CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 444 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3678

SUBJECT: Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. SUMMARY OF CHANGES: This transmittal clarifies some policy and billing information for IPF PPS.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Cost Reporting periods beginning on or after January 1, 2005

IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: ***N/A***
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 444	Date: January 21, 2005	Change Request 3678

SUBJECT: Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. GENERAL INFORMATION

A. Background: This transmittal clarifies some aspects of IPF PPS. This transmittal does not replace Change Request (CR) 3541, but will clarify recent questions CMS has received from IPFs and the Medicare fiscal intermediaries that service them. Please see CR 3541 for an overview of all of the policy and billing requirements related to IPF PPS. Please also see the November 15, 2004 final rule (69 FR 66922). Please be advised that a Correction Notice is also expected.

B. Policy:

We will be issuing a Correction Notice to the Inpatient Psychiatric Facility Prospective Payment System final rule [69 FR 66922], published November 15, 2004, to make technical corrections which will include the following clarifications:

There is an inconsistency in the labor-related share between portions of the final rule and CR 3541, published December 1, 2004. The current labor-related share is 0.72247.

Teaching Status Adjustment:

> Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the average daily census (ADC) raised to the power of 0.5150. The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to November 15, 2004.

Explanation of how to calculate the Electroconvulsive Therapy (ECT) payment:

> The ECT amount of $247.96 is subject to COLA and wage adjustments. To calculate the adjusted amount, multiply $247.96 by the labor share (0.72247) and by the area wage index. Then multiply $247.96 by the non-labor share (0.27753) and by the applicable COLA. The sum of these two products is the adjusted per-treatment ECT amount.
>
> Multiply the amount by the number of ECT occurrences and add it to the Federal per diem payment to compute the total PPS payment.

The ECT amount itself does not receive any facility or patient level adjustments; it is added to the Federal per diem payment after those adjustments have been applied.

ECT payments and charges are taken into account when calculating the outlier threshold and outlier payment.

Explanation of how to calculate outlier payments:

1. Calculate the Adjusted Fixed Dollar Loss Threshold:

   Threshold amount = $5,700;

   Multiply the threshold amount by the labor share (0.72247) and the area wage index;

   Multiply the threshold amount by the non-labor share (0.27753) and any applicable COLA (Alaska or Hawaii);

   Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural); and,

   Add this amount to the sum of the federal per diem payment and ECT payment to obtain the adjusted threshold amount.

2. Calculate Eligible Outlier Costs:

   Multiply reported hospital charges by the cost-to-charge ratio to calculate cost;

   Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments; and

   Divide this amount by the length of stay to calculate the per diem outlier amount.

   For days 1 through 9, multiply this per diem outlier amount by 0.80. For day 10 and thereafter, multiply the per diem outlier amount by 0.60. The sum of these amounts is the total outlier payment.

The effective date of the IPF prospective payment system is for discharges (or "through dates" for interim bills) occurring during cost reporting periods beginning on or after January 1, 2005.

Although the IPF PPS is effective January 1, 2005, transition is based on a providers' cost reporting year. The IPF providers will begin the new IPF PPS system at the beginning of their new cost reporting period.

For example, if an IPF provider has their cost reporting period starting on October 1, 2005, then October 1, 2005 will be the beginning date of their first transition year and the date that they begin billing under the new IPF PPS system.

If an IPF provider starts their cost reporting period on January 1, 2005, then they will begin billing under the new IPF PPS on January 1, 2005. This will also be the beginning date of their first transition year.

We have received a number of questions concerning what is considered a "new IPF." We will be issuing additional guidance shortly regarding what constitutes a new IPF.

Providers should notify their FIs 30 days prior to their fiscal year begin date, if they believe they are entitled to the ED adjustment, to allow their FI to determine if additional information or documentation is needed. However, for providers whose cost reporting periods begin January 1, 2005 through March 1, 2005, they should contact their FI before February 15, 2005.

Psychiatric units of critical access hospitals (CAH) are reimbursed under the IPF PPS. In CR 3541, dated December 1, 2004, under the heading, "Affected Medicare Providers," the second bulleted paragraph contained an error. The paragraph should read:

> "Veterans Administration Hospitals, hospitals that are reimbursed under State cost control system approved under 42 CFR 403, hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1), and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are not included in the IPF PPS. Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c)."

We will be providing guidance on the National Cost to Charge Ratios which will be established using the most current IPF data available. The file required to calculate the national cost to charge ratios is under development.

