CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1543	**Date: JUNE 27, 2008**
	Change Request 6077

Subject: Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2009

I. SUMMARY OF CHANGES: This CR outlines updates to the IPF PPS for Rate Year 2009.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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	3/190/4.2.1/Budget Neutrality Components
R	3/190/5/Patient-Level Adjustments
R	3/190/5.1/Diagnosis-Related Groups (DRGs) Adjustments
R	3/190/5.2/Application of Code First
R	3/190/6.5/Cost-of-Living Adjustment (COLA) for Alaska and Hawaii
R	3/190/7.3/Electroconvulsive Therapy (ECT) Payment
R	3/190/7.4/Stop Loss Provision (Transition Period Only)
R	3/190/10.1/General Rules
R	3/190/17.1/Inputs/Outputs to Pricer

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Manual Instruction

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1543	Date: June 27, 2008	Change Request: 6077

SUBJECT: Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2009

Effective Date: **July 1, 2008**

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background:

On November 15, 2004, 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). We are required to make updates to this prospective payment system annually. The Rate Year (RY) update is effective July 1 - June 30 and the MS-DRGs and ICD-9-CM codes are updated on October 1 of each year.

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update from the RY 2009 IPF PPS update notice, published on May 7, 2008. These changes are applicable to IPF discharges occurring during the rate year July 1, 2008, through June 30, 2009. This is the third RY update to the IPF PPS.

Issue unrelated to the RY 2009 IPF PPS Update
We have identified an error within the IPF PPS Pricer that did not calculate a comorbidity adjustment (adjustment factor 1.07) on claims that contained both diagnosis code 07070 and a discharge date occurring on or after January 1, 2005 through June 30, 2006. This will be corrected in this release of the RY 09 Pricer.

B. Policy:

Rate Year 2009 Update to the IPF PPS

1. Market Basket Update:

We use the **Rehabilitation/Psychiatric/Long-Term Care** (**RPL**) market basket to update the IPF PPS payment rate (that is the Federal per diem base rate).

2. PRICER Updates: For IPF PPS Rate Year (RY) 2009, (July 1, 2008 – June 30, 2009):

- The Federal per diem base rate is $637.78.
- The fixed dollar loss threshold amount is $6,113.00.
- The transition from payment under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to a PPS payment ends in 2008. For cost reporting periods beginning on or after January 1, 2008, payments will be 100 percent PPS.
- The IPF PPS will use the FY 2008 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 75.631 percent.
- The non-labor related share is 24.369 percent.
- The electroconvulsive therapy (ECT) rate is $274.58.

3. Stop-Loss Provision

We provided a stop-loss payment during the transition from cost-based reimbursement to the per diem payment system to ensure that an IPF's total PPS payments were no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. We 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 will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. We have 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 will be increased by 0.39 percent. The rates published in this transmittal include this increase.

4. Provider Specific File (PSF) Updates:
No updates beyond standard maintenance.

5. Electroconvulsive Therapy (ECT) Update:

The update methodology for the ECT rate is to update the previous rate year's amount by the market basket increase, wage index budget neutrality factor and stop-loss premium removal. The ECT adjustment per treatment is $274.58 for RY 2009.

6. Payment Rate:

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).

Per Diem Rate:

Federal Per Diem Base Rate	$637.78
Labor Share (0.75631)	$482.36
Non-Labor Share (0.24369)	$155.42

The rates for RY 2009 were published in the update notice and can also be found on the IPF PPS Web site at: http://www.cms.hhs.gov/InpatientPsychFacilPPS

7. The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2009:

Cost to Charge Ratio	Median	Ceiling
Urban	0.537	1.6724
Rural	0.686	1.8041

We are applying the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, we are 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.

8. MS-DRG Update

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, please note 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 After 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056	Degenerative nervous system disorders w MCC	1.05
	057	Degenerative nervous system disorders w/o MCC	
023	080	Nontraumatic stupor & coma w MCC	1.07
	081	Nontraumatic stupor & coma w/o MCC	
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	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	

Issue Unrelated to the RY 2009 IPF PPS Update

In addition to the aforementioned RY 2009 updates, we will be correcting the IPF PPS Pricer to include diagnosis code 07070 in calculating a comorbidity adjustment (adjustment factor 1.07) on claims that contained both diagnosis code 07070 and a discharge date occurring on or after January 1, 2005 through June 30, 2006.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6077.1	The IPF PPS Pricer shall include all RY 09 IPF PPS updates.										IPF PPS Pricer
6077.2	The IPF PPS Pricer shall calculate the comorbidty adjustment on claims that include diagnosis code 07070 and have a discharge date on or after January 1, 2005 through June 30, 2006.										IPF PPS Pricer
6077.3	FISS shall install and pay claims with the Rate Year 2009 IPF PPS Pricer for discharges occurring on or after July 1, 2008.						X				
6077.4	Contractors shall reprocess and finalize any affected claims (described in 6077.2) that are brought to their attention.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6077.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Matthew Quarrick at matthew.quarrick@cms.hhs.gov or 410-786-9867
Claims Processing: Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

190.4.2.1 - Budget Neutrality Components

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

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 will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will 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 will be 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.

