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Updates to the Inpatient Psychiatric Facility Benefit Policy Manual

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PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Inpatient Psychiatric Facilities (IPFs) providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11062 updates the language in the Medicare Benefit Policy Manual, Chapter 2, to add language from existing IPF regulations, to make technical corrections, or to clarify existing manual language. This CR also reflects changes to IPF regulations that were made in the Fiscal Year (FY) 2019 IPF Prospective Payment System (PPS) and Quality Reporting Updates final rule.

The changes made in the FY 2019 IPF PPS and Quality Reporting Updates final rule include changes to regulatory text at 42 Code of Federal Regulations (CFR) 412.27 to update language from International Classification of Diseases, 9th version, Clinical Modification (ICD-9-CM) to ICD-10-CM, and to note that the ICD-10-CM is the source for the principal psychiatric diagnosis.

BACKGROUND

IPFs include freestanding psychiatric hospitals, and certified psychiatric units in acute care hospitals or critical access hospitals. IPFs provide routine hospital services and psychiatric services for the diagnosis and treatment of mentally ill persons. Section 1812(b)(3) of the Social Security Act ("the Act") imposes a 190-day lifetime limit for care in freestanding psychiatric hospitals, but this limit does not apply to certified psychiatric units.

Section 124 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) required implementation of a per diem PPS for IPFs. The IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, and is comprised of a Federal per diem base rate that covers nearly all labor and non-labor costs of furnishing covered inpatient psychiatric services, including routine,

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ancillary and capital costs. The per diem base rate is then adjusted to account for differences in resource use based on patient or facility characteristics. In addition, IPFs receive outlier payments for exceptionally high cost patients and a per treatment payment for Electroconvulsive Therapy (ECT).

IPFs must also meet requirements related to admission, medical records, personnel, psychological services, social services, and therapeutic activities.

CR11062 revises the Medicare Benefit Policy Manual Chapter 2 as follows:

- Adds language from existing IPF benefit policy regulations
- Makes technical corrections
- Clarifies language or provides a reference to the supporting regulation
- Updates language as a result of regulation changes made in the FY 2019 IPF PPS and Quality Reporting Updates final rule.

The changes made in FY 2019 IPF PPS rulemaking include updating regulation language at 42 Code of Federal Regulations (CFR) 412.27 to replace references to the International Classification of Diseases, 9th version, Clinical Modification (ICD-9-CM) with references to the International Classification of Diseases, 10th version, Clinical Modification (ICD-10-CM). In addition, the regulation change to 42 CFR 412.27 requires that the psychiatric principal diagnosis for IPF patients be found in the ICD-10-CM.

None of the updates to the IPF Benefit Policy manual constitutes a change from existing policy. All changes to the IPF benefit policy manual are simply updates to the manual language to keep it current and to provide more information to IPFs about existing requirements. The key changes are as follows:

Section 10.1 - This section is revised to specify the requirements that IPFs must meet as specified in 42 CFR 412.23(a) and 42 CFR 412.27.

Section 10.4 - This section is added to provide conditions for payment under the IPF PPS, as specified in 42 CFR 412.404, including the general criteria IPFs must meet to be subject to the IPF PPS, limitations on charges to beneficiaries, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

If an IPF fails to comply fully with these conditions, CMS may, as appropriate, withhold (in full or in part) or reduce Medicare payment to the IPF until the facility provides adequate assurances of compliance, or CMS may classify the IPF as an inpatient hospital that is subject to the requirements for hospitals and paid under the hospital Inpatient Prospective Payment System.

Section 20 - This section is modified to clarify admissions requirements to emphasize that the reasons for admission must be documented clearly as stated by the patient and/or others significantly involved.

Section 30.2 - This section is revised to provide certification and recertification requirements. Medicare Part A pays for inpatient services in an inpatient psychiatric facility only if a physician

certifies and recertifies the need for services. The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required. The provider may adopt any method that permits verification of all the IPFs requirements to continue treatment. The certification period begins with the order for inpatient admission. The certification is required at the time of admission or as soon after that is reasonable and practicable.

ADDITIONAL INFORMATION

The official instruction, CR11062, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R253BP.pdf.
The complete manual revision is attached to the CR.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 14, 2018	Initial article released.