CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3575	**Date: August 1, 2016**
	Change Request 9732

SUBJECT: Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2017

I. SUMMARY OF CHANGES: This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update from the FY 2017 IPF PPS Notice, published on July 28, 2016. These changes are applicable to IPF discharges occurring during fiscal year October 1, 2016 through September 30, 2017. This Recurring Update applies to chapter 3, section 190.4.3 and 190.7.3.

EFFECTIVE DATE: October 1, 2016 - Fiscal year effective date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016 - Fiscal implementation date

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/190/190.4.3/Annual Update
R	3/190/190.7.3/Electroconvulsive Therapy (ECT) Payment

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3575	Date: August 1, 2016	Change Request: 9732

SUBJECT: Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2017

EFFECTIVE DATE: October 1, 2016 - Fiscal year effective date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016 - Fiscal implementation date

I. GENERAL INFORMATION

A. Background:

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule that established the prospective payment system for Inpatient Psychiatric Facilities (IPF) under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update from the IPF Prospective Payment System Fiscal Year 2017 Notice, displayed on July 28, 2016. These changes are applicable to IPF discharges occurring during the fiscal year October 1, 2016 through September 30, 2017.

This CR also revises Pub. 100-04, Chapter 3, 190.7.3, removing two ICD-10 PCS Electroconvulsive Therapy (ECT) codes, GZB1ZZZ and GZB3ZZZ, in accordance with Nation Coverage Determination (NCD) 160.25.

B. Policy: Fiscal Year 2017 Update to the IPF PPS

1. Market Basket Update:

For FY 2017, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and Electroconvulsive Therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2017 is 2.8 percent. However, this 2.8 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an "Other Adjustment" that reduces any update to the IPF market basket update by percentages specified in section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2016 (that is, FY 2017), section 1886(s)(3)(C) of the Act requires the reduction to be 0.2 percentage point. CMS implemented that provision in the FY 2017 IPF PPS Notice.

In addition, section 1886(s)(2)(A)(i) of the Act requires the application of the Productivity Adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent FY. For the FY beginning in 2016 (that is, FY 2017), the reduction is 0.3 percentage point. CMS implemented that provision in the FY 2017 IPF PPS Notice.

Therefore, CMS updated the IPF PPS base rate for FY 2017 by applying the adjusted market basket update of 2.3 percent (which includes the 2012-based IPF market basket update of 2.8 percent, an ACA required 0.2 percentage point reduction to the market basket update, and an ACA required productivity adjustment

reduction of 0.3 percentage point) and the wage index budget neutrality factor of 1.0007 to the FY 2016 Federal per diem base rate of $743.73 to yield a FY 2017 Federal per diem base rate of $761.37. Similarly, applying the adjusted market basket update of 2.3 percent and the wage index budget neutrality factor of 1.0007 to the FY 2016 ECT payment per treatment of $320.19 yields an ECT payment per treatment of $327.78 for FY 2017.

2. Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital

Prospective Payment System and Fiscal Year 2013 Rates" Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary shall reduce any annual update to a standard Federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied to the Federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, a 0.3 percent annual update (an update consisting of 2.3 percent reduced by 2.0 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0007 is applied to the FY 2016 Federal per diem base rate of $743.73, yielding a Federal per diem base rate of $746.48 for FY 2017.

- Similarly, a 0.3 percent annual update and the 1.0007 wage index budget neutrality factor is applied to the FY 2016 ECT payment per treatment of $320.19, yielding an ECT payment per treatment of $321.38 for FY 2017

3. PRICER Updates: IPF PPS Fiscal Year 2017 (October 1, 2016 – September 30, 2017):

- The Federal per diem base rate is $761.37 for IPFs that complied with quality data submission requirements.

- The Federal per diem base rate is $746.48 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

- The fixed dollar loss threshold amount is $10,120.00.

- The IPF PPS wage index is based on the FY 2016 pre-floor, pre-reclassified acute care hospital wage index.

- The labor-related share is 75.1 percent.

- The non-labor related share is 24.9 percent.

- The ECT payment per treatment is $327.78 for IPFs that complied with quality data submission requirements.

- The ECT payment per treatment is $321.38 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

4. The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2017

- **See Table A of Attachment One:** "Cost to Charge Ratio for the IPF PPS Fiscal Year 2017"

5. ICD-10 CM/PCS Updates

The adjustment factors are unchanged for the FY 2017 IPF PPS. However, CMS updated the ICD-10-CM/PCS code set as of October 1, 2016. These updates affect the ICD-10-CM/PCS codes which underlie the IPF PPS MS-DRG categories, the IPF PPS comorbidity categories and the IPF PPS code first list. The updated FY 2017 code lists are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.

