CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4104	**Date: August 3, 2018**
	Change Request 10880

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2019

I. SUMMARY OF CHANGES: This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update established in the "**Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019) Final Rule.** These changes are applicable to discharges occurring from October 1, 2018 through September 30, 2019 (FY 2019). This Recurring CR applies to the Claims Processing Manual (CLM), chapter 3, section 190.4.3. It includes technical corrections and updates to the CLM, chapter 3, various sections in 190 from prior rulemaking.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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	3/190/4.3/Annual Update
R	3/190/5.1/Diagnosis- Related Groups (DRGs) Adjustments
R	3/190/5.3/Comorbidity Adjustments
R	3/190/6.5/Cost-of-Living Adjustment (COLA) for Alaska and Hawaii
R	3/190/7.2.2/Determining the Cost-to-Charge Ratio
R	3/190/10.4/Reporting ECT Treatments
R	3/190/10.11/Benefit Application and Limits-190 Days

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: 4104	Date: August 3, 2018	Change Request: 10880

SUBJECT: Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2019

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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 (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 State Children's Health Insurance Program (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.

This CR identifies changes that are required as part of the annual IPF PPS update established in the "**Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019) Final Rule**". These changes are applicable to discharges occurring from October 1, 2018 through September 30, 2019 (FY 2019). This CR also includes technical corrections and updates to the manual from prior rulemaking.

B. Policy: Fiscal Year 2019 Update to the IPF PPS

1. Market Basket Update:

For FY 2019, 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 2019 is 2.9 percent. However, this 2.9 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 RY beginning in 2019. For the FY beginning in 2018 (that is, FY 2019), section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage point. CMS implemented that provision in the FY 2019 IPF PPS and Quality Reporting Updates Final Rule.

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 RY. For the FY beginning in 2018 (that is, FY 2019), the reduction is 0.8 percentage point. CMS implemented that provision in the FY 2019 IPF PPS and Quality Reporting Updates Final Rule.

Therefore, CMS updated the IPF PPS base rate for FY 2019 by applying the adjusted market basket update of 1.35 percent (which includes the 2012-based IPF market basket update of 2.9 percent, an ACA required 0.75 percentage point reduction to the market basket update, and a required productivity adjustment

reduction of 0.8 percentage point) and the wage index budget neutrality factor of 1.0013 to the FY 2018 Federal per diem base rate of $771.35, yielding a FY 2019 Federal per diem base rate of $782.78. Similarly, applying the adjusted market basket update of 1.35 percent and the wage index budget neutrality factor of 1.0013 to the FY 2018 ECT payment per treatment of $332.08 yields an ECT payment per treatment of $337.00 for FY 2019.

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 initial 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:

- For IPFs that failed to submit quality reporting data under the IPFQR program, for FY 2019, we applied a -0.65 percent payment rate update (a negative update that reflects the IPF market basket increase for FY 2019 of 2.9 percent, less the productivity adjustment of 0.8 percentage point, reduced by the ACA required 0.75 percent point, and further reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0013 to the FY 2018 Federal per diem base rate of $771.35, yielding a FY 2019 Federal per diem base rate of $767.33.

- Similarly, for FY 2019, we applied a -0.65 percent payment rate update to the FY 2018 ECT payment per treatment of $332.08, yielding a FY 2019 ECT payment per treatment of $330.35.

3. PRICER Updates: IPF PPS Fiscal Year 2019 (October 1, 2018 – September 30, 2019):

- The Federal per diem base rate is $782.78 for IPFs that complied with quality data submission requirements.
- The Federal per diem base rate is $767.33, 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 $12,865.
- The IPF PPS wage index is based on the FY 2018 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 74.8 percent.
- The non-labor related share is 25.2 percent.
- The ECT payment per treatment is $337.00 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $330.35 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

4. Provider Specific File (PSF) Updates:

The FY 2019 IPF PPS wage index uses the most recent Office of Management and Budget (OMB) statistical area delineations to identify a facility's urban or rural status for the purpose of determining if a rural adjustment will apply to the facility. There were no changes made to the OMB designations in FY 2019 IPF

PPS wage index. For FY 2019, no IPFs should have any special pay indicators or receive any wage index value other than those given in the FY 2019 IPF PPS wage index.

