CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12830	**Date: September 9, 2024**
	Change Request 13766

Transmittal 12809 issued August 21, 2024, is being rescinded and replaced by Transmittal 12830, dated September 9, 2024, to correct a typographical error in the adjustment factor in the fourth row of the table in the manual, section 190.5.4 - Age Adjustments.

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to identify changes that are required as part of the annual IPF PPS update established in IPF Final Rule entitled "**Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update."** These changes are applicable to discharges occurring from October 1, 2024 through September 30, 2025 (FY 2025). This Recurring CR applies to the Claims Processing Manual (CPM), chapter 3, section 190.

EFFECTIVE DATE: October 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2024

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	Chapter 3/190.1/Background
R	Chapter 3/190.2/Statutory Requirements
R	Chapter 3/190.4.1/Standardization Factor
R	Chapter 3/190.4.2.1/Budget Neutrality Components
R	Chapter 3/190.4.3/Annual Update
R	Chapter 3/190.4.4/Calculating the Federal Payment Rate
R	Chapter 3/190.5.1/Diagnosis-Related Groups (DRGs) Adjustments
R	Chapter 3/190.5.3/Comorbidity Adjustments
R	Chapter 3/190.5.4/Age Adjustments
R	Chapter 3/190.5.5/Variable Per Diem Adjustments
R	Chapter 3/190.6.4/Emergency Department (ED) Adjustment
R	Chapter 3/190.7.3/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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 12830	Date: September 9, 2024	Change Request: 13766

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II. 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 (PPS) 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 which 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 IPF PPS annually.

In addition, section 4125 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328), which amended section 1886(s) of the Act, requires CMS to revise the Medicare prospective payment system for psychiatric hospitals and psychiatric units. Specifically, section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 requires that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for Rate Year 2025 (FY 2025).

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update established in IPF Final Rule entitled "**Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update.**" These changes are applicable to discharges occurring from October 1, 2024 through September 30, 2025 (FY 2025).

B. Policy: Fiscal Year 2025 Update to the IPF PPS

1. Refinements to IPF PPS Adjustment Factors and ECT Payment Per Treatment

In accordance with section 4125(a) of the CAA, 2023, CMS finalized revisions to the payment adjustments for Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments, effective for FY 2025. In addition, CMS finalized a proposal to use the pre-scaled and preadjusted CY 2024 OPPS geometric mean cost of $675.93 as the basis for the IPF PPS ECT payment per treatment in FY 2025.

Section 1886(s)(5)(D)(iii) of the Act, as added by section 4125(a) of the CAA, 2023, states that revisions in payment implemented pursuant to section 1886(s)(5)(D)(i) for a rate year shall result in the same estimated amount of aggregate expenditures under this title for psychiatric hospitals and psychiatric units furnished in the rate year as would have been made under this title for such care in such rate year if such revisions had not been implemented. Accordingly, CMS applied a refinement standardization factor of 0.9524 to the IPF PPS federal per diem base rate and ECT per treatment amount to maintain budget neutrality.

A summary of the applicable adjustment factors and payment rates can be found in **Attachment One**.

2. Market Basket Update:

Since the IPF PPS inception, the Office of the Actuary periodically revises and rebases the IPF market basket to reflect more recent data on IPF cost structures. In the FY 2024 IPF PPS final rule, CMS rebased and revised the market basket applicable to IPFs and adopted a 2021-based IPF-specific market basket. For FY 2025, CMS is using the 2021-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 2021-based IPF market basket update for FY 2025 is 3.3 percent. However, this 3.3 percent is subject to one reduction required by the Social Security Act (the Act), as described below.

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 Rate Year (RY) beginning in 2012 (that is, an RY that coincides with an FY), and each subsequent RY. For the FY beginning in 2024 (that is, FY 2025), the reduction is 0.5 percentage point. CMS implemented that provision in the FY 2025 IPF PPS Final Rule.

Therefore, CMS updated the IPF PPS base rate for FY 2025 by applying the adjusted market basket update of 2.8 percent (which includes the 2021-based IPF market basket update of 3.3 percent and a productivity adjustment reduction of 0.5 percentage point), the wage index budget neutrality factor of 0.9996, and the refinement standardization factor of 0.9524 to the FY 2024 Federal per diem base rate of $895.63, yielding an FY 2025 Federal per diem base rate of $876.53.

