CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 978	Date: JUNE 9, 2006
	Change Request 5129

Subject: Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2007

**I. SUMMARY OF CHANGES:** This Change Request (CR) includes general policy and billing information to address questions on IPF PPS. Specifically, the CR indicates changes that will be required as part of the annual IPF PPS update for Rate Year 2007. These include: the market basket update, new CBSA designations used for assigning a wage index value, and PRICER updates.

New/Revised Material: Effective Date: July 1, 2006

Implementation Date: July 3, 2006

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	
N/A		

#### III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006

#### **IV. ATTACHMENTS:**

#### **Recurring Update Notification**

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

# **Attachment – Recurring Update Notification**

Pub. 100-04 Transmittal: 978 Date: June 9, 2006 Change Request 5129

SUBJECT: Update- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2007

#### I. GENERAL INFORMATION

**A. Background:** On November 15, 2004, we 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 Balance 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 of each year and the DRGs and ICD-9-CM codes are updated on October 1 of each year. This is the first RY update to the IPF PPS.

This Change Request (CR) identifies changes that are required as part of the annual IPF PPS update from the RY 2007 IPF PPS Final Rule. These changes are applicable to IPF discharges occurring during the rate year beginning on July 1, 2006, through June 30, 2007.

### **B.** Policy:

#### 1. Market Basket Update

We are now using the new **Rehabilitation/Psychiatric/Long-Term Care** (**RPL**) market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate). A rebased 2002 excluded hospital market basket is used to update the cost-based portion (TEFRA), effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

#### 2. PRICER Updates: For IPF PPS Rate Year (RY) 2007, (July 1, 2006 – June 30, 2007)

- The Federal per diem base rate is \$595.09.
- The fixed dollar loss threshold amount is \$6,200.
- The revised standardization factor is 82.54 percent.
- The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2006, but before January 1, 2007, is 50 percent PPS and 50 percent TEFRA. The transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is 75 percent PPS and 25 percent TEFRA.
- Core-Based Statistical Area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2006. There will be no separate transition blend under IPF PPS for conversion to the CBSA-based labor market areas.

- The labor-related share is <u>75.665</u> percent.
- The non-labor related share is <u>24.335</u> percent.
- The electroconvulsive therapy (ECT) rate is \$256.20.

#### 3. Provider Specific File (PSF) Updates

Data element 35 must be populated by the CBSA code. Please refer to the RY 2007 IPF PPS Final Rule to determine the CBSA code based on the county where the facility is located.

Data elements 33 and 38 are available for population, but should not be populated unless a special wage index is required. At this time, there are no special wage indexes for IPF PPS.

Data element 13 (new data element 12 per CR 4279), Actual Geographic Location-MSA, must no longer be used with the implementation of CBSAs.

### 4. Teaching Status Adjustment

The teaching adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount computed in the cost report are adjusted through lump sum payments/recoupments when the cost report is filed and later settled.

#### 5. Electroconvulsive Therapy (ECT) Update

The new update methodology for the ECT rate is to use the CY 2005 ECT rate as a base and update that amount by the market basket increase each rate year. This methodology is more consistent with the methodology we use to update the Federal per diem base rate because we will use the RPL market basket increase to increase both rates. The ECT adjustment per treatment is \$256.20 for RY 2007.

#### 6. DRG Adjustment Update

The IPF PPS has DRG specific adjustments for 15 DRGs. We provide payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or in the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our identified 15 psychiatric DRGs, the IPF receives the Federal per diem base rate and all other applicable adjustments.

Table 1 below lists the new FY 2006 ICD diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. When coded as a principal diagnosis, the IPF receives the correlating DRG adjustment. This table is only a listing of new codes and does not reflect all of the currently valid and applicable ICD codes classified in the DRGs.

