

Psychiatric Hospital PPS

The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) covers inpatient psychiatric services that are furnished in specialized hospitals, psychiatric distinct part or exempt units located in hospitals, and beds located in acute care hospitals that are in a separately certified exempt unit. Prior to 2005, psychiatric services in these hospitals and units were reimbursed for “reasonable costs” of providing service to Medicare beneficiaries, subject to a limit on allowable costs. This cost system was governed by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.

A Federal per diem base rate was established to be paid to all IPFs based on the sum of the national average routine operating, ancillary, and capital costs for each patient day of psychiatric care. This base rate is used as the standard payment per day under the IPF PPS, adjusted by the applicable wage index factor, patient-level and facility-level adjustments applicable to the IPF stay. The IPF PPS bases payments on a national per diem rate with wage index and teaching adjustments and an add-on for rural facilities. The payment for an individual patient is further adjusted for factors such as the Diagnosis Related Group (DRG) classification, age, length of stay, and the presence of specified comorbidities¹. Additional payments are provided for cost outlier cases and Electroconvulsive Therapy (ECT) treatments. This is the first update since the implementation of the IPF PPS in January 2005 and will be effective for discharges occurring on or after July 1, 2006.

The Centers for Medicare and Medicaid Services (CMS) published a proposed rule to implement the Inpatient Psychiatric Facilities Prospective Payment System in January 2006 (71 FR 3616). On February 24, 2006 a correction notice appeared in the Federal Register (71 FR 9505) to correct technical errors in the proposed rule and to extend the comment period for the policy concerning electroconvulsive therapy. CMS published final regulations for the Medicare IPF PPS in the May 9 Federal Registrar. Changes are effective for discharges beginning on or after July 1, 2006. The rule provides updates to the PPS for Medicare payment of inpatient services furnished in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and Critical Access Hospitals (CAH).

A three-year transition period began in FY 2005 to help relieve those facilities that may experience a financial hardship under the new IPF PPS as opposed to payments made under TEFRA. No updates on the stop-loss provision or the transition period will be implemented in RY 2007. Therefore, because this is year two of the transition period, discharges occurring during IPF cost reporting periods beginning in calendar year (CY) 2006 receive a blended payment amount of 50 percent TEFRA payments and 50 percent IPF PPS payments. There would also be a stop-loss payment if the IPF PPS portion of the payment is no less than 70 percent of its TEFRA payment, had the IPF PPS not been implemented. As a result, the combined effects of the transition and the stop-loss provision will ensure that the total IPF PPS payments are no less than 85 percent of TEFRA payments in FY 2006.

Transition Year	Cost-Based % (TEFRA)	PPS %	Stop-Loss %
1 (FY 2005)	75%	25%	92.5%
2 (FY 2006)	50%	50%	85%
3 (FY 2007)	25%	75%	77.5%
4 (FY 2008)	0%	100%	0%

¹ Comorbidities are specific patient conditions that are secondary to the patient’s primary diagnosis, and that require treatment during the stay. 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 LOS. The intent of the comorbidity adjustment was to recognize the increased cost associated with comorbid conditions by providing additional payments for certain concurrent medical or psychiatric conditions that are expensive to treat. Source: CMS-1306-F Pg. 92

Market Basket Update

Market basket updates are used to reflect price changes in the mix of goods and services that hospitals purchase in order to furnish patient care. In the past, CMS has been unable to create a separate market basket index specific to the IPF PPS. Because of this, the excluded hospital with capital market basket was originally used in the development of the IPF PPS. However, included in the RY 2007 final rule is the adoption of the rehabilitation, psychiatric and long-term care (RPL) market basket, which has been rebased to 2002 Medicare cost report data. The RPL method reflects operating and capital cost structures for inpatient rehabilitation facilities, IPFs, and long-term care facilities.

Base Rate

The Federal per diem base rate is calculated to provide reimbursement for the average daily cost of inpatient psychiatric care. When the methodology used to simulate the IPF PPS payments used for the November 2004 IPF PPS final rule was examined, CMS discovered that the computer code incorrectly assigned non-teaching status to the majority of teaching facilities. As a result, the total IPF PPS payments were underestimated by approximately 1.36 percent.

The standardization factor represents the amount by which the IPF PPS per diem payment rate and the ECT rate must be reduced in order to make total IPF PPS payments equal to the estimated total TEFRA payments. This assumes that IPFs continue to be paid solely under TEFRA for the first PPS payment year. Because the IPF PPS payment amount for each IPF includes applicable outlier amounts, the standardized Federal per diem base rate was reduced to account for aggregate IPF PPS payments estimated to be made as outlier payments. The outlier adjustment was calculated to be 2 percent, which reduced the standardized Federal per diem base rate by 2 percent to account for projected outlier payments. The standardization factor is calculated as the ratio of estimated total TEFRA payments to estimated total IPF PPS payment rates. Since the IPF PPS payment total should have been larger than the estimated figure, the standardization factor should have been smaller (0.8254 vs. 0.8367). In turn, the Federal per diem base rate and the ECT rate should have been reduced by 0.8254 rather than 0.8367.