Similarly, applying the adjusted market basket update of 2.8 percent, the refinement standardization factor of 0.9524, and the wage index budget neutrality factor of 0.9996 to the pre-scaled and preadjusted CY 2024 OPPS geometric mean cost of $675.93 yields an ECT payment per treatment of $661.52 for FY 2025.

3. FY 2025 Wage Index Update

CMS continued its policy from the prior fiscal year of updating the IPF PPS wage index for FY 2025 with the concurrent wage data from the FY 2025 inpatient prospective payment system wage index before reclassifications and other adjustments are considered. As discussed in the FY 2025 IPF PPS Final Rule, we are finalizing our proposal to adopt revised CBSA delineations based on OMB Bulletin 23–01.

The FY 2025 final IPF PPS wage index is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

4. 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 when calculating the Federal per diem base rate and the ECT payment per treatment as follows:

- The adjusted market basket update of 2.8 percent (which includes the 2021-based IPF market basket update of 3.3 percent and a required productivity adjustment reduction of 0.5 percentage point) is reduced by 2.0 percentage points, for an update of 0.8 percent for IPFs that failed to meet quality reporting requirements.
- For IPFs that failed to submit quality reporting data under the IPFQR program for FY 2025, the 0.8 percent update, the refinement standardization factor of 0.9524, and the wage index budget neutrality factor of 0.9996 are applied to the FY 2024 Federal per diem base rate of $895.63, yielding a Federal per diem base rate of $859.48.
- Similarly, for IPFs that failed to submit quality reporting data under the IPFQR program for FY 2025, the 0.8 percent update, the refinement standardization factor of 0.9524, and the wage index budget neutrality factor of 0.9996 are applied to the pre-scaled and preadjusted CY 2024 OPPS geometric mean cost of $675.93, yielding a per treatment ECT payment of $648.65 for FY 2025.

5. PRICER Updates: IPF PPS Fiscal Year 2025 (October 1, 2024 – September 30, 2025):

- The Federal per diem base rate is $876.53 for IPFs that complied with quality data submission requirements.
- The Federal per diem base rate is $859.48, 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 $38,110.
- The IPF PPS wage index is based on the FY 2025 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 78.8 percent.
- The non-labor related share is 21.2 percent.
- The ECT payment per treatment is $661.52 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $648.65 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.
- The revised IPF PPS adjustment factors for MS-DRG, comorbidities, patient age, and the variable per diem adjustments are summarized in **Attachment One**.
- Pricer will apply the rural transition for IPFs that will become urban in FY 2025 because of the adoption of the revised CBSA delineations based on OMB Bulletin 23–01, based on information entered in the Provider Specific File.

6. Provider Specific File (PSF) Updates

Effective beginning Fiscal Year (FY) 2023, a permanent five percent cap was adopted and applied to all IPF providers on any decrease to a provider's final wage index from that provider's final wage index of the prior fiscal year. Under the five percent cap policy, a new IPF that opens during FY 2025 would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied, because a new IPF would not have a wage index in the prior FY.

In addition, as discussed in the FY 2025 IPF PPS Final Rule, we are finalizing our proposal to phase out the rural adjustment for IPFs that will become urban in FY 2025 because of the adoption of the revised CBSA delineations based on OMB Bulletin 23–01. We will apply two-thirds of the rural adjustment for these providers for FY 2025 and one-third of the rural adjustment for FY 2026. For FY 2027, these IPFs will not receive a rural adjustment.

To implement these policies for FY 2025, the following fields will be updated in the Provider Specific File:

- **Supplemental Wage Index** - used for the prior fiscal year wage index value
- **Supplemental Wage Index Indicator** - used to indicate the value in the "Supplemental Wage Index" field is the prior fiscal year wage index, and whether a rural transition applies.

Medicare Administrative Contractors must update the "Supplemental Wage Index" and "Supplemental Wage Index Indicator" for all providers that were active in FY 2024.