6. FY 2017 IPF PPS Wage Index

The FY 2017 final IPF PPS wage index is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html. This FY 2017 IPF PPS final wage index fully incorporates the OMB statistical area delineations that were adopted in the FY 2016 IPF PPS transitional wage index.

7. COLA Adjustment

The Cost of Living Adjustment (COLA) factors are unchanged for the FY 2017 IPF PPS. For a list of these adjustment factors see **Table B of Attachment One**: "COLA Adjustment for the IPF PPS Fiscal Year 2017"

8. Rural Adjustment

Due to the OMB CBSA changes implemented in FY 2016, several rural IPFs had their status changed to "urban" as of FY 2016. As a result, these rural IPFs will no longer be eligible for the 17 percent rural adjustment which is part of the IPF PPS. Rather than ending the adjustment abruptly, CMS is phasing out the adjustment for these providers over a three year period. In FY 2016, the adjustment for these newly-urban providers is two-thirds of 17 percent, or 11.3 percent. For FY 2017, the adjustment for these providers will be one-third of 17 percent, or 5.7 percent. No rural adjustment will be given to these providers after FY 2017.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9732.1	The IPF PPS Pricer shall include all FY 2017 IPF PPS updates.									IPF Pricer
9732.2	FISS shall install and pay claims with the FY 2017 IPF PPS Pricer for discharges occurring on or after October 1, 2016.					X				
9732.3	Medicare Contractors shall perform the updates as outlined in the policy section, item 4 "Provider Specific File (PSF) Updates" of this notification.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9732.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Katherine Lucas, Katherine.Lucas@cms.hhs.gov , Sherlene Jacques, 410-672-5676 or sherlene.jacques@cms.hhs.gov (Centers for Medicare and Medicaid Services Center for Medicare Chronic Care Policy Group Division of Chronic Care Management 7500 Security Boulevard Baltimore, Maryland 21244-1850) , Shauntari Cheely, 410-786-1818 or Shauntari.Cheely@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

ATTACHMENT ONE

Table A: Cost to Charge Ratios for the IPF Prospective Payment System Fiscal Year 2017

Cost to Charge Ratios	Median	Ceiling
Urban	0.4455	1.6374
Rural	0.5960	1.9315

CMS is applying the national Cost-to-Charge Ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

- The 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.

Table B: COLA Adjustment for the IPF Prospective Payment System Fiscal Year 2017

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

190.4.3 - Annual Update

(Rev.3575, Issued: 08-01-16, Effective: 10-01-16; Implementation: 10-03-16)

Prior to rate year (RY) 2012, the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) was on a July 1st – June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006 and every July 1 thereafter.

Effective with RY 2012, the IPF PPS payment rate update period switched from a rate year that began on July 1st ending on June 30th to a period that coincides with a fiscal year (FY.) To transition from a RY to a FY, the IPF PPS RY 2012 covered the15 month period from July 1st – September 30th. This change to the payment update period will allow one consolidated annual update to both the rates and the ICD-10-CM coding changes (MS-DRG and comorbidities). Coding and rate changes will continue to be effective October 1st – September 30th of each year thereafter.

In accordance with 42 CFR 412.428, the annual update includes revisions to the Federal per diem base rate, the hospital wage index, ICD-10-CM coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) rate, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

Below are the Change Requests (CRs) for the applicable Rate Years (RYs) and Fiscal Years (FYs) which are issued via Recurring Update Notification.

RY 2009 - CR 6077
RY 2010 - CR 6461
RY 2011 - CR 6986
RY 2012 - CR 7367
FY 2013 - CR 8000
FY 2014 - CR 8395
FY 2015 - CR 8889
FY 2016 - CR 9305
FY 2017 - CR 9732

Change Requests can be accessed through the following CMS Transmittals Website:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Inpatient-Psychiatric-Facility-PPS-Transmittals.html

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev.3575, Issued: 08-01-16, Effective: 10-01-16; Implementation: 10-03-16)

IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket and wage budget neutrality factor. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

In order to receive the payment, an IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

Effective with the implementation of ICD-10 the following ICD-10-PCS codes apply:

ICD-10-PCS Code and Description

GZB0ZZZ - Electroconvulsive Therapy, Unilateral-Single Seizure
GZB2ZZZ - Electroconvulsive Therapy, Bilateral-Single Seizure
GZB4ZZZ – Other Electroconvulsive Therapy

It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with 42 CFR 412.404(d)(3), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers.