  - Day 7 (adjustment factor 1.01) x $683.57 = $690.41
  - Day 8 (adjustment factor 1.01) x $683.57 = $690.41
  - Day 9 (adjustment factor 1.00) x $683.57 = $683.57
  - Day 10 (adjustment factor 1.00) x $683.57 = $683.57

Payment Example (con't)

- **Calculate The Variable Per Diem Adjustment**
  - **Step 3**
    - Add the adjusted variable per diem amounts
      - Gives the total IPF PPS payment

Day 1	$895.48
Day 2	$765.60
Day 4	$738.26
Day 5	$717.75
Day 6	$710.91
Day 3	$697.24
Day 7	$690.41
Day 8	$690.41
Day 9	$683.57
Day 10	$683.57
Total	$7273.20

CMS Calculator

- **CMS website**
  - **Calculator IPFs and FIs may use to calculate PPS payment amounts***
    - **http://www.cms.hhs.gov/providers/ipfpps/**

**Note that calculator only calculates 100% PPS payment.*

Electroconvulsive Therapy (ECT) Adjustment

$247.96 Adjustment

- **Payment**
  - Distinct payment
  - Wage index adjustment
  - COLA adjustment
- **Billing**
  - Rev Code 0901
  - Appropriate units
  - 94.27 procedure code

ECT Adjustment Example

- **IPF "A" In Anchorage, AK, Submitted A Claim With Three ECT Treatments**
  - Multiply $247.96 by the labor share (0.72247) and by the area wage index (1.2109)
    - = $247.96 x 0.72247 x 1.2109 = $216.93
  - Multiply $247.96 by the non-labor share (0.27753) and by the applicable COLA (1.25)
    - =$247.96 x 0.27753 x 1.25 = $86.02

ECT Adjustment Example (con't)

- The sum of these two products is the adjusted per-treatment ECT amount
  - =$216.93 + 86.02 = $302.95
- Multiply the amount by the number of ECT occurrences and add it to the IPF's Federal per diem payment to compute the total ECT payment
  - =$302.95 x 3 = $908.85
- The total payment to IPF "A" for its three ECT treatments in this example is $908.85

IPF Outlier Policy

- **Outliers**
  - 2% outlier policy
  - Accounts for higher costs
    - Longer lengths of stay
  - Per case basis
    - Overall financial “gain” or “loss”

IPF Outlier Policy (con't)

- **Threshold Amount**
  - PPS payment plus fixed dollar loss amount ($5700)
  - The threshold amount is adjusted for the IPF's adjustments for:
    - Wage area
    - Teaching
    - Rural locations
    - Cost of living adjustment for Alaska and Hawaii

IPF Outlier Policy (con't)

Threshold=PPS payment plus fixed dollar loss amount Fixed Dollar Loss Amount: $5,700 Declining Risk Sharing Ratio	
Days 1-9	Medicare Share 80%
Days over 9	Medicare Share 60%

Outlier Payment Example

- If an IPF's total estimated payment for a case Is $7273.20, calculate the adjusted threshold amount to determine outlier payment
  - **Step 1**
    - Multiply threshold by labor share and the wage area
    - $5700 X 0.72247 (labor share) X 0.7743 (area wage index) = $3188.63
  - **Step 2**
    - Add this number to the non-labor share threshold amount
    - $5700 X 0.27753 (non-labor share) = $1581.92
    - $1581.92 + $3188.63 = $4770.55

Outlier Payment Example (con't)

- **Step 3**
  - Apply any applicable facility-level adjustments
    - $4770.55 X 1.17 (rural adjustment) = $5581.54
- **Step 4**
  - Add the estimated payment amount to payment amount ($7273.20) to calculate the adjusted threshold amount
    - $5581.54 + $7273.20 = $12854.74

Outlier Payment Example (con't)

- If estimated costs exceed the adjusted threshold amount ($12854.74), then the case will qualify for an outlier payment
  - Assume the IPF in this example
    - Reports charges of $21000.00 and
    - Has a cost-to-charge ratio of 0.8,
      - Then the estimated cost of the case is $16800.00

