



**WISCONSIN HOSPITAL  
ASSOCIATION**

**SUMMARY  
OF THE  
RATE YEAR (RY)  
2007 MEDICARE FINAL RULE  
FOR THE  
INPATIENT PSYCHIATRIC FACILITY  
PROSPECTIVE PAYMENT SYSTEM**

**May 2006**

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# **Summary of the Rate Year (RY) 2007 Medicare Final Rule for the Inpatient Psychiatric Facility Prospective Payment System**

The Centers for Medicare and Medicaid Services (CMS) published final regulations for the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in the May 9 *Federal Register*. 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 (CAHs).

This document summarizes the changes in the final rule. Where *Federal Register* page numbers are provided, they refer to the May 9, 2006 *Federal Register*. Text in italics is extracted from the *Federal Register*.

## **INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM**

### **I. BACKGROUND**

The 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. Before 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. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 governed this reasonable cost system.

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 comorbidities. Additional payments are provided for cost outlier cases and electroconvulsive therapy 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.

### **II. Transition Period**

**Background:** CMS has provided a three-year transition period to help relieve those facilities that may experience a financial hardship under the new IPF PPS as opposed to payments made under TEFRA. Therefore, changes to the blended percentages will occur at the start of an IPF’s cost report period and they will receive a blended payment of the PPS per diem amount and a hospital-specific amount based on the IPF’s TEFRA payment.

**CMS Proposal:** CMS proposed no changes to the three-year transition period.

**CMS Final Rule** (*Federal Register* page 27042): “We note that we are not making any changes to the transition approach established in the November 2004 IPF PPS final rule.” Facilities will start to receive

the second year blended payment amount beginning with the start date of their cost report period. At that time, payment will be based on 50% of the PPS per diem payment amount and 50% of the hospital-specific amount based on the IPF's TEFRA payment.

### III. Stop-Loss Provision

**Background:** In addition to providing a transition period, CMS also added a stop-loss provision that would apply during the transition period. CMS states: “. . . we provide a stop-loss payment to ensure that an IPF's total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented.” The stop-loss provision will guarantee that each facility's IPF PPS payments are at least 70% of the payments that would have been received under TEFRA.

**CMS Proposal:** CMS proposed no changes to the stop-loss provision.

**CMS Final Rule** (*Federal Register* pages 27074 - 27075): “We are not making any changes to the Stop-Loss provision.” Therefore, during the second year of the transition period, IPFs will receive a blended payment amount of 50% TEFRA payments and 50% IPF PPS payments with an additional stop-loss payment provided if the IPF PPS portion of the payment is less than 70% of the amount that would have been received under TEFRA. 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% of TEFRA payments in the second year. The combined effects of the transition and the stop-loss provision are shown on the following table.

#### Three-Year Transition Period

Cost Reports Beginning During the Period:		Transition Blend	Stop-Loss	Maximum Loss Compared to TEFRA	
January 1, 2005 - December 31, 2005	TEFRA	75%		75.0%	
	PPS	25%	70%	17.5%	
				92.5%	7.5%
January 1, 2006 - December 31, 2006	TEFRA	50%		50.0%	
	PPS	50%	70%	35.0%	
				85.0%	15.0%
January 1, 2007 - December 31, 2007	TEFRA	25%		25.0%	
	PPS	75%	70%	52.5%	
				77.5%	22.5%
January 1, 2008 and Subsequent	PPS	100%			

## **IV. IPF PPS Payment Methodology**

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

### **IPF PPS Payment Example**

A 68-year-old patient presented at a qualified emergency department (ED) and was 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.