In the RY 2007 final rule, CMS amends the Federal per diem base rate and the ECT payment rate prospectively. Using the standardization factor of 0.8254, the base rate should have been \$568.17 for the implementation year of the IPF PPS. It is this base rate that is updated using the increased market basket rate of 4.3 percent and the budget-neutral wage index factor of 1.0042. Applying these factors yields a Federal per diem base rate of \$595.09 for the RY beginning July 1, 2006 through June 30, 2007.

Wage Index

The IPF PPS adjusts the labor-related portion of the per diem base rate for differences in area wage levels. Labor costs are adjusted using the federal fiscal year (FFY) 2006 pre-reclassified inpatient acute care hospital wage indices on the assumption that inpatient acute care data reflect similar wage levels to psychiatric units and freestanding psychiatric hospitals. Hospitals that are geographically reclassified for inpatient acute payment do not receive the reclassified wage index for IPF payment and there is no provision for a rural floor.

As set forth in the RY 2007 final rule, no transition period or hold-harmless provision for purposes of the IPF PPS wage index will be implemented. Final wage indices for Massachusetts Core Based Statistical Areas (CBSA) are as follows²:

² These are the pre-reclass 2006 inpatient PPS AWIs with no rural floor application. For rural Massachusetts CMS is using last year's data.

CBSA	Name	Counties	Wage Index
22	Rural MA	Rural MA	1.0216
12700	Barnstable	Barnstable County	1.2600
14484	Boston-Quincy	Norfolk, Plymouth, Suffolk	1.1558
21604	Essex	Essex	1.0538
15764	Cambridge-Newton-Framingham	Middlesex	1.1172
49340	Worcester	Worcester County	1.1028
39300	Providence-New Bedford-Fall River	Bristol County	1.0966
38340	Pittsfield	Berkshire	1.0181
44140	Springfield	Franklin, Hamden, Hampshire	1.0248

Additionally, based on the relative weights from the RPL market basket, CMS increased the labor-related share of the rate for IPF PPS to 75.665 percent with a non-labor related share of 24.335 percent.

Patient-Level Adjustments

CMS provides adjustments to the per diem base rate for patient characteristics based on each patient's age, case-mix (DRG), and for specified comorbid conditions. In the final rule for RY 2007, no changes have been implemented to any of the patient-level adjustment factors until one year of IPF claims data are available to analyze. An analysis done previously determined that the per diem costs rise as the patient's age increases. Therefore, the age adjustment factor is determinant upon the patient's age at time of admission, not at time of discharge. CMS will continue to use the current age group adjustment factors for RY 2007.

Age at Admission (yrs.)	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

Although the mental health community uses the Diagnostic and Statistical Manual of Mental Disorders (DSM) for diagnostic patient assessment, they are required to report the ICD-9-CM code on the medical claim. All DRGs that contain a psychiatric ICD-9-CM code will be paid under the IPF PPS system, however, only the 15 specifically designated psychiatric DRGs have unique adjustment factors applicable to the per diem.

DRG Code	DRG Definition	Adjustment Factor
DRG 12	Degenerative nervous system disorders	1.05
DRG 23	Non-traumatic stupor & coma	1.07
DRG 424	Procedure with principal diagnosis of mental illness	1.22
DRG 425	Acute adjustment reaction	1.05
DRG 426	Depressive neurosis	0.99
DRG 427	Neurosis, except depressive	1.02
DRG 428	Disorders of personality	1.02
DRG 429	Organic disturbances	1.03
DRG 430	Psychosis	1.00
DRG 431	Childhood disorders	0.99
DRG 432	Other mental disorders	0.92
DRG 433	Alcohol/Drug use Leave against Medical Advice (LAMA)	0.97
DRG 521	Alcohol/Drug use with comorbid conditions	1.02
DRG 522	Alcohol/Drug use without comorbid conditions	0.98
DRG 523	Alcohol/Drug use without rehabilitation	0.88

The following table lists the new 2006 ICD-9-CM codes that are eligible to receive a DRG adjustment under IPF PPS in RY 2007.