Outlier Payment Example (con't)

- Step 1
  - Calculate the difference between the estimated cost and the adjusted threshold amount

    $16800 - $12854.74 = $3945.26
- Step 2
  - Divide by the length of stay (in this example, 10 days)

    $3945.26 / 10 = $394.53

Outlier Payment Example (con't)

- Step 3
  - For days one through nine of the stay, the IPF receives 80% of this difference
    - $394.53 X 0.80 = $315.62
    - $315.62 X 9 days = $2840.58
    - $394.53 X 0.60 = $236.72 (in the example, the patient stays for 10 days, so the IPF receives the $236.72 for day 10 only)
- Total outlier payment is $3077.30
  = $2840.58 + $236.72 = $3077.30

Stop-Loss Policy

- 3-Year Transition Period Only
- 70% Of TEFRA Payments
- Calculated At Cost Report Settlement

Stop-Loss Example

- **Payment Example (1)**

1. TEFRA payments for cost reporting year
   $250,000.00
2. PPS payments for cost reporting year
   $275,000.00
3. Line 1 x .70
   $175,000.00
4. If line 3 is greater than line 2, then subtract line 2 from line 3. Otherwise, enter “0”.
   $0.00 → **Did not qualify**

Stop-Loss Example

- **Payment Example (1 – con't)**

5. PPS payments (line 2 + line 4)
   $275,000.00
6. TEFRA portion (line 1 x .75)
   $187,500.00
7. PPS portion (line 5 x. 25)
   $68,750.00
8. IPF aggregate payments for cost report year (line 6 + line 7)
   $256,250.00

Stop-Loss Example

- **Payment Example (2)**

1. TEFRA payments for cost reporting year
   $250,000.00
2. PPS payments for cost reporting year
   $100,000.00
3. Line 1 x .70
   $175,000.00
4. If line 3 is greater than line 2, then subtract line 2 from line 3.
   $75,000.00 → **Did qualify**

   Otherwise, enter “0”.

Stop-Loss Example

- **Payment Example (2 – con't)**

5. PPS payments (line 2 + line 4)
   $175,000.00
6. TEFRA portion (line 1 x .75)
   $187,500.00
7. PPS portion (line 5 x. 25)
   $43,750.00
8. IPF aggregate payments for cost report year (line 6 + line 7)
   $231,250.00

Increased this number by $75,000

Cost-to-Charge Ratio

- **Methodology**
  - Latest settled cost report or tentatively settled cost report
    - Total Medicare Charges
      - Sum of inpatient routine charges
      - Sum of inpatient ancillary charges including capital
    - Total Medicare Costs
      - 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

Cost-To-Charge Ratio (con't)

- **Methodology (con't)**
  - **Based on current Medicare cost reports and worksheets, these are the specific FI instructions:**
    - For freestanding IPFs,
      - Medicare charges will be obtained from worksheet D-4, column 2, lines 25 through 30, plus line 103 from the cost report.
      - Total Medicare costs will be 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.

Cost-To-Charge Ratio (con't)

- **Methodology (con't)**
  - For IPFs that are distinct part psychiatric units:
    - Total Medicare inpatient routine changes are obtained from the PS&R report associated with the latest settled cost report.
    - If PS&R data is not available:
      - Medicare routine charges are estimated by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6
      - Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges

Cost-To-Charge Ratio (con't)

- **Methodology (con't)**
  - For IPFs that are distinct part psychiatric units:
    - To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101)
      - All references to Worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit that is the letter "S" or "M" in the third position of the Medicare provider number.
    - Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

Cost-To-Charge Ratio (con't)

- **Methodology (con't)**
  - **IPFs dissatisfied with its cost-to-charge ratio**
    - Use applicable appeal rights

Periodic Interim Payments (PIPs)

- **PIP payments will continue under IPF PPS for providers that qualify**
  - Outlier payments
    - Paid on a discharge or benefits exhausted claim and not in the PIP amount
  - ECT payments
    - Paid on a discharge or benefits exhausted claim and not in the PIP amount