Medicare Administrative Contractors (MACs) shall update the PSF as necessary.

5. The National Urban and Rural Cost to Charge Ratios for the IPF PPS Fiscal Year 2019

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

6. ICD-10 CM/PCS Updates

For FY 2019, the IPF PPS adjustment factors are unchanged from those used in FY 2018. However, CMS updated the ICD-10-CM/PCS code set, effective October 1, 2018. 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 2019 MS-DRG code lists are available on the IPPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html, and the updated FY 2019 IPF PPS comorbidity categories are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html. There were no changes from FY 2018 to FY 2019 to the IPF Code First list or the IPF Electroconvulsive Therapy procedure code list.

7. FY 2019 IPF PPS Wage Index

The FY 2019 final IPF PPS wage index is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.

8. COLA Adjustment

The IPF PPS Cost of Living Adjustment (COLA) factors list for FY 2019 was unchanged from FY 2018. See **Attachment One**: "Cost of Living Adjustments (COLAs)."

9. Rural Adjustment

For FY 2019, IPFs designated as "rural" continue to receive a 17 percent rural adjustment.

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	
10880.1	FISS shall install and pay claims with the FY 2019 IPF PPS Pricer for discharges occurring on or after October 1, 2018.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10880.2	Medicare Contractors shall perform the updates as outlined in the policy section, item 4 “Provider Specific File (PSF) Updates” of this notification.	X								
10880.3	The IPF PPS Pricer shall include all FY 2019 IPF PPS updates.									CMS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10880.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	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): Sherlene Jacques, 410-786-0510 or sherlene.jacques@cms.hhs.gov , 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 1

Cost to Charge Ratios (CCRs) for the IPF PPS Fiscal Year 2019

	Rural	Urban
National Median CCRs	0.5890	0.4365
National Ceiling CCRs	2.0068	1.6862

CMS is applying the national Cost-to-Charge Ratios 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.

Cost of Living Adjustments (COLAs) for IPF PPS Fiscal Year 2019

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

190.4.3 - Annual Update

(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

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/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

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

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)
(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

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. 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-IV-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.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS-DRGs which were effective October 1, 2007:

(v24) DRG Prior to 10/01/07	(v25) MS-DRG From 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07

(v24) DRG Prior to 10/01/07	(v25) MS-DRG From 10/01/07	MS-DRG Descriptions	Adjustment Factor
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

190.5.3 - Comorbidity Adjustments

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)
(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

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 17 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 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	**Adjustment Factor**
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	1.13
Eating and Conduct Disorders	1.12
Infectious Disease	1.07
Drug and/or Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings - Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii

(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the *area* in which the IPF is located. An adjustment for IPFs located in Alaska and Hawaii is made by multiplying the non-labor related share of the Federal per diem base rate and ECT rate by the applicable COLA factor.

The CMS notes that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR §591.207, the OPM established the following COLA areas:

(a) City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(b) City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(c) City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(d) Rest of the State of Alaska.

In FY 2018, we updated the IPF COLA amounts; these updated amounts will remain in effect for FY 2018 through FY 2020.

State	Location	COLA
Alaska	Anchorage	1.2*5*
	Fairbanks	1.2*5*
	Juneau	1.2*5*
	Rest of Alaska	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.*21*
	Kauai County	1.25
	Maui County	1.25
	Kalawao County	1.25

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

For discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine the IPF's CCR. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals:

1) Identify total Medicare costs from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

Distinct Part Units

For IPFs that are distinct part psychiatric units:

1) Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IPF unit that has the letter "S" or "M" in the third position of the Medicare provider number.

A. - Use of Alternative Data in Determining CCRs For IPFs Subject to the IPF PPS

Under 42 CFR 412.424(d)(3)(i,), for discharges in cost reporting periods beginning on or after January 1, 2005, CMS may direct Medicare contractors to use an alternative CCR to the CCRs from the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data.