190.5 - Patient-Level Adjustments

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Patient-level adjustments include a DRG*, or MS-DRG,* adjustment, comorbidity adjustment, an age adjustment, and a variable per diem adjustment.

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

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 ICD-9-CM or the DSM-IV-TR. However, 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 ICD-9-CM code of 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-9-CM 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. Further information concerning the Official Version of the ICD-9-CM can be found in the IPPS final regulation.

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*	*Nontraumatic stupor & coma w MCC*	*1.07*

	081	*Nontraumatic stupor & coma w/o MCC*	
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*

190.5.2 - Application of Code First

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

According to the ICD-9-CM Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable ICD-9-CM coding convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches the secondary codes for a psychiatric code to assign the DRG*/MS-DRG* in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.

The most current Code First list is posted on the IPF PPS Web site at www.cms.hhs.gov/InpatientPsychFacilPPS

Code First Example

Diagnosis code 294.11 “Dementia in Conditions Classified Elsewhere with Behavioral Disturbances” is designated as “NOT ALLOWED AS PRINCIPAL DX” code.

Four digit code 294.1 “Dementia in Conditions Classified Elsewhere”, is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 “Persistent Mental Disorders Due to Conditions Classified Elsewhere” appears in the ICD-9-CM as follows:

294 PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

Alzheimer’s disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (331.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0 – 345.9)
Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington’s chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances

NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 “Huntington’s Chorea” as the principal diagnosis code and 294.11 “Dementia In Conditions Classified Elsewhere With Behavioral Disturbances” as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs*, or 17 MS-DRGs,* for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG*/MS-DRG*, the PRICER would search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.

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

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county 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 the November 2004 and May 2006 IPF PPS final rules, the CMS showed only one COLA for Alaska because all four areas were the same amount (1.25). Effective September 1, 2006, the OPM updated the COLA amounts and there are now two different amounts for the Alaska COLA areas (1.24 and 1.25).

	Location	***COLA***
Alaska	*Anchorage* *Fairbanks* *Juneau* *Rest of Alaska*	*1.24* *1.24* *1.24* *1.25*

	Location	COLA
Hawaii	*Honolulu County* *Hawaii County* *Kauai County* *Maui County* *Kalawao County*	*1.25* *1.17* *1.25* *1.25* *1.25*

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

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.

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.

190.7.4 - Stop Loss Provision (Transition Period Only)

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The IPF PPS includes a stop-loss provision during the 3-year transition. The purpose is to ensure each facility receives an average payment per case under the IPF PPS that is no less than 70 percent of its average payment under the TEFRA. It is calculated at cost report settlement. New providers are not eligible for stop-loss payments. See §190.9.1.

Example of stop-loss calculation in year 3 of the transition:

1. Enter Total (100%) TEFRA payments for cases during cost reporting period

2. Enter Total (100%) PPS payments for cases during cost reporting period

3. Multiply Step 1 by 0.70.

4. If Step 3 is greater than Step 2, subtract Step 2 from Step 3. Otherwise, enter 0.

5. Add Steps 2 and 4 to calculate total PPS payments.

6. Multiply Step 1 by 0.25 to calculate the TEFRA portion.

7. Multiply Step 5 by 0.75 to calculate the PPS portion.

8. Add Steps 6 and 7 to calculate the IPF's aggregate payments in the third year of the IPF PPS. Determine if this amount is at least 70 percent of what would have been paid under TEFRA, then pay the difference.

NOTE: Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will 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 will be increased by 0.39 percent.

190.10.1 - General Rules

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must code diagnoses correctly; using ICD-9-CM codes for the principal diagnosis, and up to eight additional diagnoses, if applicable;
- The IPF must code procedures correctly using ICD-9-CM Volume III codes for one principal procedure and up to five additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and

- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date (or effective December 3, 2007, benefits exhaust date, if present) on the claim will determine the DRG*/MS-DRG* assignment.

190.17.1 - Inputs/Outputs to PRICER

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator
9	Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.
12	Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)
17	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
18	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)

23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)
38	Special Wage Index
48	New Hospital

Bill Data

National Provider Identifier	**Covered Charges**
OSCAR Number	Discharge Date (or benefits exhaust date if present)
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment
DRG*/MS-DRG* Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
Per Diem Adjusted Payment
Facility Adjusted Payment
Age Adjusted Payment
Rural Adjusted Payment
Teaching Adjusted Payment
ED Adjusted Payment
ECT Adjusted Payment
Return Code
MSA/CBSA
Wage Index
National Labor Rate

National Non-Labor Rate
Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate
Standardized Factor
Labor Share
Non-Labor Share
COLA
Day of Stay Adjustment
Age Adjustment
Comorbidity Adjustment
DRG Adjustment
Rural Adjustment
ECT Adjustment
Blend Year Calculation Version