Medicare Administrative Contractors must follow the steps below to ensure the appropriate values are applied in the Supplemental Wage Index and Supplemental Wage Indicator fields:

1. If the provider was not active for FY 2024, then skip all of the below steps and leave the "Supplemental Wage Index" and "Supplemental Wage Index Indicator" fields blank. If the provider was active for FY 2024, then follow the steps below.
2. Validate the accuracy of the provider's FIPS state and county codes.
3. Validate the accuracy of the provider's FY 2024 CBSA based on the provider's FIPS state and county codes and the CBSA delineations defined in OMB Bulletin No. 18–04.
4. Identify the FY 2024 IPF wage index calculated by the pricer software and used to pay claims for each provider in FY 2024, and add this wage index value to "Supplemental Wage Index" field.
5. Identify the provider's FY 2025 CBSA based on the provider's FIPS state and county codes and the CBSA delineations defined in OMB Bulletin No. 23–01. A crosswalk from the FY 2024 CBSA delineations to the FY 2025 CBSA delineations is available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.
6. If the provider's FY 2024 CBSA was rural and the provider's FY 2025 CBSA is urban, then update the value of "Supplemental Wage Index Indicator" to be "3". Otherwise, for all other providers that were active for FY 2024, update the value of "Supplemental Wage Index Indicator" to be "1".

7. The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2025

- **See Attachment One:** "National Cost to Charge Ratios (CCRs)"

8. ICD-10 CM/PCS Updates

For FY 2025, CMS is revising the IPF PPS adjustment factors as discussed above. Additionally, CMS updated the ICD-10-CM/PCS code set, effective October 1, 2024. These updates affect the ICD-10-CM/PCS codes that underlie the IPF PPS MS-DRGs and the IPF PPS comorbidity categories. The updated FY 2025 MS-DRG code lists are available on the IPPS website at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps, and the updated FY 2025 IPF PPS comorbidity categories are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools

There were no changes for FY 2025 to the IPF Electroconvulsive Therapy procedure code list.

9. COLA Adjustment

The IPF PPS Cost of Living Adjustment (COLA) factors for FY 2025 are the same as those used in FY 2024.

- See **Attachment One**: "Cost of Living Adjustments (COLAs)."

10. Rural Adjustment

For FY 2025, IPFs designated as "rural" continue to receive a 17 percent rural adjustment. In addition, as discussed in the FY 2025 IPF PPS Final Rule, we are finalizing our proposal to phase out the rural adjustment for IPFs that will become urban in FY 2025 because of the adoption of the revised CBSA delineations based on OMB Bulletin 23–01. We will apply two-thirds of the rural adjustment for these providers for FY 2025 and one-third of the rural adjustment for FY 2026. For FY 2027, these IPFs will not receive a rural adjustment.

III. 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	
13766.1	Medicare contractors shall perform the updates as outlined in the policy section, item 6 "Provider Specific File (PSF) Updates" of this notification.	X								
13766.1.1	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 1, 2024.	X								
13766.2	As specified in publication 100-04, Medicare Claims Processing Manual, chapter 3, section 20.2.3.1, Medicare contractors shall maintain the accuracy of the data and update the PSF file as changes occur in data element values.	X								
13766.3	CMS shall ensure that the IPF PPS Pricer includes all FY 2025 IPF PPS updates.									CMS
13766.4	Contractors shall access the IPF PPS Pricer via the Cloud to pay FY 2025 payment rates on claims with discharge dates on or after October 1, 2024.	X								

IV. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13766.5	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	X				

V. 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

VI. CONTACTS

Pre-Implementation Contact(s): Nicolas Brock, 410-786-5148 or nicolas.brock@cms.hhs.gov , Amy Miller, 410-786-8213 or amy.miller@cms.hhs.gov

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

VII. 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 1

FY 2025 IPF PPS Final Rates and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	*$876.53*
Labor Share (78.8%)	*$690.71*
Non-Labor Share (21.2%)	*$185.82*

Per Diem Rate Applying the 2 Percentage Point Reduction:

Federal Per Diem Base Rate	*$859.48*
Labor Share (78.8%)	*$677.27*
Non-Labor Share (21.2%)	*$182.21*

Fixed Dollar Loss Threshold Amount:

$38,110

Wage Index Budget Neutrality Factor:

0.9996

Refinement Standardization Factor:

0.9524

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	FY 2025 Pre-floor, Pre-reclassified IPPS Hospital Wage Index

Cost of Living Adjustments (COLAs):

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22
City of Juneau and 80-kilometer (50-mile) radius by road	1.22
Rest of Alaska	1.24
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Patient Adjustments:

ECT – Per Treatment	$661.52
ECT – Per Treatment Applying the 2 Percentage Point Reduction	$648.65

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 -- Facility Without a Qualifying Emergency Department	1.28
Day 1 -- Facility With a Qualifying Emergency Department	1.54
Day 2	1.20
Day 3	1.15
Day 4	1.12
Day 5	1.08
Day 6	1.06
Day 7	1.03
Day 8	1.02
Day 9	1.01
Day 10 and After	1.00