Age adjustment is determined as of admission.

Code First Chart (Page 6 of CR 3541). The last row containing code 320.7 should be deleted. We are including a table (Attachment 1), that shows what adjustment factors apply. In addition, we are supplying a new example below because our original example on page 7 of CR 3541 had an error in it:

CODE FIRST EXAMPLE:

Diagnosis code 294.10 "Dementia in Conditions Classified Elsewhere without Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

Four digit code 294.1"Dementia in Conditions Classified Elsewhere," is designated as a "Code first" diagnosis and 3-digit code 294 "Persistent Mental Disorders Due to Conditions Classified Elsewhere" appears in the ICD-9-CM as follows:

294 PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

Code first underlying condition

294.1 Dementia in Conditions Classified Elsewhere

Code first any underlying physical condition, as:

Dementia in:

Alzheimer's disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (33.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0 – 345.9)
Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

294.10 DEMENTIA IN CONDITIONS CLASSIFIED ELSEWHERE WITHOUT BEHAVIORAL DISTURBANCE

NOT ALLOWED AS PRINCIPAL DX

According to "code first" requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's Chorea" as the primary diagnosis code and 294.10 "Dementia In Conditions Classified Elsewhere Without Behavioral Disturbances" as a secondary diagnosis or comorbidity code on the patient claim.

The submitted claim then goes through Pricer which will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code listed in the "Code First" list to assign a DRG adjustment.

- The ICD-9-CM procedure codes for oncology treatments are 92.21 through 92.29 and 99.25.

- Comorbidity chart (Page 7 of CR 3541) is corrected as follows:

Oncology Treatment	1400 – 2399 with a radiation therapy or chemotherapy code 92.21 – 92.29 or 99.25
Chronic Obstructive Pulmonary Disease	V4611 and V4612

- For IPFs that are distinct part psychiatric units, total Medicare inpatient routine charges will be obtained from the PS&R report associated with the latest settled cost report. If

PS&R data is not available, estimate Medicare routine charges 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 the total Medicare charges. 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.

- More information is available at http://www.cms.hhs.gov/providers/ipfpps/

- Payment to Hospitals and Units Excluded from the Acute Inpatient Prospective Payment System (IPPS) for Direct Graduate Medical Education (DGME) and Nursing & Allied Health (N&AH) Education for Medicare Advantage Beneficiaries:

    - Current IPFs are already following the requirements in Transmittal A-03-007, published on February 3, 2003. New IPFs and IPF distinct part units located in a Critical Access Hospital should familiarize themselves with these instructions. There is no authority for IPFs to bill for the indirect medical education as is done under the IPPS.

- Stays Prior to and Discharge After IPF PPS Implementation Date

Cost Report Period begins Prior to April 1, 2005

Until the IPF PPS system changes are in place, IPF providers should continue to follow current billing instructions when patients are in the facility over the fiscal year begin date, i.e., split the bill. Once the changes are implemented, the IPF providers should follow the billing instructions as outlined in CR 3541. These instructions include the criteria for canceling and rebilling if the stay crosses the provider's PPS effective date. For IPF providers, the claims submitted prior to their PPS effective date should only be canceled if the stay contains at least one benefit day applied on or after the PPS effective period. Stays that are benefits exhausted or noncovered prior to the provider's PPF effective date should not be canceled and rebilled as one stay. For patients admitted into the IPF after the PPS effective date, our system will automatically adjust those bills for the IPF.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3678.1	CWF shall disregard requirement 3541.11 in CR 3541.								X	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3678.1	CWF determined during their requirements walkthrough that this requirement was not needed.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Cost Reporting periods beginning on or after January 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Policy-Dorothy Colbert, email dcolbert@cms.hhs.gov; Billing-Cindy Murphy, email cmurphy1@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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ATTACHMENT

CODE FIRST

Chapter 5 Code that has a Code First note.	Adjustment Factor
290.0	1.03
290.10	1.03
290.11	1.03
290.12	1.03
290.13	1.03
290.20	1.03
290.21	1.03
290.3	1.03
290.40	1.03
290.41	1.03
290.42	1.03
290.43	1.03
290.8	1.03
290.9	1.03
293.0	1.05
293.1,	1.05
293.81,	1.03
293.82	1.03
293.83	1.03
293.84	1.03
293.89	1.03
293.9	1.05
294.0	1.03
294.10	1.03
294.11	1.03
307.89	1.02