



WISCONSIN HOSPITAL ASSOCIATION, INC.

**SUMMARY
OF THE
2005 MEDICARE FINAL RULE
FOR THE
INPATIENT PSYCHIATRIC FACILITY
PROSPECTIVE PAYMENT SYSTEM**

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SUMMARY OF THE 2005 MEDICARE FINAL RULE FOR THE INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM

The Centers for Medicare and Medicaid Services (CMS) has published final regulations for the new Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in the November 15 *Federal Register*. The new system takes effect for cost-reporting periods beginning on or after January 1, 2005. This document summarizes the 2005 IRF PPS final rule. For ease of use, November 15, 2004 *Federal Register* page numbers are provided. The final rule is available online at http://www.wha.org/financeAndData/pps_inpatientpsych.aspx.

I. BACKGROUND

The IPF PPS will cover 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. Previously, 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. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 governed this reasonable cost system.

The final IPF PPS will base payments on a federal per diem rate with adjustments for wage index, teaching status, and facilities with full-service emergency departments, with an add-on for rural facilities. The payment for an individual patient will be further adjusted for factors such as the Diagnosis Related Group (DRG) classification, age, length of stay, and the presence of specified comorbidities. Additional payments will be provided for cost outlier cases and electroconvulsive therapy procedures.

The Balanced Budget Act of 1997 replaced many cost-based methods of reimbursement with prospective payment systems, including for rehabilitation hospitals and units, long-term care hospitals, and psychiatric hospitals and units. The Balanced Budget Refinement Act of 1999 mandated the development of a per diem PPS for Medicare inpatient psychiatric services provided in psychiatric hospitals or psychiatric distinct part units. The IPF PPS was to be implemented for cost-reporting periods beginning on or after October 1, 2002. However, according to CMS, proper analysis and administrative tasks delayed the release of the inpatient psychiatric payment rules. Consequently, the final IPF PPS is effective for cost-reporting periods beginning on or after January 1, 2005.

CMS has noted however, that it will not have appropriate computer systems up and running until April 4, 2005. Therefore, claims submitted after January 1, 2005 but before April 4, 2005 will be paid as if the TEFRA rate was still in effect. CMS has instructed fiscal intermediaries to reconcile the payments made during this period under the IPF PPS by May 1, 2005. This reconciliation will only occur for those facilities with cost-reporting periods beginning on or after January 1, 2005 but before April 1, 2005.

The annual rate year for the IPF PPS will be from July 1 to June 30, with the first update scheduled for July 1, 2006. Therefore, for those facilities with cost-reporting periods beginning on or after January 1, the first IPF PPS payment period would be the 18-month period from January 1, 2005 through June 30, 2006. CMS has updated the base rate to the mid-point of this period.

II. TRANSITION AND STOP-LOSS PROVISION

CMS has established a transition period for the implementation of the IPF PPS. During the transition period, IPFs will receive a blended payment of the PPS per diem amount and a hospital-specific amount based on the IPF's TEFRA payment. CMS rejected suggestions that IPFs be given the option to forego the transition and be paid at 100% of the PPS amount in the first year.

In the final rule, CMS has added a stop-loss provision that will apply during the transition period. The stop-loss provision will guarantee that each facility's IPF PPS payments are not less than 70% of the payments that would have been received under TEFRA. Under the transition in the first year, IPFs will receive a blended payment amount consisting of 75% based on TEFRA payments and 25% based on IPF PPS payments and a stop-loss payment will be provided if the IPF PPS portion of the payments is less than 70% of the amount that would have been received under TEFRA. Therefore, the combined effects of the transition and the stop-loss policies will ensure that the total IPF PPS payments are no less than 92.5% of the TEFRA payments in the first year. The combined effects of the transition and the stop-loss policies are shown on the following table.

Transition Period Payments

Cost Reports Beginning During the Period:		Transition Blend	Stop-Loss	Maximum Loss Compared to TEFRA	
January 1, 2005 - June 30, 2006	TEFRA	75%		75.0%	
	PPS	25%	70%	17.5%	
				92.5%	7.5%
July 1, 2006 - June 30, 2007	TEFRA	50%		50.0%	
	PPS	50%	70%	35.0%	
				85.0%	15.0%
July 1, 2007 - June 30, 2008	TEFRA	25%		25.0%	
	PPS	75%	70%	52.5%	
				77.5%	22.5%
7/1/2008 and Subsequent	PPS	100%			

III. PPS PAYMENT METHODOLOGY

Below is an example of the IPF PPS payment calculation. Subsequent sections of this summary explain the calculation and provide details of the factors that are incorporated in the IPF PPS final rule.