B. - Request by the IPF for use of a Different CCR

For discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may request that an alternative CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request after

evaluation by the Medicare contractor of the evidence presented by the IPF. Revised CCRs are applied prospectively to all IPF claims. Medicare contractors shall send notification to the CMS Central Office via the following address and e-mail address:

CMS
C/O Division of Chronic Care Management-IPF Outlier Team
7500 Security Blvd.
Mail Stop C5-05-27
Baltimore, MD. 21244
outliersipf@cms.hhs.gov

C. - Application of National Average CCRs for IPFs

For discharges in cost reporting periods occurring on or after January 1, 2005, the Medicare contractor may use the national CCRs for an IPF in one of the following circumstances:

1. New IPFs that have not yet submitted their first Medicare cost report.

2. IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

3. Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using the national CCRs 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. **NOTE**: IPF PPS provides two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.

The policies in section E below can be applied as an alternative to the national average CCR.

For those IPFs assigned the national average CCR, the CCR must be updated every July 1 based on the latest national average CCRs published in each year's IPF annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D. - Notification to IPFs Under the IPF PPS of a Change in the CCR

The Medicare contractor shall notify an IPF whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to an IPF about a change to their CCR(s).

E. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Entities Subject to the IPF PPS

For discharges beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentatively settled cost report (whichever is from the later period) to determine the IPF's CCR. Under the IPF PPS, Medicare contractors must update the IPFs CCR on the Provider Specific File to reflect the IPFs CCR from the most recent tentative settlements or final settled cost reports, (whichever is the later period). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

Subject to the approval of CMS, an IPF's CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all IPF PPS claims processed after the update.

F. - Alternative CCRs

Effective for discharges in cost reporting periods beginning on or after January 1, 2005, the CMS Central Office may direct Medicare contractors to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office and CMS Central Office must approve any such request after evaluation by the Medicare contractor of the evidence presented by the IPF.

G. - IPF Mergers, Ownership Changes, and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IPF with the surviving provider number. If a new provider number (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement) is issued the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact CMS Central Office to seek guidance. Medicare contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Contractors shall contact the CMS regional and Central Office for further instructions. Contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

H. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

190.10.4 - Reporting ECT Treatments

(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

IPFs must report on their claims under Revenue Code 0901: the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Providers will code ICD-9-CM procedure

code 94.27 if ICD-9-CM is applicable, or, effective with the implementation of ICD-10, providers will code the ICD-10-PCS codes listed below in the procedure code field, and for the procedure date will use the date of the last ECT treatment the patient received during their IPF stay.

ICD-10-PCS Code and Description

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

190.11 - Benefit Application and Limits-190 Days

(Rev.4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

The psychiatric benefit lifetime maximum of 190 days of inpatient care applies to *Medicare participating* psychiatric hospitals per 42 CFR 409.62. The 190-day lifetime limitation does not apply to *inpatient* psychiatric *care provided in certified* psychiatric *units of an acute care hospital or critical access hospital.* Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. This limitation does not apply to inpatient psychiatric services furnished in a non-psychiatric hospital. This limitation does not apply to inpatient psychiatric services furnished in a hospital, a CAH or distinct part psychiatric unit. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

The Benefit Period provisions described in Medicare Publication 100-01, Medicare General Information, Eligibility, and Entitlement, chapter 3, §§10.4-10.4.4 are applicable to inpatients in either a *Medicare participating* psychiatric hospital or a *certified psychiatric unit of an acute care hospital or critical access hospital.*

The CWF keeps track of days paid for inpatient psychiatric services and informs the Medicare contractor on claims where the 190-day limit is reached.

For a more detailed description see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §30.C. and chapter 4, §50 for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services. For details concerning the pre-entitlement inpatient psychiatric benefit reduction provision see Pub. 100-02, Medicare Benefit Policy Manual, chapter 4, §§10 - 50.