



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY
OF THE
RATE YEAR
2008 UPDATE NOTICE
FOR THE MEDICARE
INPATIENT PSYCHIATRIC FACILITY
PROSPECTIVE PAYMENT SYSTEM**

May 2007

TABLE OF CONTENTS

I.	Background.....	1
II.	Transition Period	2
III.	Stop-Loss Provision	2
IV.	IPF PPS Payment Methodology.....	2
	Federal Per Diem Base Rate.....	4
	Marketbasket Update.....	4
	Wage Index.....	4
	Facility-Level Adjustments	5
	- Teaching Adjustment	5
	- Rural Location Adjustment	5
	- Emergency Department Adjustment	6
	Patient-Level Adjustments	6
	- DRG Adjustment.....	6
	- Patient Age	7
	- Comorbidities	8
	- Variable Per Diem Adjustment	10
	Other IPF PPS Payments.....	10
	- Outlier Payments	10
	- Electroconvulsive Therapy Adjustment	12
V.	Recertification Requirements	12

Summary of the Rate Year (RY) 2008 Update Notice for the Medicare Inpatient Psychiatric Facility Prospective Payment System

The Centers for Medicare and Medicaid Services (CMS) published an update notice for the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in the May 4 *Federal Register*. Changes are effective for discharges beginning on or after July 1, 2007. The notice provides updates to the rates for Medicare payment of inpatient services furnished in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and Critical Access Hospitals (CAHs).

More specifically, CMS will:

- increase the per diem rate to \$614.99 for RY 2008;
- increase the outlier fixed-dollar loss threshold to \$6,488; and
- increase the payment for electroconvulsive therapy (ECT) treatment to \$264.77.

CMS normally provides for a period of public comment before provisions in a notice take effect. However, this notice does not enact any policy change within the IPF PPS. The notice only reflects the application of previously established methodologies that already have been subject to public comment; therefore, CMS has waived a public comment period for this notice.

This document discusses updates to the rates per the RY 2008 final notice. Where *Federal Register* page numbers are provided, they refer to the May 4, 2007 *Federal Register*.

Note: 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.

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. More specifically, the transition provides a blended rate as follows: Year 1 – 75% hospital-specific TEFRA payment amount and 25% IPF PPS per diem; Year 2 – 50% TEFRA and 50% IPF PPS; and Year 3 – 25% TEFRA and 75% IPF PPS.

CMS Final Rule (*Federal Register* pages 25603 - 25604): “For RY 2008, we are not making any changes to the transition period established in the November 2004 IPF PPS final rule. We are currently in the third year of the transition period. As a result, for discharges occurring during IPF cost reporting periods beginning in calendar year (CY) 2007, IPFs would receive a blended payment consisting of 25 percent of the facility-specific TEFRA payment and 75 percent of the IPF PPS payment amount.”

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 Final Rule (*Federal Register* page 25618): “For the RY 2008, we are not making any changes to the stop-loss policy. We will continue to monitor expenditures under this policy to evaluate its effectiveness in targeting stop-loss payments to IPFs facing the greatest financial risk.” Therefore, during the third year of the transition period, IPFs will receive a blended payment amount of 25% TEFRA payments and 75% 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 77.5% of TEFRA payments in the third year.

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 payments.

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 a rural CBSA 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

Budget-Neutral Base Rate Per Diem	\$614.99	
Calculate Wage-Adjusted Rate		
Labor portion of the base rate (labor share of 0.75788)		\$466.09
Apply wage index (0.8232 for rural CBSA)		\$383.68
Add the non-labor portion of the base rate		\$148.90
Wage-adjusted rate		\$532.59
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		\$823.39
Apply variable per diem adjustment for 13 days:	Adjustment Factor	Payments
Day 1 (for hospital with full emergency department)	1.31	1,078.64
Day 2	1.12	922.19
Day 3	1.08	889.26
Day 4	1.05	864.56
Day 5	1.04	856.32
Day 6	1.02	839.86
Day 7	1.01	831.62
Day 8	1.01	831.62
Day 9	1.00	823.39
Day 10	1.00	823.39
Day 11	0.99	815.15
Day 12	0.99	815.15
Day 13	0.99	815.15
Total IPF PPS Payments		\$11,206.31

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 federal rate for this budget neutrality is referred to as the standardization factor. CMS' calculation of the RY 2008 federal per diem base rate is discussed on the next page.

CMS Final Rule (*Federal Register* page 25605): **The federal per diem base rate for RY 2008 is \$614.99.** This updated base rate includes a marketbasket increase (discussed below), and a budget neutrality factor of 1.0014.

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. Prior to RY 2007, CMS had been unable to create a separate marketbasket index specific to the IPF PPS and the excluded hospital with capital marketbasket was used to update the IPF PPS rates. This marketbasket was based on 1997 Medicare cost report data and included data for Medicare participating IPFs, IRFs, LTCHs, cancer, and children's hospitals.