IPF PPS Payment Example

A 68-year-old patient presents at a qualified emergency department (ED) and is subsequently admitted to an inpatient psychiatric unit within an acute care hospital. The ED is determined to be full-service and the patient had not been discharged from an inpatient PPS stay. The hospital is located in rural New York and has a teaching program.

The patient had a primary diagnosis of Neurotic Depression—International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM code 3004), which is assigned to DRG 426:

Depressive Neurosis. The patient had comorbid conditions of Mechanical Complication of Tracheostomy (ICD-9-CM code 519.02), Diabetes with Ophthalmic Manifestations (ICD-9-CM code 250.53), and Diabetes with Peripheral Circulatory Manifestations (ICD-9-CM code 250.73). The patient length of stay was 13 days.

Budget-Neutral Base Rate Per Diem	\$575.95	
Calculate Wage-Adjusted Rate		
Labor portion of the base rate (labor share of 0.72528)		\$417.73
Apply wage index (0.9498 for rural Wisconsin)		\$396.76
Add the non-labor portion of the base rate		\$158.22
Wage-adjusted rate		\$554.98
Facility-Level Adjustments		
Teaching adjustment (see example shown in Teaching Adjustment section for calculation)		1.0902
Rural adjustment		1.17
Patient-Level Adjustments		
DRG 426: Depressive Neurosis		0.99
Age adjustment		1.10
Comorbidity adjustments:		
Code 519.2 assigned to Tracheostomy Category		1.06
Code 250.53 assigned to Diabetes Category		1.05
Code 250.73 assigned to Diabetes Category (no adjustment for second code in category)		-
Total PPS Adjustment Factor (multiply all facility and patient level adjustments together)		1.5460
Wage-adjusted rate times total PPS adjustment factor		\$858.00
Apply variable per diem adjustment for 13 days:	Adjustment	
	Factor	Payments
Day 1 (for hospital with full emergency department)	1.31	1,123.98
Day 2	1.12	960.96
Day 3	1.08	926.64
Day 4	1.05	900.90
Day 5	1.04	892.32
Day 6	1.02	875.16
Day 7	1.01	866.58
Day 8	1.01	866.58
Day 9	1.00	858.00
Day 10	1.00	858.00
Day 11	0.99	849.42
Day 12	0.99	849.42
Day 13	0.99	849.42
Total IPF PPS Payments		\$ 11,677.38

FEDERAL PER DIEM BASE RATE

The IPF PPS establishes a per diem payment rate for inpatient psychiatric services. The rate is calculated to provide reimbursement for the average daily cost of inpatient psychiatric care, including capital-related costs. It is adjusted to make total payments under the IPF PPS budget-neutral compared to the payments that would have been provided by the TEFRA methodology. These adjustments include a reduction of the standardization to the projected TEFRA, outlier payments, stop-loss payments, and behavioral offset. **The per diem base rate for the IPF PPS is \$575.95.**

CMS' calculation of the federal per diem base rate is discussed below.

Base Year Cost (*Federal Register* 66927): CMS calculated the average cost per day for routine and ancillary services as reported in the 2002 cost reports filed by psychiatric hospitals and distinct part units. To create an efficient process of updates for the various Medicare payment systems, CMS will implement the annual updates for the IPF PPS on July 1 each year. Therefore, CMS calculated the federal per diem base rate for the 18-month period January 1, 2005 through June 30, 2006. CMS updated the 2002 costs to the midpoint of the 18-month period, resulting in an unadjusted national per diem cost of \$724.43 for each day of inpatient psychiatric care.

Budget Neutrality Adjustment (*Federal Register* 66927): The IPF PPS is required to be budget-neutral compared to payment under the TEFRA methodology. CMS projected the TEFRA payments by updating the TEFRA data reported in the 2002 cost reports to the mid-point of the January 1, 2005 through June 30, 2006 rate period. The projected TEFRA payments were then compared to estimated PPS payments. A 16.33% reduction in the PPS standard rate was required to make it budget-neutral compared to the projected TEFRA cost.

Outlier Adjustment (*Federal Register* 66932): CMS is establishing cost outlier payments at a level that will result in 2% of total IPF PPS payments allocated to outliers. Therefore, CMS reduced the per diem base rate by 2%. A complete discussion of the IPF PPS outlier policy is included in the Outlier Payments section of this summary.