TABLE 1-- FY 2006 New Diagnosis Codes

Diagnosis Code	Description	DRG
291.82	Alcohol induced sleep disorders	521, 522, 523

Diagnosis Code	Description	DRG
292.85	Drug induced sleep disorders	521, 522, 523
327.00	Organic insomnia, unspecified	432
327.01	Insomnia due to medical condition classified elsewhere	432
327.02	Insomnia due to mental disorder	432
327.09	Other organic insomnia	432
327.10	Organic hypersomnia, unspecified	432
327.11	Idiopathic hypersomnia with long sleep time	432
327.12	Idiopathic hypersomnia without long sleep time	432
327.13	Recurrent hypersomnia	432
327.14	Hypersomnia due to medical condition classified elsewhere	432
327.15	Hypersomnia due to mental disorder	432
327.19	Other organic hypersomnia	432

Table 2 below lists ICD diagnosis codes whose titles have been modified in FY 2006. Title changes do not impact the DRG adjustment. When used as a principal diagnosis, these codes still receive the correlating DRG adjustment. This table is only a listing of FY 2006 changes and does not reflect all of the currently valid and applicable ICD codes classified in the DRGs.

**TABLE 2-- Revised Diagnosis Code Titles** 

Diagnosis Code	Description	DRG
307.45	Circadian rhythm sleep disorder of nonorganic origin	432
780.52	Insomnia, unspecified	432
780.54	Hypersomnia, unspecified	432
780.55	Disruption of 24 hour sleep wake cycle, unspecified	432
780.58	Sleep related movement disorder, unspecified	432

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the DRG adjustment factors, the ICD-9-CM coding changes and the DRG classification changes that are currently being paid are shown below in Table 3. Please note these are the same adjustment factors in place since implementation.

TABLE 3-- FY 2006 DRGs and Adjustment Factor

DRG	DRG Definition	Adjustment Factor
DRG 424	O.R. Procedure with Principal Diagnosis of Mental Illness	1.22
DRG 425	Acute Adjustment Reaction & Psychosocial Dysfunction	1.05
DRG 426	Depressive Neurosis	0.99
DRG 427	Neurosis, Except Depressive	1.02
DRG 428	Disorders of Personality & Impulse Control	1.02
DRG 429	Organic Disturbances & Mental Retardation	1.03
DRG 430	Psychoses	1.00
DRG 431	Childhood Mental Disorders	0.99
DRG 432	Other Mental Disorder Diagnoses	0.92
DRG 433	Alcohol/Drug Abuse or Dependence, Leave Against Medical Advice (LAMA)	0.97
DRG 521	Alcohol/Drug Abuse or Dependence with CC	1.02
DRG 522	Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy without CC	0.98
DRG 523	Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without CC	0.88

DRG	DRG Definition	Adjustment Factor
DRG 12	Degenerative Nervous System Disorders	1.05
DRG 23	Non-traumatic Stupor & Coma	1.07

In order to maintain consistency with the IPPS, for discharges occurring on or after October 1, 2005, ICD code 305.1, Tobacco Use Disorder, will not be a covered principal diagnosis under the IPF PPS.

**NOTE:** All IPFs must follow the ICD-9-CM Official Guidelines for Coding and Reporting, including Code First. The ICD-9-CM Official Guidelines for Coding and Reporting can be found at <a href="https://www.cdc.gov/nchs/data/icd9/icdguide.pdf">www.cdc.gov/nchs/data/icd9/icdguide.pdf</a>

#### 7. Comorbidity Adjustment Update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and 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 should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

We are using the FY 2006 GROUPER, Version 23.0 and are effective for discharges occurring on or after October 1, 2005.

Table 4 lists the updated FY 2006 new ICD diagnosis codes that impact the comorbidity adjustment under the IPF PPS. Table 4 only lists the FY 2006 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

TABLE 4-- FY 2006 New ICD Codes Applicable for the Comorbidity Adjustment

Diagnosis Code	Description	DRG	Comorbidity Category
585.3	Chronic kidney disease, Stage III (moderate)	315 - 316	Renal Failure, Chronic
585.4	Chronic kidney disease, Stage IV (severe)	315 - 316	Renal Failure, Chronic
585.5	Chronic kidney disease, Stage V	315 - 316	Renal Failure, Chronic
585.6	End stage renal disease	315 - 316	Renal Failure, Chronic
585.9	Chronic kidney disease, unspecified	315 - 316	Renal Failure, Chronic
V46.13	Encounter for weaning from respirator [ventilator]	467	Chronic Obstructive Pulmonary Disease
V46.14	Mechanical complication of respirator [ventilator]	467	Chronic Obstructive Pulmonary Disease

Since the purpose of the comorbidity adjustment is to account for the higher resource costs associated with comorbid conditions that are expensive to treat on a per diem basis, we are not providing a comorbidity adjustment for 585.1, "Chronic Kidney Disease, Stage I" and 585.2, "Chronic Kidney Disease, Stage II (Mild)." These conditions (585.1 and 585.2) are less costly to treat on a per diem basis because patients with these conditions are either asymptomatic or may have only mild symptoms.