IPF PRICER

- **Calculates Medicare Payment**
- **Incorporates Phase-In Period Info**
- **Required Inputs For FIs**
  - Provider specific file data

Future Updates

- **July 1, 2006, First Update**
  - Annual update cycle-12 months
  - The Federal per diem base rate will include updates using
    - Excluded hospital with capital market basket
    - Hospital wage index
    - Fixed dollar loss threshold amount
    - ECT amount
- **July 1, 2008, First Payment Update**

Q/A Session

IPF PPS Billing

IPF PPS Billing Considerations

IPF PPS Billing

- **Participants Will Learn The Following Information During The Course Of This Chapter:**
  - IPF PPS billing schedule
  - Claims processing issues
  - Billing requirements
  - Interrupted stay policy
  - Code first issues

Billing Transition to IPF PPS

- **Effective January 1st**
  - If IPF X's cost report period ends January 31, 2005, it would use PPS billing guidelines on February 1, 2005
- **IPFs Use PPS Billing Guidelines**
  - FIs will use these guidelines to accurately price and pay claims

Billing Transition to IPF PPS (con't)

- **PPS Payment And Billing Rules**
  - **Apply For Patient Stays Beginning Prior To And Ending On Or After An IPF's FY Start**
    - An IPF that did not submit any interim bills for a patient prior to the IPF PPS implementation
      - Submit one bill using the PPS coding guidelines
    - An IPF that submitted only one interim bill to Medicare for a patient
      - Submit a 117 type of bill
    - An IPF that submitted multiple interim bills
      - Submit 118 cancellation claims for all paid interim bills
      - Afterward, submit one claim from admission through discharge using the IPF PPS coding guidelines
    - If the beneficiary's benefits were exhausted or is in a non-covered level of care
      - Submit no-pay bills (TOB 110) to Medicare

FISS Delay In Implementing Software

- **Not Updated Until April 4, 2005**
  - IPF claims submitted between January 1st and April 4th will be processed under TEFRA methodology
    - Mass adjustments should be completed by July 1, 2005
    - Only affects IPFs that transition during this time

Billing Instructions

- Billing Requirements
- UB-92 (or CMS-1450)
  - Or Electronic Equivalent (ANSI X-12 837I)
- Pre-Admission Services

Billing Instructions (con't)

- **Form Locator (FL) 4 Type of Bill**
  - 11X
  - Claim submission requirements
    - One admit through discharge claim
    - After the IPF's PPS begin date:
      - No split billing
      - Adjustment bills
        - No late charges

Billing Instructions (con't)

- **FL 7**
  - Covered days
- **FL 8**
  - Noncovered days

Billing Instructions (con't)

- **FL 9**
  - Coinsurance days
- **FL 10**
  - Lifetime reserve days

Billing Instructions (con't)

- **FL 14**
  - Patient birth date
- **FL 20**
  - Source of admission
- **FL 22**
  - Patient status

Billing Instructions (con't)

- **FL 24-30**
  - **Condition codes**
    - Example
      - Adjustment reason codes
        - D3
        - D4
        - D6
      - Condition code 67
- **FL 32-35**
  - **Occurrence codes and dates**
    - Example
      - Occurrence code 31

Billing Instructions (con't)

- **FL 36 Occurrence Span Codes And Dates**
  - **Span code 74**
    - Interrupted stay
    - Readmission to any IPF within three consecutive days
    - Case considered continuous
      - Variable per diem
      - Outlier

Billing Instructions (con't)

- **Span code 74 (con't)**

  Example: Interrupted Stay

  - Patient leaves IPF January 1 and returns to any IPF January 3
    - Considered an interrupted stay
    - Occurrence span code 74 will show January 1-2

  - If patient left IPF A on January 1 and was admitted to IPF B on January 3 and IPF B didn't know
    - Two bills allowed
    - If FIs note a trend, review as appropriate

IPF Name Address Telephone Number	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL 111

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/17/05	01/31/05	11	2			

The non-covered days must match the days listed with Rev code 0180.