Diagnosis Code	DRG Definition	DRG
291.82	Alcohol induced sleep disorders	521,522,523
292.85	Drug induces sleep disorders	521,522,523
327.00	Organic insomnia, unspecified	432
327.01	Insomnia due to medical condition classified elsewhere	432
327.02	Insomnia due to mental disorder	432
327.09	Other organic insomnia	432
327.10	Organic hypersomnia with long sleep time	432
327.11	Idiopathic hypersomnia with long sleep time	432
327.12	Idiopathic hypersomnia without long sleep time	432
327.13	Recurrent hypersomnia	432
327.14	Hypersomnia due to medical condition classified elsewhere	432
327.15	Hypersomnia due to mental disorder	432
327.19	Other organic hypersomnia	432

Included in the RY 2007 final rule are subcategories for patient diagnosis, called comorbidities. Comorbidities are ICD-9-CM codes assigned to specific patient conditions that are secondary to the patient's primary diagnosis, and require treatment during the stay. In order to receive any additional comorbidity adjustments, the condition must co-exist at time of admission or develop subsequently, thus impacting the patient's length of stay. A patient may be diagnosed with more than one comorbidity, but only one per the 17-comorbid categories will be used in the determination of reimbursement. All comorbid treatments must be accurately documented throughout the patient stay.

Psychiatric patients with comorbid conditions are generally more costly on a per diem basis. For RY 2007, CMS will continue to apply the following 17 comorbid condition adjustment factors to the per diem base rate. However, CMS has added some new ICD-9-CM codes and removed one code that was no longer applicable for the comorbidity adjustment.

Comorbidity Category	ICD-9-CM	Adjustment Factor
Developmental Disabilities	317, 318.0, 318.1, 318.2, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheotomy	51900 through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 6363, 6373, 6383, 6393, 66932, 66934, 9585,	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 585, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH either 99.21-99.29 OR 99.25	1.07
Uncontrolled Type I Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Atherosclerosis of Extremity with Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	V4611 or V4612	1.12
Artificial Openings – Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Facility-Level Adjustments

In the 2007 final rule, no changes to the facility-level adjustments were implemented until one year of IPF cost claims data and cost report data are available to analyze. Any facility-level adjustments will remain based on CMS' prior regression analysis. CMS states in the final rule for RY 2007 that they are finalizing the proposal to adopt the CBSA labor market area definitions without a transition, without a hold-harmless policy, and without an out-commuting or out-migration adjustment.

Teaching Adjustment

The teaching adjustment is intended to account for the higher indirect operating costs associated with psychiatric teaching facilities. Psychiatric teaching hospitals paid under TEFRA did not receive separate medical education payments, since payments were based on the hospitals' reasonable costs. Therefore, these higher costs would have been paid automatically through a hospital's TEFRA payment. However, since psychiatric teaching hospitals are now paid under the PPS, those higher costs needed to be incorporated in the hospital's IPF PPS payment. The teaching adjustment is made on a claim basis as an interim payment, and the final "full" payment is made during the final settlement of the cost report.

To limit the incentives for IPFs to add full time equivalents (FTEs), a cap was imposed on the number of psychiatric residents which was similar to the cap that limits increases in residents under the Inpatient PPS. For purposes of determining the teaching adjustment under the IPF PPS, the number of residents cannot exceed the number of residents in the hospital's base year.

In the 2007 final rule, CMS will continue the teaching adjustment at the current level. Thus, IPFs that are, or part of, teaching institutions will receive a payment adjustment comparable to IME payments made under IPPS. Based on a ratio of FTE Interns & Residents (I&R) assigned to the psych unit or hospital to the IPFs average daily census (ADC), the ratio will be adjusted to yield an add-on adjustment factor (Formula: $((1 + (I\&R/ADC)) ^ .5150)$).

Rural Location Adjustment

Because CMS is not implementing any changes to the rural location adjustment in the 2007 final rule, facilities will continue to receive a 17 percent payment adjustment, as a result of higher per diem costs typically associated with IPFs in these areas. Those facilities that were classified as urban under the old labor market definitions but are now considered rural under the new definitions will qualify for this adjustment for discharges occurring on or after July 1, 2006. However, facilities once designed as rural but are now considered urban will lose this adjustment as of July 1, 2006.

Emergency Department Adjustment

A facility-specific adjustment to the federal per diem base rate is provided to account for the costs associated with maintaining a full-service Emergency Department (ED). In addition, a facility-level adjustment is provided for psychiatric hospitals, acute care hospitals with a distinct part psychiatric unit and CAHs with a distinct part psychiatric unit that maintain qualifying EDs. IPFs with qualifying EDs receive a higher variable per diem adjustment for the first day of each stay.

As set forth in the 2007 final rule, IPF providers with qualifying EDs will continue to receive a variable per diem adjustment of 1.31 for the first day of a stay instead of 1.19. When the IPF PPS was first implemented, CMS instructed all hospitals or CAHs with qualifying EDs to submit a letter or verification

to their fiscal intermediary to be eligible for the qualifying rate. However, explained in the 2007 final rule, is that the letter was a one-time verification which does not need to be repeated each year.