Table 5 lists the invalid ICD codes no longer applicable for the comorbidity adjustment. This table does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

TABLE 5-- FY 2006 Invalid ICD Codes No Longer Applicable for the Comorbidity Adjustment

Diagnosis Code	Description	DRG	Comorbidity Category
585	Chronic renal failure	315-36	Renal Failure, Chronic

We are aware that ICD code 404.03, hypertensive heart and renal disease, malignant, with heart failure and renal failure, has caused confusion since this ICD code is currently used to code an adjustment in two separate IPF comorbidity categories, (that is, both "Renal Failure, Chronic" and "Cardiac Conditions"). It more appropriately corresponds to the "Cardiac Conditions" comorbidity than to the "Renal Failure, Chronic" comorbidity. Therefore, to be more clinically cohesive and to eliminate confusion, we removed ICD code 404.03 from the comorbidity adjustment category, "Renal Failure, Chronic," but retained it in the "Cardiac Conditions" comorbidity category.

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the Comorbidity Category factors, the ICD-9-CM coding changes and Comorbidity Category classification changes that are <u>currently</u> being paid are shown below in Table 6. Please note these are the same adjustment factors in place since implementation.

TABLE 6-- FY 2006 Diagnosis Codes and Adjustment Factors for Comorbidity Categories

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheostomy	51900 - through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

#### 8. 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	\$595.09
Labor Share (0.75665)	\$450.27
Non-Labor Share (0.24335)	\$144.82

The rates for RY 2007 were published in the final rule and can also be found on the IPF PPS Web site at <a href="http://www.cms.hhs.gov/InpatientPsychFacilPPS">http://www.cms.hhs.gov/InpatientPsychFacilPPS</a>

#### 9. The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2007:

Cost to Charge Ratio	Median	Ceiling
Urban	0.55	1.7179
Rural	0.71	1.7447

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.

# II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement "Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H	C a	D M		red S intair	Syste ners	m	Other
			H I	r r i e r	E R C	F I S S	M C S	V M S	C W F	
5129.1	FISS shall install and pay claims with IPF PPS Pricer Version 070, for discharges occurring on or after July 1, 2006. This Pricer will include all Rate Year 2007 updates.	X				X				
5129.2	At a minimum, FIs shall update all IPF PPS Provider Specific Files with a CBSA code for the July 2006 release. Other fields shall be updated as necessary.  Reminder: FIs shall update the TEFRA target amount based on the rate of increase published in FY 2007 IPPS rule for cost reporting periods occurring on or after October 1.	X								

# III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Sha	red S	1	С	Other
5129.3	A provider education article related to this instruction will be available at <a href="www.cms.hhs.gov/MLNMattersArticles">www.cms.hhs.gov/MLNMattersArticles</a> 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	X								

Requirement	Requirements	Responsibility ("X" indicates the								
Number		columns that apply)								
		F	R	C	D		red S		m	Other
		1	H H	a	M E	Mai	Maintainers			
			п Т	r r	R	F	M	V	C	
			-	i	C	I	C S	M		
				e		S	3	S	F	
				r		5				
	link to this article, on their website and include									
	information about it in a listsery message within									
	1 week of the availability of the provider									
	education article. In addition, the provider									
	education article shall be included in your next									
	regularly scheduled bulletin and incorporated									
	into any educational events on this topic.									
	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.									

#### IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces:** IPF Pricer Version 070

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

## V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date\*: July 1, 2006.

**Implementation Date:** July 3, 2006

**Pre-Implementation Contact(s):** 

Policy: Dorothy Colbert, (410) 786-9671

Claims Processing: Sarah Shirey-Losso, (410) 786-

0187

Post-Implementation Contact(s): Appropriate

**CMS** Regional Office

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

<sup>\*</sup>Unless otherwise specified, the effective date is the date of service.