12 PATIENT NAME	13 PATIENT ADDRESS
Medicare Beneficiary's Name	123 XXX, City, State Zip Code

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITIO 24	25	26	27
05111930	M		01/17/05	13	1	1		01					

32 OCCURRENCE CODE	DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								74	01/20/05	01/21/05	A
											B
											C

Report occurrence span code 74 and the leave of absence days.

A patient leaves an IPF on Jan. 20 and returns to the IPF on Jan. 22. This is an interrupted stay, so the IPF should report Jan. 20–Jan. 21 with the occurrence span code 74.

38	39 VALUE CODE	CODE	AMOUNT	40 VALU	CODE	AMOUNT
		A1	912.00			

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0124	Room & Board – Semiprivate Psych Room	1500.00		12	18000	00		
0180	Leave of Absence Days			2				
0250	Pharmacy			186	1121	39		
0300	Laboratory Tests			3	21	09		
0301	Chemistry			4	58	37		
0324	Chest X-ray			1	115	00		
0001	Total Charges			208	19315	85		

Report Rev code 0180 and the number of days associated with the leave of absence.

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	xx-4001	Y	Y			

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Medicare Beneficiary's Name	01	Beneficiary's Medicare Number		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
30390	3004	4019	4659						30390		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID DOCTOR'S NAME AND UPIN

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS	OTHER PHY
INTERRUPTED STAY CLAIM EXAMPLE	

85 PROVIDER REPRESENTATIVE	86 DATE
x	

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

Billing Instructions (con't)

- **FL 39-41 Value Codes**
  - Value code 17
    - Outliers
- **FL 42-49**
  - Revenue codes, descriptions, and charges
    - Accommodation charges
      - Rev code 0100

Billing Instructions (con't)

- **FL 42-49**
  - Revenue codes, descriptions, and charges
    - Ancillary charges
      - Definition
      - Part A
      - Part B

IPF Name Address Telephone Number	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			111

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/17/05	01/31/05	14				

12 PATIENT NAME	13 PATIENT ADDRESS
Medicare Beneficiary's Name	123 XXX, City, State Zip Code

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05111930	M		01/17/05	13	1	1		01									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

Report room & board accommodations

38	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	AI	912.00				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0124	Room & Board – Semiprivate Psych Room	1500.00		14	21000	00		
0250	Pharmacy			186	1121	39		
0300	Laboratory Tests			3	21	09		
0301	Chemistry			4	58	37		
0324	Chest X-ray			1	115	00		
0001	Total Charges					85		

List ancillary services on the claim.

50 PAYER	51 PRC	. AMOUNT	56
Medicare			

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Medicare Beneficiary's Name	01	Beneficiary's Medicare Number		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
30390	3004	4019	4659						30390		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID DOCTOR'S NAME AND UPIN
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

84 REMARKS

LIST OF ANCILLARY SERVICES

OTHER PHY

85 PROVIDER REPRESENTATIVE	86 DATE
X	

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

UB-92 HCFA-1450

Billing Instructions (con't)

- **FL 42-49**
  - Revenue codes, descriptions, and charges
    - ECT treatments
      - Revenue code 0901

Billing Instructions (con't)

- **FL 51**
  - Psychiatric Hospital
    - xx-4000 – xx-4499
  - IPFs as Distinct Units in Acute Care Hospitals
    - xx-S001 – xx-S999
  - In CAHs
    - xx-M300 – xx-M399

Billing Instructions (con't)

- **FL 67-75 Diagnoses Codes**
  - FL 67
    - Principal diagnosis
  - FL 68 -75
    - Secondary diagnoses

Billing Instructions (con't)

- **FL 67**
  - Principal diagnosis
    - DRGs
      - IPPS Grouper
        - IPF GROUPER for FY 2005 is Version 22
      - "Code first" situations

Billing Instructions (con't)