Behavioral Offset (*Federal Register* 66932): CMS is reducing the federal per diem base rate by 2.66% for "behavioral offsets" because CMS expects that, under the new payment system "IPFs may experience usage patterns that are significantly different from current usage patterns." CMS states that the per diem payment system may create an incentive for IPFs to keep patients in the facility longer. In addition, the current TEFRA payment system does not rely on ICD-9-CM coding. Proper comorbidity coding will affect PPS payments and CMS expects that IPFs will improve their coding practices once the IPF PPS is implemented.

Stop-Loss Payments (*Federal Register* 66932): If an IPF's aggregate IPF PPS payments are less than 70% of its aggregate payments under TEFRA during the transition period, a stop-loss payment will be provided for that IPF. CMS estimated the stop-loss payment amounts and determined that a reduction of 0.39% was necessary to maintain budget neutrality.

FACILITY-LEVEL ADJUSTMENTS

Based on an analysis of cost differences across facility types, CMS is adjusting the per diem base rate for wage index, teaching status, rural location, and if the facility has a full-service emergency department.

Wage Index (*Federal Register* 66952)

The IPF PPS adjusts the labor-related portion of the per diem base rate for differences in area wage levels. **CMS adjusts for labor costs using the federal fiscal year (FFY) 2005 pre-reclassified inpatient acute care hospital wage indices** on the assumption that inpatient acute data reflect wage levels similar to psychiatric units as well as freestanding psychiatric hospitals. CMS believes the actual location of the IPF is most appropriate for determining the wage adjustment; hospitals that are geographically reclassified for inpatient acute payment will not use the reclassified wage index for IPF payment and there will be no provision for a rural floor. **CMS is calculating the wage indices using the Metropolitan Statistical Area (MSA) definitions defined by the Office of Management and Budget in 1993 and will not use the new wage area definitions that were implemented for the FFY 2005 inpatient PPS.** CMS will assess the implications of the new wage area definitions for future use in the IPF PPS. The IPF PPS wage index is consistent with the wage adjustment in other post-acute settings.

CMS has established the labor-related share of the rate for the IPF PPS at 72.528% and the non-labor related share at 27.472%.

Teaching Status (*Federal Register* 66954)

To account for the higher costs associated with psychiatric teaching facilities, the IPF PPS provides an adjustment based on the ratio of the number of interns and residents assigned to the psychiatric unit to the average daily census (ADC) for the unit. **The IPF PPS teaching payment adjustment would be equal to the (1 + resident to ADC ratio) raised to the power of .5150.**

An example of the calculation of the teaching adjustment is shown below.

$$\begin{aligned} \text{IPF ADC} &= 4,000 \text{ (total IPF patient days)} / 365 = 10.96 \\ \text{IPF Resident to ADC Ratio} &= 2.0 \text{ (residents)} / 10.96 \text{ (calculated ADC)} = 0.1825 \\ \text{IPF Teaching Adjustment} &= \{1 + 0.1825\} ^ .5150 = 1.0902 \end{aligned}$$

CMS will establish a cap on the number of psychiatric residents that is similar to the cap that limits increases in residents under the inpatient PPS. CMS will calculate the “base year” number of residents that trained in the IPF based on the hospital’s most recently filed cost report as of November 15, 2004. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year will be counted in proportion to the time they spend in their assignment with the IPF. Hospitals can file adjusted cost report data with their fiscal intermediary if they believe the resident counts as submitted on that cost report are incorrect. 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.

Currently, Direct Graduate Medical Education (DGME) payments are provided to teaching hospitals for residents training in the acute hospital and residents training in exempt rehabilitation or psychiatric units. These DGME payments will continue after implementation of the IPF PPS.

Rural Location (*Federal Register* 66954)

Based on a regression analysis, CMS found that rural facilities have average costs approximately 17% higher than facilities located in metropolitan areas. CMS believes this is due to the small size of most rural IPFs. Smaller facilities are generally more costly on a per diem basis. **Therefore, CMS has established a 17% adjustment to the per diem base rate for rural IPFs.**

IPFs with Emergency Departments (ED) (*Federal Register* 66959)

In the IPF PPS final rule, CMS has added an adjustment to the federal per diem base rate to account for the costs associated with maintaining a full-service ED. Comments were submitted requesting an adjustment for patients admitted through the ED. However, CMS was concerned about creating an incentive for psychiatric units in acute care hospitals to admit all psychiatric patients through the ED. As an alternative, CMS will provide a facility-level adjustment for psychiatric hospitals and acute care hospitals with a distinct part psychiatric unit that maintain qualifying EDs. The adjustment is provided only to hospitals with EDs that are staffed and equipped to furnish a comprehensive array of emergency services and that meet the definition of a “dedicated emergency department.”