In the final rule for RY 2007, CMS adopted a rehabilitation, psychiatric, and long-term care (RPL) marketbasket based on 2002 Medicare cost report data. *"We have excluded cancer and children's hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which are implemented in regulations at § 413.40. They are not reimbursed under a PPS. Also, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs."*

CMS Final Rule (*Federal Register* pages 25605 - 25608): *"The RY 2008 (that is, beginning July 1, 2007) update for the IPF PPS using the FY 2002-based RPL market basket and Global Insight's 1st quarter 2007 forecast for the market basket components is 3.2 percent. This includes increases in both the operating section and the capital section for the 12-month RY period (that is, July 1, 2007 through June 30, 2008)."*

Based on the relative weights from the RPL marketbasket, CMS is increasing the labor-related share of the per diem base rate for IPF PPS to 75.788% with a non-labor related share of 24.212%.

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) 2007 pre-reclassified inpatient acute care hospital wage indices based 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. In addition, CMS does not apply the out-migration adjustment to IPF PPS wage index because this policy only pertains to inpatient PPS. RY 2007 was the first year that IPF PPS wage index values were based on the Core-Based Statistical Area (CBSA) labor market designations rather than the prior Metropolitan Statistical Areas.

CMS Final Rule (*Federal Register* pages 25615 - 25616): “. . . for RY 2008, we will be using the full CBSA based wage index values. . .”

Facility-Level Adjustments

CMS will continue to use the same facility-level adjustments as in RY 2007. 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. CMS calculates the number of FTE residents that train in the IPF during a “base year” and use that FTE resident number as the cap. An IPF’s FTE resident cap will 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 Final Rule (*Federal Register* page 25616): CMS will continue the teaching adjustment at the current level making it equal to $(1 + \text{residents to Average Daily Census (ADC) ratio})$ raised to the power of .5150.

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

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

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 Final Rule (*Federal Register* page 25616): CMS will continue to apply the 17% rural adjustment in RY 2007.

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 Final Rule (*Federal Register* page 25617): 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 on page 10 of this summary.

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. For RY 2008, CMS will continue to use the same patient-level adjustment factors as in RY 2007.

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 continue to believe that 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 PPS proposed and final rule each year.

CMS Final Rule (*Federal Register* pages 25609 - 25610): CMS will continue to recognize the following 15 DRGs for payment under the IPF PPS in RY 2008.

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 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 2007 ICD-9-CM codes that are eligible to receive a DRG adjustment in RY 2008.

New FY 2007 ICD Diagnosis Codes that Qualify for a DRG Adjustment Under IPF PPS

Diagnosis Code	DRG
331.83 Mild cognitive impairment	12
333.71 Althetoid cerebral palsy	12

Patient Age

Background: 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 Final Rule (*Federal Register* pages 25613 - 25614): CMS will continue to use the current age group adjustment factors for RY 2008.

IPF PPS Age Groupings

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

Background: Psychiatric patients with comorbid conditions are generally more costly on a per diem basis.

CMS Final Rule (*Federal Register* pages 25609 - 25613): For RY 2008, CMS will continue to apply the current 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

Background: 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 Final Rule (*Federal Register* pages 25614 - 25615): CMS will continue to use the current variable per diem adjustment factors for RY 2008.

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

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 an IPF's cost is consistent with the approach used under the IPPS and other PPSs.*" 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 Final Rule (*Federal Register* pages 25617 - 25618): CMS will increase the fixed-dollar loss amount from \$6,200 to \$6,488 for RY 2008, 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.

Fixed-Dollar Loss Threshold Amount	\$6,488
Labor portion of the base rate (labor share of 0.75788)	4,917
Apply wage index (0.8232 for rural CBSA)	4,048
Add the non-labor portion of the base rate	1,571
The total wage-adjusted threshold	5,619
Teaching adjustment	1.0902
Rural adjustment	1.17
Adjusted fixed-dollar loss threshold amount	\$7,167
IPF PPS Payment (from IPF PPS calculation example)	\$11,206
Outlier Threshold (PPS payment plus fixed-dollar loss threshold amount)	\$18,373

Charges	\$40,000
CCR	0.55
Cost	\$22,000
Cost above threshold	\$3,627
Patient length of stay	13
Outlier cost per day	\$278.99

Payment for days 1 through 9	
Days	9
Cost (days * outlier cost per day)	\$2,511
Outlier payment factor	80%
Outlier payment	\$2,009
Payment for days ten and beyond	
Days	4
Cost (days * outlier cost per day)	\$1,116
Outlier payment factor	60%
Outlier payment	\$670
Total Outlier Payment	\$2,678

In addition, CMS will annually update the national urban and rural CCRs (median and ceiling) for IPFs based on the latest available IPF PPS provider-specific file. *“The upper threshold CCR for IPFs in RY 2008 is 1.7255 for rural IPFs, and 1.7947 for urban IPFs, based on CBSA-based geographic designation. If an IPF’s CCR is above the applicable ceiling, the ratio is considered statistically inaccurate and we assign the appropriate national (either rural or urban) median CCR to the IPF.”*

The national CCRs for RY 2008 are .71 for rural IPFs and .55 for urban IPFs. CMS will apply the updated national urban and rural CCRs to the following three 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); or Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.”

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 Final Rule (*Federal Register* page 25605): The ECT payment rate for RY 2008 is \$264.77. The ECT payment is adjusted by the wage index.

V. Recertification Requirements

In the final rule for RY 2007, CMS revised the recertification requirements from 18 days to 12 days. Therefore, payment for inpatient psychiatric care is made only if a physician’s first recertification is done as of the 12th day of hospitalization. Thereafter, a hospital’s utilization review committee is responsible for establishing subsequent recertifications on a case-by-case basis, but no less than every 30 days.