In the past, in order to ensure that the ED adjustment is not paid for patients who are discharged from a CAH or an acute care hospital and admitted to the same CAH's/ hospital's psychiatric unit, IPFs were directed to enter source of admission code "4" (transfers from hospital inpatient) on those claims. However, as the IPF PPS was implemented, it became evident the admission code "4" was too broad to distinguish these claims, as it reflects transfers from any acute care hospital or CAH. Currently, where admission code "4" is entered on a claim, the ED adjustment is not paid, even if the patient is transferred from a different acute hospital or CAH. Included in the 2007 final rule was the new source of admission code "D" which became effective April 1, 2006. IPFs are required to use this new admission code to identify IPF patients who have been transferred to the IPF from the same hospital or CAH.

Variable per Diem Adjustments

The variable per diem adjustment recognizes the higher cost of psychiatric stays earlier on in the treatment period. As a result, once the per diem has been adjusted for appropriate patient and facility-level adjustments, the variable per diem is applied for that day of the patient's stay in the IPF. In the 2007 final rule, the variable per diem adjustment factors from the previous year will continue to be used. .

Day-of-Stay	Adjustment Factor
Day 1-- Facility Without a 24/7 Full-service Emergency Department	1.19
Day 1-- Facility with a 24/7 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
After Day 21	0.92

Other Adjustments & Policies ~ Outlier Payments

Outlier payments are provided when the estimated cost of the patient's entire stay exceeds the outlier threshold amount³. The costs that exceed the outlier threshold are adjusted by the loss sharing ratio. The outlier calculation requires that the charges for a patient stay be converted to cost using the facility's cost-to-charge ratio (CCR). The CCR is used from the latter of the most recently settled (or tentatively settled) Medicare IPF cost report. Additionally, a ceiling is applied in determining a facility's CCR that is based on three times the standard deviation for the urban and rural IPF CCR.

³ Defined as the total IPF PPS payment for the stay plus the fixed-dollar loss threshold amount.

In the 2007 final rule, the fixed-dollar loss amount will increase from \$5,700 to \$6,200, which will be adjusted by the IPF's facility adjustments (rural location, teaching status, and wage). The current loss sharing ratios will continue to be used, therefore, the outlier payment adjustment for days one through nine of the stay is 80 percent. For days ten and thereafter, the adjustment would be 60 percent. Total outlier payments are expected to equal 2 percent of the total IPF PPS payments.

Furthermore, the national urban and rural CCRs (median and ceilings) for IPFs will be updated annually based on the previous full calendar year provider specific file, and will be published each year in the Federal Registrar. For the rate year 2007, these updates will be based on the full CY 2005 CCRs entered in the provider specific file. The new national urban and rural CCRs will be applied to the following situations:

1. New IPFs that have not yet submitted their first Medicare cost report;
2. IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (the ceiling);
3. Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

Electroconvulsive Therapy Adjustment

Facilities that furnish electroconvulsive therapy (ECT) treatments for their patients during an IPF stay can add significant costs to that stay; approximately twice as expensive as the case without ECT due primarily to the length of stay. To receive this additional IPF payment, facilities are instructed to indicate revenue code 901 and include ICD-9-CM procedure code 94.27 on their claims with the total number of ECT treatments provided.

In the 2007 final rule, the ECT payment rate is \$256.20. The ECT rate is finalized using the CY 2005 ECT rate as a base, updated by the market basket increase each rate year, and adjusted by the wage index.

Same Day Transfers

Currently, when a transfer, discharge, or death occurs on the same day as an admission to an IPF, the IPF PPS PRICER does not recognize any covered IPF days, meaning the IPF claims are suspended. Studies show that many patients in this situation are seen first in the Emergency Department, later admitted to an IPF, and then finally determined that acute care was needed. IPF stays are subject to the 190-day lifetime limit on inpatient psychiatric care, therefore it is crucial to distinguish which days can be counted. When a patient is admitted and then transferred from one participating provider to another before midnight of the same day, a day (except for utilization purposes) is counted at both providers. A day of Medicare utilization is charged only for the admission to the second provider. Therefore, the transferring IPF provider does not count this day against a beneficiary's lifetime psychiatric limit. Before implementing a new policy for same-day transfers, CMS plans on continuing to analyze the IPF PPS data in RY 2007.

Recertification Requirements

Currently, payment for inpatient psychiatric care is made only if a physician certifies and recertifies on the 18th day following admission. In the 2007 final rule, the first recertification is required to be completed by the 12th day of hospitalization. Subsequent recertifications will be required at intervals established by the hospital's UR committee (on a case-by-case basis if desired), but no less frequently than every 30 days. It is believed that this will create consistency among provider types, for purposes of payment under the IPF PPS.