However, where a psychiatric unit would otherwise qualify for the ED adjustment and an individual patient is discharged to the unit from the acute care hospital that the unit is part of, CMS will not apply the ED adjustment. CMS states that, in these cases, the costs associated with the ED are covered through the DRG payment to the acute care hospital. CMS maintains that an ED adjustment would result in double payment for the overhead costs of the ED in these cases.

The ED adjustment will be incorporated into the variable per diem adjustment for the first day of each stay. That is, IPFs with qualifying EDs will receive a higher variable per diem adjustment for the first day of each stay than will other IPFs. **The first day variable per diem adjustment for IPFs with a qualifying ED will be 1.31 instead of 1.19.** The variable per diem payments are described in the Length of Stay section of this summary.

PATIENT-LEVEL ADJUSTMENTS

In the final IPF PPS, CMS adjusts the per diem base rate for patient characteristics based on each patient’s DRG assignment based on patients’ principal diagnoses, age, selected comorbidities, and length of stay adjustment.

Patient Classification and Diagnosis Related Groups (*Federal Register* 66936)

Currently, the mental health community routinely uses the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for diagnostic patient assessment and planning. The ICD-9-CM coding system is currently used for reporting diagnostic information for payment purposes under the inpatient PPS. IPF PPS claims include ICD-9-CM codes and, although the TEFRA payment methodology does not use DRGs, the CMS administrative files include the DRG that would have been valid for payment purposes if the IPF were not exempt from the PPS. Currently, this DRG information is used only for statistical information purposes.

The final IPF PPS retains the reference to the DSM, but the DSM codes may not be reported on Medicare claims. The ICD-9-CM codes are to be used to classify IPF patients into DRGs. This will require that IPFs use the psychiatric diagnosis codes in Chapter Five (“Mental Disorder”) of the ICD-9-CM to report diagnostic information for the IPF PPS payments.

Medicare regulations require that psychiatric units of acute care hospitals admit only those patients with a principal diagnosis listed in the DSM or classified in Chapter Five (“Mental Disorders”) of the ICD-9-CM. Therefore, if a patient is admitted to a general hospital for a medical condition such as pneumonia and presents psychiatric symptoms requiring an admission to the psychiatric unit, the principal diagnosis for the admission to the unit should be the psychiatric symptom. CMS analyzed the DRG assignment for psychiatric diagnoses included in the ICD-9-CM or the DSM and determined that most are assigned to one of 15 DRGs. Adjustment factors were determined for these DRGs. Below is a table of the DRGs

recognized under the IPF PPS and the adjustment factor.

IPF PPS DRGs

DRG	Adjustment Factor
12 Degenerative Nervous System Disorders	1.05
23 Nontraumatic Stupor and Coma	1.07
424 Procedure with Principal Diagnosis of Mental Illness	1.22
425 Acute Adjustment	1.05
426 Depressive	0.99
427 Neurosis, Except Depressive	1.02
428 Disorders of Personality	1.02
429 Organic	1.03
430 Psychosis	1.00
431 Childhood Disorders	0.99
432 Other Mental Disorders	0.92
433 Alcohol/Drug Use Left Against Medical Advice	0.97
521 Alcohol/Drug Use With Comorbid Conditions	1.02
522 Alcohol/Drug Use Without Comorbid Conditions	0.98
523 Alcohol/Drug Use Without Rehabilitation Therapy	0.88

CMS found that a small number of psychiatric cases were assigned to other DRGs besides the 15 DRGs recognized under the IPF PPS. CMS states there are not enough admissions in these DRGs to establish accurate relative weights. In the proposed rule, CMS would have required that claims submitted with information that results in assignment to a DRG not recognized under the IPF PPS would be returned to the IPF for resubmission. Based on comments opposing this requirement, CMS dropped it from the final rule. Instead, psychiatric cases not assigned to the 15 designated DRGs will be paid without an adjustment for the DRG.

Patient Age (*Federal Register 66946*)

CMS’ analysis determined that the per diem cost rises as a patient’s age increases. The proposed rule had a single adjustment for patients 65 years of age and over. In the final rule, CMS expanded the adjustment factor to include eight age groups as shown below.