Age Adjustments:

Age (in years)	**Adjustment Factor**
Under 45	1.00
45 and under 55	1.02
55 and under 60	1.05
60 and under 65	1.06
65 and under 70	1.09
70 and under 80	1.11
80 and over	1.13

DRG Adjustments:

MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.12
057	Degenerative nervous system disorders w/o MCC	1.11
876	OR procedure w principal diagnoses of mental illness	1.29
880	Acute adjustment reaction & psychosocial dysfunction	1.08
881	Depressive neuroses	1.06
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.17
884	Organic disturbances & intellectual disabilities	1.08
885	Psychoses	1.00
886	Behavioral & developmental disorders	1.07
887	Other mental disorder diagnoses	1.00
894	Alcohol/drug abuse or dependence, left AMA	0.86
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.90
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.00
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.95
917	Poisoning and toxic effects of drugs w MCC	1.19
918	Poisoning and toxic effects of drugs w/out MCC	1.12
947	Signs and Symptoms w MCC	1.12
948	Signs and Symptoms w/out MCC	1.09

Comorbidity Adjustments:

Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Tracheostomy	1.09
Eating Disorders	1.09
Renal Failure, Acute	1.06
Renal Failure, Chronic	1.08
Oncology Treatment	1.44
Uncontrolled Diabetes Mellitus	1.05
Severe Protein Malnutrition	1.17
Cardiac Conditions	1.04
Gangrene	1.12
Chronic Obstructive Pulmonary Disease and Sleep Apnea	1.09
Artificial Openings – Digestive & Urinary	1.07
Severe Musculoskeletal & Connective Tissue Diseases	1.05
Poisoning	1.16
Intensive Management for High-Risk Behavior	1.07

National Median and Ceiling Cost-to-Charge Ratios (CCRs):

CCRs	Rural	Urban
National Median	0.5720	0.4200
National Ceiling	2.3181	1.8287

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.12830; Issued:09-09-24)

190.1 - Background
(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

This section and its subsections provide instructions about the IPF PPS. The IPF PPS replaces reasonable cost-based payments subject to Tax Equity and Fiscal Responsibility Act (TEFRA) limits under section 1886 (b) of the Social Security Act (the Act) for discharges occurring on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at 42 CFR 412, Subpart N, provides payment for inpatient psychiatric treatment when provided to an inpatient in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs).

190.2 - Statutory Requirements
(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary: (1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P. L. 108173), section 405(g) extended the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

Section 4125 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328), which amended section 1886(s) of the Act, requires CMS to revise the Medicare prospective payment system for psychiatric hospitals and psychiatric units. Section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 requires that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for RY 2025 (FY 2025).

190.4.1 - Standardization Factor
(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

The CMS standardized the IPF PPS Federal per diem base rate *for Rate Year 2005* in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, CMS compared the IPF PPS payment amounts calculated from the FY 2002 MedPAR file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments

under the TEFRA payment system by estimated payments under the IPF PPS. CMS then applied this factor to the average per diem cost of an IPF stay.

For FY 2025, CMS applied a refinement standardization factor to the IPF PPS federal per diem base rate and ECT per treatment amount to ensure that the rates reflect the FY 2025 update to the patient-level adjustment factors in a budget neutral manner.

190.4.2.1 - Budget Neutrality Components

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

The following are the three components of the budget neutrality adjustment:

(1) Outlier Adjustment: Since the IPF PPS payment amount for each stay includes applicable outlier amounts, CMS reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The appropriate outlier amount was determined by comparing the adjusted prospective payment for the entire stay to the computed cost per case. If costs were above the prospective payment plus the adjusted fixed dollar loss threshold amount, an outlier payment was computed using the applicable risk-sharing percentages. The outlier adjustment was calculated to be 2 percent of total IPF PPS. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments;

(2) Stop-Loss Adjustment: CMS provides 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. CMS reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition *was* completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs *are* paid 100 percent PPS and, therefore, the stop loss provision *is* no longer be applicable. The CMS has previously stated that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition. Therefore, for RY 2009, the Federal per diem base rate and ECT rates *was* increased by 0.39 percent.

(3) Behavioral Offset: The implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may incur higher payments than assumed in the calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, CMS reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes.

