

Transitioning Your Organization to the Medicare Inpatient Psychiatric Prospective Payment System (PPS)



A Toolkit for Action
from the
National Association of Psychiatric Health Systems

In Consultation with

T. Giovanis & Company (Health Policy & Regulatory Consultants)

Steven M. Mirin, M.D. (Strategic Partner, Best Practice Management, Inc.)

Linda Martins, RHIA (Butler Hospital, Providence, RI)

This document is based on the best available information as of January 1, 2005. Please check the Web site of the Centers for Medicare and Medicaid Services at <http://www.cms.hhs.gov/providers/ipfpps/> for ongoing clarifications.

National Association of Psychiatric Health Systems

701 13th Street, NW
Suite 950
Washington, DC 20005-3903
Phone: 202/393-6700
Fax: 202/783-6041
Email: naphs@naphs.org
Web: www.naphs.org

Theodore Giovanis, FHFMA, CHPF

T. Giovanis & Company

Health Policy and Regulatory Consultants
P.O. Box 130
Highland, MD 20777
Phone: 301/854-2496
Fax: 301/854-2248
Email: TNGiovanis@aol.com
Web: www.tgiovanis.com

Steven M. Mirin, M.D.

Strategic Partner, Best Practice Management Inc.

384 Catarina Heights
Concord, MA 01742-4752
Phone: 978/369-0515
Fax: 978/369-0514
Email: smirin@earthlink.net

Linda Martins, RHIA

Butler Hospital

345 Blackstone Blvd.
Providence, RI 02906
Phone: 401/455-6200
Email: lmartins@butler.org

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1. Introduction

By Congressional mandate, Medicare is moving in 2005 to a totally new method of reimbursement for services delivered in psychiatric hospitals and psychiatric units in acute care hospitals that are currently under the (TEFRA) payment system. A final rule detailing how the system will work was published in the November 15, 2004, *Federal Register* (available at http://www.access.gpo.gov/su_docs/fedreg/a041115c.html). The final rule is also available through the Web site of the Centers for Medicare and Medicaid Services at <http://www.cms.hhs.gov/providers/ipfpps/>. PPS will be implemented for cost-reporting periods beginning on or after January 1, 2005, and there will be a three-year transition.

Few regulatory changes will match the far-reaching impact of this transition from cost-based reimbursement under the “TEFRA” system to prospective payment for inpatient psychiatric care. Not since the advent of Medicare have psychiatric providers been required to think in such a new way about how they are reimbursed—and how they can deliver cost-effective care in the future. By its very definition, “prospective payment” means that you will receive a fixed, “prospectively” determined payment amount for psychiatric care delivered to patients covered under Medicare. This per diem rate will be adjusted for a number of factors (described in detail later in this kit). These include patient-specific characteristics like the patient’s principal diagnosis and facility-specific variables such as area wages. By knowing in advance what will be paid, providers can expect more consistent reimbursement and can better plan their clinical programming. In addition, prospective payment creates incentives for efficiency. More efficient providers will do better financially under this system.

How This Kit Can Help You Smooth the Transition to PPS

NAPHS has contracted with top consultants to deliver a package of practical, ready-to-use materials that will give you the most comprehensive overview of the final inpatient PPS regulation. The kit includes:

- the technical information you will need to **evaluate the financial impact** of the move to inpatient PPS. Developed by Ted Giovanis, this analysis of the final rule explains in detail how the inpatient rate will be calculated and how you can understand where you stand.
- the information you will need to **educate your staff** on the ramifications of the new payment system.
- the checklists and timelines you will need to **facilitate change**.

For More Information

NAPHS is committed to helping behavioral healthcare provider organizations prepare for this major payment system change. A complete list of resources is provided in the final chapters.

2. At-a-Glance: What Is Being Implemented

Brief History

Over the past two decades, Medicare has been steadily moving toward prospective payment for health-care services. Acute healthcare services converted to prospective payment in 1983 through a system based on diagnosis related groups (DRGs). The *Balanced Budget Act of 1997* (BBA—Public Law 105-33) and subsequent legislation set a time schedule for care in many other types of healthcare settings previously reimbursed under the *Tax Equity and Fiscal Responsibility Act of 1982* (or TEFRA) to change to prospective payment. For example, virtually all skilled nursing facilities, hospital outpatient departments, home health agencies, rehabilitation, and long-term care facilities are now reimbursed for care using a prospective payment system.

In 1999, through the *Balanced Budget Refinement Act* (BBRA—Public Law 106-113), Congress mandated that the Centers for Medicare and Medicaid Services (CMS) develop a Medicare psychiatric prospective payment system (PPS) for psychiatric hospitals and psychiatric units in acute general hospitals. In contrast to reimbursement under TEFRA, the BBRA mandated that inpatient psychiatric PPS must be **per diem-based** (as opposed to the per-stay basis of the DRG system) with an “adequate patient classification system.” The new system must also be budget-neutral.

On November 28, 2003, CMS released a proposed rule for inpatient psychiatric prospective payment. You may view the proposed rule from the November 28, 2003, *Federal Register* at http://www.access.gpo.gov/su_docs/fedreg/a031128c.html under Centers for Medicare and Medicaid Services.

After receiving comments on the proposed rule, CMS published a final rule in the November 15, 2004, *Federal Register* at http://www.access.gpo.gov/su_docs/fedreg/a041115c.html. The final rule implements PPS for cost-reporting periods beginning on or after January 1, 2005, and there will be a three-year transition. The final rule is also available through the Web site of the Centers for Medicare and Medicaid Services at <http://www.cms.hhs.gov/providers/ipfpps/>. Check this CMS Web site frequently for a central source of updates and further CMS actions related to the final rule.