Age Group	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

Comorbidities (*Federal Register 66938*)

Psychiatric patients with comorbid conditions are generally more costly on a per diem basis. After review of ICD-9-CM codes, **CMS identified 17 comorbid conditions that would receive an adjustment to the per diem base rate.** The IPF PPS creates groups of ICD-9-CM codes to describe the similar comorbid conditions. Below is a table of the comorbidity groups and the adjustment factors.

IPF PPS Comorbidity Categories

Comorbidity Category	ICD-9-CM Codes	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, and 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 V58.0 OR V58.1	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
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, and V461	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

If a patient has multiple diagnoses in several categories, the adjustment factors for each applicable category are multiplied by the federal base rate. However, IPFs may only receive one adjustment factor for each comorbidity category.

CMS provides the following definition of comorbidity in the IPF regulations: “Comorbidity means all specific patient conditions that are secondary to the patient’s primary diagnosis and that co-exist at the time of admission, develop subsequently, or affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.” CMS further instructs that “a serious medical condition that does not require treatment during the hospital stay must not be reported as a secondary or tertiary diagnosis and will not qualify for a comorbidity adjustment.”

CMS applied this principle in the definition of the Oncology Treatment category. The proposed rule provided a comorbidity adjustment for patients with a malignant neoplasm diagnosis. In the final rule, the “Malignant Neoplasm” category was replaced by the “Oncology Treatment” category. This was done because CMS determined that the higher cost was related to the treatment of the neoplasm rather than the presence of the tumor. As a result, CMS is requiring that, to receive the comorbidity adjustment for

malignant neoplasm, IPFs must code the ICD-9-CM code for the specific malignant neoplasm from the ICD-9-CM Chapter 2 codes (codes 140 through 239) and one of the two ICD-9-CM procedure codes for chemotherapy (V58.0) or radiation treatment (V58.1) to indicate the treatment modality the patient received.

Length of Stay (*Federal Register* 66947)

The final IPF PPS applies a further adjustment to the per diem rate to account for the higher costs associated with the first days of an IPF stay. The final IPF PPS re-evaluated the relationship between per diem cost and the day-of-stay and revised the variable per diem adjustment to include both higher payments for the first days of the stay and lower payments for the later days. Below is a table of the day-of-stays and the IPF PPS adjustment.

IPF PPS Variable Per Diem Adjustment

Day-of-Stay	Adjustment Factor
Day 1	1.31 (with ED) or 1.19 (without ED)
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7 and Day 8	1.01
Day 9 and Day 10	1.00
Day 11 through Day 14	0.99
Day 15	0.98
Day 16 and Day 17	0.97
Day 18	0.96
Day 19 through Day 21	0.95
Over 21 Days	0.92

No Additional Payment for Patients Involuntarily Committed to an IPF (*Federal Register* 66951): CMS rejected requests for an adjustment to compensate for extra legal, operational, and management costs incurred when treating patients who are involuntarily committed to an IPF. CMS states that the data do not indicate that patients involuntarily committed to the IPF are more costly on a per diem basis. CMS also believes that many of the costs associated with involuntary commitments (for example, legal fees, staff time to accompany the patient to court, and transportation costs) are part of the hospital’s average routine per diem cost and that some of the costs are paid by the court system or law enforcement.

ADDITIONAL IPF PPS PAYMENTS

Electroconvulsive Therapy (ECT) Adjustment (*Federal Register* 66951)

The IPF PPS provides an adjustment for each ECT treatment furnished during the IPF stay. To receive the payment adjustment, IPFs must indicate on their claims the revenue code and procedure code for ECT (Rev Code 901; procedure code 90870) and the number of units of ECT, that is, the number of ECT treatments the patient received during the IPF stay. Providing the data will ensure that facilities are appropriately reimbursed for the treatments they provided. **The rate of adjustment for ECT, after**

applying the standardization factor, behavioral offset, stop-loss adjustment, and outlier adjustment, is \$247.96. The ECT payment will be adjusted by the wage index.

Outlier Payments (*Federal Register 66960*)

CMS has established an outlier policy for cases that require more costly care. The methodology is designed to result in outlier payments that are 2% of total payments. Outlier payments will be provided when the estimated cost of the patient’s entire stay exceeds the outlier threshold amount, defined as the total IPF PPS payment for the stay plus the fixed loss threshold of \$5,700. The fixed loss threshold will be adjusted by the wage index, the teaching adjustment, and for rural location. The costs that exceed the outlier threshold would be further adjusted by the loss-sharing ratio. The IPF PPS has two loss sharing ratios. Since the per diem payment under the IPF PPS is highest in the early days of the stay, **the outlier payment adjustment for days one through nine of the stay is 80%. For days ten and thereafter, the adjustment is 60%.**

Outlier Methodology - Example

Based on data shown for the IPF PPS calculation example.