190.4.3 - Annual Update

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

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 1st 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 the 15 month period from July 1st -September 30th. This change to the payment update period allow*ed* one consolidated annual update to both the rates and the ICD-10-CM/PCS coding changes (MS-DRG, comorbidities, and code first). 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) payment per treatment, 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 a 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
FY 2018 - CR 10214
FY 2019 - CR 10880
FY 2020 - CR 11420
FY 2021 – CR 11949
FY 2022- CR 12417
FY 2023 – CR 12859
FY 2024 – CR 13335
FY 2025 – CR

Change Requests can be accessed through the following CMS Transmittals Website:*https://www.cms.gov/medicare/regulations-guidance/transmittals*

190.4.4 - Calculating the Federal Payment Rate

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

To calculate an IPF PPS payment, follow the steps below:

1 - Multiply the Federal per diem base rate by the labor share.

2 - Multiply the resulting amount by the appropriate wage index factor.

3 - Multiply the Federal per diem base rate by the non-labor share.

4 - Multiply the resulting amount from this by any applicable cost-of-living adjustment (COLA) (Alaska or Hawaii).

5 - Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate (Add the results of steps 2 and 4). This is the Federal rate.

You must multiply this sum (step 5) by all applicable facility and patient level adjustment factors described in §§190.5 and 190.6, to calculate the final payment.

190.5.1 - Diagnosis-Related Groups (DRGs) Adjustments

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

On claims with discharges before October 1, 2007, the IPF PPS provides adjustments for 15 designated DRGs. On claims with discharges on or after October 1, 2007, the IPF PPS provides adjustments for 17 designated MS-DRGs. *On claims with discharges on or after October 1, 2024, the IPF PPS provides adjustments for 19 designated MS-DRGs.* Payment is made under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the International Classification of Diseases (ICD-9- or ICD-10 as applicable) or the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision (DSM-V-TR). The language about the source of the principal diagnosis code is from our regulations at 42 CFR 412.27, and has been in place since 2006, but there have since been updates to the versions of these code sets.

In a final rule published on September 5, 2012 (77 FR 54664), the Secretary of HHS adopted the ICD–10–CM and ICD–10–PCS, in place of the ICD–9–CM, as the standard medical data code sets for HIPAA covered entities. Because we are required to use the HIPAA standards, effective October 1, 2015, IPF claims for eligible patients must have a psychiatric principal diagnosis that is listed in the ICD–10–CM. It should be noted that the DSM codes map to ICD-10 codes, but the mapping is not exclusive to chapter 5 of the ICD–10–CM, as it was with ICD–9–CM.

Nevertheless, only those claims with diagnoses that group to a psychiatric DRG/MS-DRG will receive the DRG adjustment in addition to all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the following psychiatric DRGs/MS-DRGs, the IPF will receive the Federal per diem base rate and all other applicable adjustments.

IPFs must submit claims providing the principal diagnosis. To classify the case to the appropriate DRG/MS-DRG, the GROUPER software for the hospital IPPS is used and the IPF PRICER applies the appropriate adjustment factor to the Federal per diem base rate.

Changes to the ICD coding system are addressed annually in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information.

(v25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
056	Degenerative nervous system disorders w MCC	*1.12*
057	Degenerative nervous system disorders w/o MCC	*1.11*
876	O.R. procedure w principal diagnoses of mental illness	*1.29*
880	Acute adjustment reaction & psychosocial dysfunction	*1.08*
881	Depressive neuroses	*1.06*
882	Neuroses except depressive	1.02

(v25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
883	Disorders of personality & impulse control	*1.17*
884	Organic disturbances & mental retardation	*1.08*
885	Psychoses	1.00
886	Behavioral & developmental disorders	*1.07*
887	Other mental disorder diagnoses	*1.00*
894	Alcohol/drug abuse or dependence, left AMA	*0.86*
895	Alcohol/drug abuse or dependence w rehabilitation therapy	*0.90*
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	*1.00*
897	*Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC*	*0.95*
917	*Poisoning and toxic effects of drugs w MCC*	*1.19*
918	*Poisoning and toxic effects of drugs w/out MCC*	*1.12*
947	*Signs and Symptoms w MCC*	*1.12*
948	*Signs and Symptoms w/out MCC*	*1.09*

190.5.3 - Comorbidity Adjustments

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and not reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay or affect both treatment and the length of stay. IPFs enter the full codes for up to twenty four additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has *15* comorbidity categories, each containing codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-10-CM/PCS codes that are associated with each category is on the IPF PPS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/inpatientpsychfacilpps. Select Tools and Worksheets from the column at the left.