**IPF PPS Payment Methodology - Example**

<b>Budget-Neutral Base Rate Per Diem</b>	<b>\$595.09</b>	
<b>Calculate Wage-Adjusted Rate</b>		
Labor portion of the base rate (labor share of 0.75665)		\$450.27
Apply wage index (ex: 0.8154)		\$367.15
Add the non-labor portion of the base rate		\$144.82
<b>Wage-adjusted rate</b>		<b>\$511.97</b>
<b>Facility-Level Adjustments</b>		
Teaching adjustment (see example shown in Teaching Adjustment section for calculation)		1.0902
Rural adjustment		1.17
<b>Patient-Level Adjustments</b>		
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)		-
<b>Total PPS Adjustment Factor (multiply all facility and patient level adjustments together)</b>		<b>1.5460</b>
<b>Wage-adjusted rate times total PPS adjustment factor</b>		<b>\$791.51</b>
<b>Apply variable per diem adjustment for 13 days:</b>	<b>Adjustment</b>	
	<b>Factor</b>	<b>Payments</b>
Day 1 (for hospital with full ED)	1.31	1,036.88
Day 2	1.12	886.50
Day 3	1.08	854.84
Day 4	1.05	831.09
Day 5	1.04	823.18
Day 6	1.02	807.34
Day 7	1.01	799.43
Day 8	1.01	799.43
Day 9	1.00	791.51
Day 10	1.00	791.51
Day 11	0.99	783.60
Day 12	0.99	783.60
Day 13	0.99	783.60
<b>Total IPF PPS Payments</b>		<b>\$10,772.51</b>

**Federal Per Diem Base Rate**

**Background:** The federal per diem payment rate for the IPF PPS is calculated to provide reimbursement for the average daily cost of inpatient psychiatric care, including capital-related costs. The 2005 base rate was adjusted to make total payments under the IPF PPS budget-neutral compared to the payments that would have been provided under TEFRA. The adjustment that CMS made to the 2005 federal rate for this budget neutrality is referred to as the standardization factor. CMS' calculation of the RY 2007 federal per diem base rate is discussed on the next page.

**CMS Final Rule** (*Federal Register* pages 27045 - 27046): **The federal per diem base rate for RY 2007 is \$595.09.** This updated base rate includes a marketbasket increase (discussed below), budget-neutrality adjustment, and a correction for an error in computing the standardization factor for 2005. CMS states: *“In reviewing the methodology used to simulate the IPF PPS payments used for the November 2004 IPF PPS final rule, we discovered that the computer code incorrectly assigned non-teaching status to most teaching facilities. As a result, total IPF PPS payments were underestimated by about 1.36 percent.”*

**Outlier Adjustment:** CMS will reduce total IPF PPS payments by 2% for cost outlier payments. A complete discussion of the IPF PPS outlier policy is included in the Outlier Payments section to follow.

**Stop-Loss Payments:** 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. In the 2005 IPF PPS final rule, CMS estimated the stop-loss payment amounts and determined that a reduction of 0.39% was necessary to maintain budget neutrality.

## **Marketbasket Update**

**Background:** CMS uses marketbasket updates to reflect price changes in the mix of goods and services that hospitals purchase to furnish patient care. Currently, CMS is unable to create a separate marketbasket index specific to the IPF PPS. Therefore, the excluded hospital with capital marketbasket was used in developing the IPF PPS. *“This market basket was based on 1997 Medicare cost report data and includes data for Medicare participating IPFs, IRFs, LTCHs, cancer, and children’s hospitals.”*

**CMS Proposal:** CMS proposed to adopt the rehabilitation, psychiatric, and long-term care (RPL) marketbasket. The RPL method reflects operating and capital cost structures for inpatient rehabilitation facilities, IPFs, and long-term care facilities.

**CMS Final Rule** (*Federal Register* pages 27046 - 27053): **CMS is adopting the RPL marketbasket in RY 2007.** CMS has rebased the RPL marketbasket to 2002 Medicare cost report data. *“We are excluding children’s and cancer hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits. They are not reimbursed under a PPS. Also, the FY 2002 cost structures for children’s and cancer hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. The RY (that is, beginning July 1, 2006) update for the IPF PPS using the FY 2002-based RPL market basket and Global Insight’s 1st quarter 2006 forecast is 4.3 percent. This includes increases in both the operating section and the capital section for the 18 month period (that is, January 1, 2005 through June 30, 2006).”*

## **Wage Index**

**Background:** 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) 2006 pre-reclassified inpatient acute care hospital wage indices** on the assumption that inpatient acute care data reflect wage levels similar to those of 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 do not receive the reclassified wage index for IPF payment and there is no provision for a rural floor. CMS states, *“In the FY 2005 IPPS final rule . . . revised labor market area definitions were adopted under the IPPS . . . which were effective October 1,*

2004. These new standards, called Core-Based Statistical Areas (CBSAs) were announced by the OMB late in 2000 . . . .” The IPF PPS wage index is consistent with those in other post-acute settings.

**CMS Proposal:** CMS proposed to adjust for labor costs using the inpatient acute care hospital wage indices under the new labor market definitions defined by the Office of Management and Budget (OMB). *“The OMB’s CBSA designations . . . reflect the most recent available geographic classifications (Metropolitan Area definitions). Therefore, we are proposing to revise the labor market area definitions used under the IPF PPS based on the OMB’s CBSA designations. . . . ensure that the IPF PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. . . . effective for IPF PPS discharges occurring on or after July 1, 2006.”*

**CMS Final Rule** (*Federal Register* pages 27061 - 27067): CMS does not believe the new CBSA-based labor market areas will significantly impact IPF providers, despite numerous comments received requesting a “hold harmless” provision in order to protect those facilities that may be harmed by the new labor market definitions. CMS does not believe a transition period or hold-harmless provision are necessary since IPF providers are already in their second year of a three-year transition period and are eligible to receive the stop-loss provision (see Stop-Loss Provision section). **To this end, CMS is not implementing a transition period or hold-harmless provision for purposes of the IPF PPS wage index in RY 2007.**

**In addition, based on the relative weights from the RPL marketbasket, CMS increased the labor-related share of the rate for IPF PPS to 75.665% with a non-labor related share of 24.335%.**

## **Facility-Level Adjustments**

CMS in the final rule implemented no changes to the facility-level adjustments until one year of IPF cost claims data and cost report data are available to analyze. Therefore, the following facility-level adjustments will remain based on CMS’ prior regression analysis.

### **Teaching Adjustment**

**Background:** 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 hospitals’ IPF PPS payment.

To limit the incentives for IPFs to add full time equivalents (FTEs), CMS imposed a cap on the number of psychiatric residents that is similar to the cap that limits increases in residents under the Inpatient PPS. *“ . . . we calculated the number of FTE residents that trained in the IPF during a “base year” and use that FTE resident number as the cap. An IPF’s FTE resident cap would ultimately be determined based on the final settlement of the IPF’s most recent cost report filed before 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 are counted in proportion to the time they spend in their assignment with the IPF.”* 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.

**CMS Proposal:** CMS proposed to continue the teaching adjustment at the current level.

**CMS Final Rule** (*Federal Register* pages 27067 - 27070): **CMS will continue the teaching adjustment at the current level making it equal to (1 + residents to Average Daily Census (ADC) ratio) raised to the power of .5150.**

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

IPF ADC = 4,000 (total IPF patient days) / 365 = 10.96  
IPF Resident to ADC Ratio = 2.0 (residents) / 10.96 (calculated ADC) = .1825  
IPF Teaching Adjustment = {1 + .1825 (teaching status)} ^ .5150 = 1.0902

**CMS also added new language** to clarify that “ . . . *the teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for the claim is made during the final settlement of the cost report.*”

### **Rural Location Adjustment**

**Background:** CMS provides a rural location adjustment to account for the higher costs that smaller facilities experience on a per diem basis.

**CMS Proposal:** CMS proposed no changes to the rural adjustment.

**CMS Final Rule** (*Federal Register* page 27067): **CMS will continue to apply the 17% rural adjustment in RY 2007.** 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 designated as rural but are now considered urban will lose this adjustment as of July 1.

### **Emergency Department Adjustment**

**Background:** CMS provides a facility-specific adjustment to the federal per diem base rate to account for the costs associated with maintaining a full-service ED. CMS was concerned about creating an incentive for psychiatric units in acute care hospitals to admit all psychiatric patients through the ED. Therefore, as an alternative, CMS decided to provide a facility-level adjustment for psychiatric hospitals, acute care hospitals with a distinct part psychiatric unit, and CAHs with a distinct part psychiatric unit that maintain qualifying EDs. The adjustment is provided only to hospitals or CAHs 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.” “*The ED adjustment is made on every qualifying claim except . . . where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit.*” CMS states that, in those cases, the costs associated with the ED are covered through the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH. CMS maintains that an ED adjustment would result in double payment for the overhead costs of the ED in these cases. The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay; that is, IPFs with qualifying EDs receive a higher variable per diem adjustment for the first day of each stay.

**CMS Proposal:** CMS proposed no changes to the ED adjustment.

**CMS Final Rule** (*Federal Register* pages 27070 - 27071): **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.** The variable per diem payments are described later in this summary.

When the IPF PPS was first implemented, CMS instructed all hospitals or CAHs with qualifying EDs to submit a letter of verification to their fiscal intermediary to be eligible for the qualifying rate. In this final rule, CMS acknowledged that the letter was a one-time verification and does not need to be repeated each year.

### **Emergency Department Adjustment Admission Code**

**Background:** *“In order to ensure that the ED adjustment is not paid for patients who are discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit, we directed IPFs to enter source of admission code 4 (transfers from hospital inpatient) on those claims. . . . we realized that admission code “4” is too broad to distinguish these claims because 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.”*

**CMS Proposal:** CMS requested a new source of admission code from the National Uniform Billing Committee to identify transfers from the same hospital or CAH. The request was granted; therefore, CMS proposed that IPFs, effective April 1, 2006, use source of admission code “D” to identify IPF patients who have been transferred to the IPF from the same hospital or CAH.

**CMS Final Rule** (*Federal Register* pages 27071 - 27072): *“We are finalizing our decision to adopt the new source of admission code “D.” Claims with source of admission code “D” will not receive the ED adjustment.”* **Beginning April 1, 2006, IPFs are required to use admission code “D” to identify IPF patients who have been transferred to the IPF from the same hospital or CAH.**

### **Patient-Level Adjustments**

CMS provides adjustments to the per diem base rate for patient characteristics based on each patient’s DRG assignment, age, and for specified comorbid conditions. CMS in the final rule implemented no changes to any of the patient-level adjustment factors until one year of IPF claims data are available to analyze.

### **DRG Adjustment**

**Background:** Even though 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. *“We believe it is vital to maintain the same diagnostic coding and DRG classification for IPFs that is used under the IPPS for providing the same psychiatric care.”* Annual updates to the ICD-9-CM coding are addressed in the Inpatient Prospective Payment System (IPPS) proposed and final rule each year.

**CMS Final Rule** (*Federal Register* pages 27055 - 27057): **CMS will continue to recognize the following 15 DRGs for payment under the IPF PPS in RY 2007.**

**IPF PPS DRGs**

<b>DRG</b>	<b>Adjustment Factor</b>
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 Reaction	1.05
426 Depressive Neurosis	0.99
427 Neurosis, Except Depressive	1.02
428 Disorders of Personality	1.02
429 Organic Disturbances	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

In addition, the following table lists the new 2006 ICD-9-CM codes that are eligible to receive a DRG adjustment in RY 2007.

**New FY 2006 ICD Diagnosis Codes that Qualify for a DRG Adjustment Under IPF PPS**

<b>Diagnosis Code</b>	<b>DRG</b>
291.82 Alcohol induced sleep disorders	521, 522, 523
292.85 Drug induced 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, unspecified	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

**Patient Age** (*Federal Register* page 27060): CMS' prior analysis determined that the per diem costs rise as a patient's age increases. CMS established adjustment factors for eight age groups as shown below. **CMS will continue to use the current age group adjustment factors for RY 2007.**

**IPF PPS Age Groupings**

<b>Age Group</b>	<b>Adjustment Factor</b>
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* pages 27058 - 27060): 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. The following table reflects the updated ICD-9-CM codes within each of the comorbidity categories.