Fixed Dollar Threshold	\$5,700
Labor Portion (Labor Share of 0.72528)	4,134
Apply Wage Index (0.8403 for Rural New York)	3,474
Add the Non-Labor Portion (0.27472)	1,566
The Total Wage-Adjusted Threshold	5,040
Teaching Adjustment	1.0902
Rural Adjustment	1.17
Adjusted Fixed Loss Threshold	\$6,428
IPF PPS Payment (from IPF PPS Calculation Example)	\$10,715
Outlier Threshold (PPS Payment Plus Fixed Loss Threshold)	\$17,143
Charges	\$40,000
Cost-to-Charge Ratio	0.55
Cost	\$22,000
Cost Above Threshold	\$4,857
Patient Length of Stay	13
Outlier Cost Per Day	\$373.58
Payment for Days 1 Through 9	
Days	9
Cost (Days * Outlier Cost Per Day)	\$3,362
Outlier Payment Factor	80%
Outlier Payment	\$2,690
Payment for Days 10 and Beyond	
Days	4
Cost (Days * Outlier Cost Per Day)	\$1,494
Outlier Payment Factor	60%
Outlier Payment	\$897
Total Outlier Payment	\$3,586

No Payment for Administratively Necessary Days (*Federal Register* 66952): CMS rejected requests for payment for administratively necessary days for continued inpatient care when discharge is delayed due to a lack of community resources. CMS cited a lack of data to evaluate the cost of these days and a concern that such payments could create an incentive to unnecessarily delay discharge to receive additional payment for administratively necessary days.

IV. INTERRUPTED STAYS (*Federal Register* 66962)

Under the IPF PPS, the per diem rate is increased for the first nine days of the IPF stay. CMS was concerned that an IPF could maximize payment by prematurely discharging patients after the nine days during which they receive higher payments and then readmit the same patient. Therefore, **if a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following the discharge from the original IPF stay, the case is considered to be continuous for applying the variable per diem adjustments and determining whether the case qualifies for outlier payments.**

V. RECERTIFICATION REQUIREMENTS (*Federal Register* 66964)

Although CMS proposed modifying the regulations on recertification requirements, the final PPS rule made no modifications. Therefore, current recertification requirements remain. Specifically, current regulations specify that a physician must recertify that inpatient psychiatric services furnished since the previous certification were, and continue to be, required: (1) for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study and (2) if the hospital's records show that the services furnished were intensive treatment services, admission, and related services necessary for diagnostic study or equivalent services. Current regulations require the first recertification after admission to occur as of the eighteenth day of hospitalization.

VI. NEW PROVIDERS (*Federal Register* 66966)

CMS defines a new IPF as a provider of inpatient psychiatric hospital services that meets the qualifying criteria under present or previous ownership, and whose first cost reporting period as an IPF begins on or after January 1, 2005. New IPFs would be paid based on the IPF PPS without the transition period.

VII. PERIODIC INTERIM PAYMENTS (PIP) (*Federal Register* 66980)

Under TEFRA, IPFs may request interim payments approximating the actual costs of the provider. In addition, an IPF that is experiencing financial difficulties due to a delay by the fiscal intermediary in making payments, or a temporary delay in the IPF's preparation and submittal of bills because of an exceptional situation, may request accelerated payments. **CMS continues both PIP and accelerated payments under the IPF PPS.**

VIII. FUTURE UPDATES AND REFINEMENTS

Updates (*Federal Register* 66966): Future updates for the IPF PPS will be from July 1 through June 30. Since CMS believes there will be insufficient time to update the IPF PPS during the first year, the first update will not occur until July 1, 2006. Thus, the implementation period for the IPF PPS is the 18-month period from January 1, 2005 through June 30, 2006. CMS will publish a notice in the spring of calendar year 2006 to update the IPF PPS effective July 1, 2006 and will publish an update notice for each 12-month period thereafter.

Future Refinements (*Federal Register 66967*): CMS believes that future refinement of the payment system may require additional patient information and the proposed rule discussed the development of a standard assessment tool. CMS, in conjunction with the University of Michigan's Public Health Institute, is attempting to develop a patient classification system based on a standard assessment tool called the Case Mix Assessment Tool (CMAT). CMS noted in the final rule that the draft CMAT instrument, which has not been proposed, is currently undergoing Office of Management and Budget review.