- **"Code First" Example**
  - If a patient is diagnosed with 333.4 as the primary diagnosis and 294.10 as the secondary diagnosis
    - The system will:
      - Identify the primary diagnosis code as non-psychiatric
      - Search the secondary codes for a psychiatric code to assign a DRG code for adjustment

IPF Name Address Telephone Number	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			111

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/17/05	01/31/05	14				

12 PATIENT NAME	13 PATIENT ADDRESS
Medicare Beneficiary's Name	123 XXX, City, State Zip Code

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05111930	M		01/17/05	13	1	1		01									

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A
											B
											C

38

	39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A1	912.00				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0124	Room & Board – Semiprivate Psych Room	1500.00		14	21000	00		
0250	Pharmacy			186	1121	39		
0300	Laboratory Tests			3	21	09		
0301	Chemistry			4	58	37		
0324	Chest X-ray			1	115	00		
0001	Total Charges			208	22315	85		

For example, suppose a patient is assigned a primary diagnosis of 333.4, *Huntington's chorea*, and a secondary diagnosis of 294.10, "*Dementia in conditions classified elsewhere.*"

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	xx-4001	Y	Y			

57 *DUE FROM PATIENT*

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Medicare Beneficiary's Name	01	Beneficiary's Medicare Number		

63 C… R NAME

The GROUPER will assign the submitted claim's appropriate DRG.

PRICER will continue to search the secondary codes for those that are appropriate for comorbidity adjustments.

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
3334	29410	4019	4659						3334		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID DOCTOR'S NAME AND UPIN

OTHER PROC CODE

Then, if the assigned DRG is not one of the 15 DRGs for which an adjustment is paid, PRICER would search the secondary code for a psychiatric diagnosis to assign a DRG adjustment.

83 OTHER PHYS. ID

OTHER PHY

84 REMARKS

85 PROVIDER REPRESENTATIVE X

86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

Billing Instructions (con't)

- **FL 80-81**
  - FL 80 principal procedure code
  - FL 81 other procedure codes
    - ECT treatments
      - 94.27
    - "Oncology treatment" comorbidity
      - Radiation Therapy
        - 92.21 – 92.29
      - Chemotherapy
        - 99.25

IPF Name Address Telephone Number	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			111

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	01/17/05	01/31/05	14				

12 PATIENT NAME	13 PATIENT ADDRESS
Medicare Beneficiary's Name	123 XXX, City, State Zip Code

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05111930	M		01/17/05	13	1	1		01									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

38		39 VALUE CODE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a	A1	912.00				
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0124	Room & Board – Semiprivate Psych Room	1500.00		14	21000 00		
0250	Pharmacy			186	1121 39		
0300	Laboratory Tests			3	21 09		
0301	Chemistry			4	58 37		
0901	Electroconvulsive Therapy			2	800 00		
0001	Total Charges			208	23000 85		

IPFs should include revenue code 0901 in FL 42. Record the total number of ECT treatments provided to the patient in FL 46 listed as "service units."

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
Medicare	xx-4001	Y	Y			

57	DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Medicare Beneficiary's Name	01	Beneficiary's Medicare Number		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
2952	2962	3062	4019						2952		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PRO CODE
	94.27	01/25/04	
	OTHER PROCEDURE CODE	DATE	OTHER PROCE CODE

Code the ICD-9-CM procedure code 94.27 in the procedure code field. For the required procedure date, use the date for the last ECT treatment provided to the patient during their stay.

84 REMARKS

ECT CLAIM EXAMPLE

OTHER PHY

85 PROVIDER REPRESENTATIVE

86 DATE

X

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

UB-92 HCFA-1450

FI Actions

- **Read**
  - November 15, 2004 Final Rule
  - Read Change Requests
    - 3541
    - 3678
    - 3572
  - Training Guide
- **Examine**
  - Content on CMS website
  - PowerPoint slides
- **Apply**
  - Create and populate provider-specific file
  - Educate IPFs prior to PPS implementation
- **Prepare**
  - Systems testing
  - April 2005 release
  - Claim adjustments

Q/A Session