**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
Tracheostomy	51900 – through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, and 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled 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, 29212, 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, V4611 and V4612, V4613 and V4614	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

CMS states, “An IPF may receive only one comorbidity adjustment per comorbidity category, but it may receive an adjustment for more than one comorbidity category.”

**Variable Per Diem Adjustment** (*Federal Register* page 27060): CMS applies an adjustment to the per diem rate to account for the higher costs associated with the earlier days of an IPF stay. **CMS will continue to use the current variable per diem adjustment factors for RY 2007.**

<b>Day-of-Stay</b>	<b>Adjustment Factor</b>
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

## **Other IPF PPS Payments**

### **Outlier Payments**

**Background:** Outlier payments are 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-dollar loss threshold amount. 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). CMS states, “*This approach to determining a provider’s cost is consistent with the approach used under the IPPS and other prospective payment systems.*” Therefore, CMS uses the CCR from the latter of the most recently settled Medicare IPF cost report or the most recent tentatively settled IPF Medicare cost report. CMS also applies a ceiling in determining a facility’s CCR that is based on three times the standard deviation for the urban and rural IPF CCR.

**CMS Proposal:** CMS proposed to increase the fixed-dollar loss amount from \$5,700 to \$6,200, with no proposed changes to the current loss sharing ratios.

**CMS Final Rule** (*Federal Register* pages 27072 - 27075): **CMS will increase the fixed-dollar loss amount from \$5,700 to \$6,200 for RY 2007**, which would be adjusted by the IPF’s facility adjustments (wage, rural location, and teaching status). CMS will continue to use the current loss sharing ratios. Therefore, the **outlier payment adjustment for days one through nine of the stay is 80%. For days**

ten and thereafter, the adjustment would be 60%. Total outlier payments are expected to equal 2% of total IPF PPS payments.

### Outlier Methodology - Example

Based on data shown for the IPF PPS calculation example.

<b>Fixed-Dollar Loss Threshold Amount</b>	<b>\$6,200</b>
Labor portion of the base rate (labor share of 0.75665)	4,691
Apply wage index (ex: 0.8154)	3,825
Add the non-labor portion of the base rate	1,509
The total wage-adjusted threshold	5,334
Teaching adjustment	1.0902
Rural adjustment	1.17
Adjusted fixed-dollar loss threshold amount	<b>\$6,804</b>
<b>IPF PPS Payment (from IPF PPS calculation example)</b>	<b>\$10,773</b>
<b>Outlier Threshold (PPS payment plus fixed-dollar loss threshold amount)</b>	<b>\$17,576</b>
Charges	\$40,000
Cost-to-charge ratio	0.55
Cost	\$22,000
Cost above threshold	\$4,424
Patient length of stay	13
Outlier cost per day	\$340.29
Payment for days 1 through 9	
Days	9
Cost (days * outlier cost per day)	\$3,063
Outlier payment factor	80%
Outlier payment	\$2,450
Payment for days ten and beyond	
Days	4
Cost (days * outlier cost per day)	\$1,361
Outlier payment factor	60%
Outlier payment	\$817
<b>Total Outlier Payment</b>	<b>\$3,267</b>

In addition, CMS will annually update the national urban and rural CCRs (median and ceilings) for IPFs based on the previous full calendar year (CY) provider specific file. For RY 2007 these updates will be based on the full CY 2005 CCRs entered in the provider specific file. CMS is also “. . . updating the ceilings and national median CCRs . . . on CBSA-based geographic designations because the CBSAs are the geographic designations we are adopting for purposes of computing the proposed wage index adjustment to IPF payments beginning July 1, 2006.”

CMS will apply the new national urban and rural CCRs to the following situations: *New IPFs that have not yet submitted their first Medicare cost report; IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling); Other*

*IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.” The updated CCRs will be published each year in the Federal Register.*

### **Electroconvulsive Therapy Adjustment**

**Background:** Facilities that furnish electroconvulsive therapy (ECT) treatments for their patients during an IPF stay can add significant costs to that stay. CMS conducted an analysis and found that ECT cases can be approximately twice as expensive as a 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.

**CMS Proposal:** CMS proposed an ECT payment rate of \$254.86. *“We are proposing to pay the median cost for an ECT treatment, posted as part of the calendar year (CY) 2006 OPPS update, which is based on CY 2004 outpatient hospital claims.”*

**CMS Final Rule** (*Federal Register* pages 27075 - 27076): The ECT payment rate for RY 2007 is \$256.20. *“ . . . we will finalize the update methodology for the ECT rate by using the CY 2005 ECT rate as a base and then updating that amount by the market basket increase each rate year.”* The ECT payment is adjusted by the wage index.

## **V. Same Day Transfers**

**Background:** *“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 and the IPF claims are suspended.”* This becomes an issue from the perspective of counting Medicare days for the purpose of Medicare cost reporting. Based on reviews performed by CMS, it appears that many patients in this situation are seen first in the ED and later that day admitted to an IPF, then determined to need acute care. Since IPF stays are subject to the 190-day lifetime limit on inpatient psychiatric care, it is important to distinguish which days can be counted. CMS states, *“ . . . 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.

**CMS Proposal:** CMS did not propose a change in the payment policy for same-day transfers; however, CMS considered alternative methods in how these days should be covered under the IPF PPS. The following are three methods that CMS considered: 1) treat these days as covered days under the IPF PPS; 2) make no PPS payment but continue making TEFRA payments during the IPF PPS transition period; or 3) treat these cases as covered days under the IPF PPS but limit payment to the federal per diem rate or some other payment amount.

**CMS Final Rule** (*Federal Register* pages 27079 - 27080): **Before implementing a new policy for same-day transfers, CMS will continue to analyze the IPF PPS data in RY 2007.** CMS stated, *“ . . . we received multiple comments on the same day transfer. We will take all comments into consideration as we develop a payment policy for same day transfers.”*

## VI. Recertification Requirements

**Background:** Currently, payment for inpatient psychiatric care is made only if a physician certifies and recertifies on the 18th day following admission. CMS states, “. . . *recertifying a patient’s need for continued inpatient care in an IPF, a physician must indicate that the patient continues to need, on a daily basis, inpatient psychiatric care (furnished directly by or requiring the supervision of IPF personnel) or other professional services that, as a practical matter, can be provided only on an inpatient basis . . . .*”

**CMS Proposal:** CMS proposed to “. . . *provide that the initial physician certification would be required at the time of admission or as soon thereafter as is reasonable and practicable and the first recertification would be required as of the 12th day of hospitalization. Subsequent recertifications would 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.*”

**CMS Final Rule** (*Federal Register* pages 27076 - 27077): **CMS for RY 2007** “. . . *will require the first recertification as of 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.*” CMS believes this will create consistency among provider types, for purposes of payment under the IPF PPS.

## VII. Therapeutic Recreation

**Background:** “*Before the implementation of the IPPS payment methodology, Medicare coverage guidelines gave specific recognition to therapeutic recreation in inpatient psychiatric hospitals. The Medicare Intermediary Manual . . . specifically identify therapeutic recreation as one of the services that can constitute “active treatment” in this setting when they are—* • *Provided under an individualized treatment or diagnostic plan;* • *Reasonably expected to improve the patient’s condition or for the purpose of diagnosis;* and • *Supervised and evaluated by a physician. In order to participate in the Medicare program, psychiatric hospitals not only had to meet the conditions of participation (COPs) that apply to general, acute-care hospitals, but additionally had to meet special conditions related to medical records and staffing.*”

**CMS Proposal:** CMS proposed “. . . *removing recreational therapy from § 412.27(b).*” Although CMS proposed to remove the specific reference to recreation therapy, they emphasized that recreation therapy is, and would continue to be, an accepted therapeutic intervention in psychiatric treatment.

**CMS Final Rule** (*Federal Register* page 27077): CMS states, “. . . *we are adopting the language as specified in §482.62) from the COPs for §412.27(b). Specifically, 412.27(b) will state—Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing services and therapeutic activities.*”