The *15* comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	Adjustment Factor
Developmental Disabilities	1.04
Tracheostomy	*1.09*

Description of Comorbidity	Adjustment Factor
Renal Failure, Acute	*1.06*
Renal Failure, Chronic	*1.08*
Oncology Treatment	*1.44*
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	*1.17*
Eating Disorders	*1.09*
Cardiac Conditions	*1.04*
Gangrene	*1.12*
Chronic Obstructive Pulmonary Disease *& Sleep Apnea*	*1.09*
Artificial Openings - Digestive and Urinary	*1.07*
Severe Musculoskeletal and Connective Tissue Diseases	*1.05*
Poisoning	*1.16*
Intensive Management for High-Risk Behavior	*1.07*

190.5.4 - Age Adjustments

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

The IPF PPS has an age adjustment with *7* age categories; under 45, over 80, and categories in 5 year groupings in between. IPFs receive this adjustment for each day of the stay. The age adjustment is determined based on the age at admission and does not change regardless of the length of stay.

Age	Adjustment Factor
Under 45	1.00
45 and under *55*	*1.02*
55 and under 60	*1.05*
60 and under 65	*1.06*
65 and under 70	*1.09*
70 and under 80	*1.11*
80 and over	*1.13*

190.5.5 - Variable Per Diem Adjustments

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

The variable per diem adjustments account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. The variable per diem adjustments decline each day of the patient's stay through day *10*. After day *10*, the adjustments remain the same each day for the remainder of the stay.

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 1 - Facility Without a Qualifying Emergency Department	*1.28*
Day 1 - Facility With a Qualifying Emergency Department	*1.54*
Day 2	*1.20*
Day 3	*1.15*
Day 4	*1.12*
Day 5	*1.08*
Day 6	*1.06*
Day 7	*1.03*
Day 8	*1.02*
Day 9	*1.01*
Day 10 *and After*	1.00

*The adjustment for day 1 would be *1.54* or *1.28* depending on whether the IPF has a qualifying emergency department or is a psychiatric unit in an acute care hospital or CAH with a qualifying emergency department (see §190.6.4).

190.6.4 - Emergency Department (ED) Adjustment

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

An adjustment is provided for IPFs that maintain a qualifying ED. This is a facility-level adjustment that applies to all IPF admissions (with the one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive a *54* percent adjustment as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a *28* percent adjustment as the variable per diem adjustment for day 1 of each patient stay.

A qualifying ED means an ED of psychiatric units located in a hospital or CAH with EDs that are staffed and equipped to furnish a comprehensive array (medical as well as psychiatric) of emergency services and meets the definition of "provider-based status" (42 CFR 413.65) and meets the definition of a "dedicated emergency department" (42 CFR 489.24).

- "Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of this section." 42 CFR 413.65

- "Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." See 42 CFR 489.24.

As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit, the IPF receives the *1.28* adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF.

IPFs should notify their Medicare contractors 30 days before the beginning of their cost reporting period regarding if they have a qualifying ED. Medicare contractors have the discretion to determine how they wish to be notified and the documentation they require. Once the Medicare contractor is satisfied that the IPF has a qualifying ED, the Medicare contractor should enter the information in the provider-specific file within a reasonable timeframe so that the IPF can begin to receive the ED adjustment. Application of the ED adjustment is prospective.

Medicare contractors may also use the date the documentation was received from the IPF to implement the ED adjustment. The provider specific file can be updated from the date of the attestation and claims processed from that date will receive the ED adjustment. CMS does not intend that IPFs would have to wait until the beginning of their next cost report period to receive the ED adjustment.

However, if an IPF no longer meets the definition of a qualified ED, the IPF must promptly notify their Medicare contractor. The Medicare contractor would immediately remove the flag from the provider-specific file and the provider will not receive the ED adjustment. If the provider should once again meet the definition of a qualified ED, they should contact their Medicare contractor immediately in order to update their file.

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev. 12830; Issued: 09-09-24; Effective: 10-01-24; Implementation: 10-07-24)

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 *(OPPS)* 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.

For FY 2025, CMS used the pre-scaled and preadjusted CY 2024 OPPS geometric mean cost of $675.93 as the basis for the IPF PPS ECT payment per treatment. CMS applied the final FY 2025 IPF PPS payment rate update, refinement standardization factor, and wage index budget neutrality factor to this amount to determine the ECT payment per treatment for FY 2025.

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.