What the Final Rule Requires

(NOTE: View more details in Chapter 3.)

According to the final rule, the PPS will be based on a statistical model that relates per diem resource use for beneficiaries to patient and facility characteristics available from CMS’s administrative data base (cost reports and claims data). Patient-specific characteristics include principal diagnoses, comorbid conditions, and age. Facility-specific variables include an area wage index, rural setting, and the extent of teaching activity. **The key elements of the final rule are:**

- A base per diem rate of **\$575.95** (which includes capital) will be adjusted by several factors, including facility and patient characteristics as well as day of stay. (This rate is up from \$530 in the proposed rule.)

- Per diems will be adjusted upwards to reflect higher costs on the first day and earlier days of the stay (compared to the end of the stay). In the final rule, the **variable per diems** are as follows: first day=1.19 (1.31 with full-service emergency department); day 2=1.12; day 3=1.08; day 4=1.05; day 5=1.04; day 6=1.02; days 7 and 8=1.01; days 9 and 10=1.00; below 1.00 for days 11-21. (This is a change from the proposed rule.)
- **Patient characteristic adjusters** are diagnosis (DRGs), age, and comorbid conditions.
 - The final rule has added DRGs that were not included in the proposed rule. If a patient's diagnosis does not group into the DRGs listed in the final rule, it is paid at 1.0. DRG weights were derived through the regression analysis based on their impact on cost on a per-day basis (vs. per-stay).
 - Age breaks are different from the proposed rule. There are now eight age breaks in the final rule (vs. only two age breaks in the proposed rule). The age breaks and adjustments in the final rule are: 45 and under 50=1.01; 50 and under 55=1.02; 55 and under 60=1.04; 60 and under 65=1.07; 65 and under 70=1.10; 70 and under 75=1.13; 75 and under 80=1.15; 80 and over=1.17.
 - NAPHS and others had argued that many comorbid conditions were not included in the proposed rule. The final rule includes additional codes within the list of comorbidities.
- **Facility characteristic adjusters** include area wage index, rural status, and teaching status.
 - In the final rule, rural status is at 1.17 (up from 1.16 in the proposed rule).
 - The final rule uses the 2005 hospital wage index (unadjusted/pre-reclassified) based on MSA definitions defined by OMB in 1993 (not new definitions). CMS will seek public comment before any changes are made to the wage index for inpatient psychiatric PPS.
 - The teaching adjustment is similar to the adjustment used for the DRG system for acute care hospitals. The final rule establishes a cap on the number of residents that can be counted for purposes of the adjustment. The cap is the amount of FTE residents in the hospital as of the hospital's most recently filed cost report year. The final rule raises the teaching variable from .5215 power to .5150 power based on the latest regression analysis.
- The final rule adds a facility-specific **adjustment for those having a full-service emergency department**. This is an issue that NAPHS and others had advocated in responding to the proposed rule.
- There will be a **separate ECT payment per treatment** (of \$247.96), which will be wage-adjusted and COLA-adjusted.
- A **stop-loss provision** has been added to the final rule. Hospitals will receive no less than 70% of their current payment during the transition. Transition and stop-loss provisions will ensure that per-case payments are no less than 92.5% in year 1, 85% in year 2, and 77.5% in year 3.
- An **interrupted-stay** provision is included. If a patient is discharged from an inpatient psychiatric facility (IPF) and readmitted to any IPF within three days, the stay will be treated as continuous for purposes of the variable per diem adjustment and any applicable outlier payment.

- An **outlier policy** will compensate hospitals for higher-cost patients. The threshold in the final rule increased from \$4,200 to \$5,700 due to more recent data. Two percent of total Medicare payments are set aside for outlier payments. It is estimated that about 5% of total cases will qualify for the outlier payment.
- **Physician recertification** in the final rule remains at 18 days. (The proposed rule had suggested reducing physician recertification to the 10th day of the stay.)
- The PPS will be **phased in over three years** with the first year blending 25% federal rate/75% hospital-specific costs, the second year blending 50% federal rate/50% hospital-specific costs, and the third year blending 75% federal rate/25% hospital-specific costs. The fourth year will be 100% federal rate.

Effective Date

The new system applies for cost-reporting periods beginning on or after January 1, 2005.

[NOTE: *There will be a three-year transition period to the full PPS.*]

Timeline

November 28, 2003	CMS issues proposed rule in <i>Federal Register</i> 60-day comment period begins
January 27, 2004	60-day comment period ends
February 26, 2004	Extended response date to comment period
November 15, 2004	Final rule issued
Cost-report periods beginning on or after 1/1/05	Effective date of final rule

What This Kit Includes

The core of this toolkit is a technical analysis that will walk you through the implications of all aspects of the final rule (described in detail in *Chapter 3*). These materials are designed to help you understand the economic impact of the rule on your organization and the short- and long-term planning that you need to undertake starting today.

Chapter 4 includes practical checklists that you can copy and distribute within your organization to help educate your staff about the move to Medicare inpatient PPS.

Chapter 5 provides more information on the organizations that have developed this toolkit and the resources they can provide to assist your facility in understanding and managing the change to inpatient prospective payment.

Chapter 6 highlights additional resources available to you, including upcoming telephone and audiotape trainings as well as useful Web sites.

3. The Final Rule: A Detailed Analysis

CMS Adopts Psychiatric PPS Final Rule

On November 15, 2004, the Centers for Medicare and Medicaid Services (CMS) published its final rule for the new Medicare inpatient psychiatric prospective payment system (IPPPS) for inpatient psychiatric facilities (IPFs). The new rules apply to payments to psychiatric hospitals, distinct-part units of acute hospitals, and state psychiatric hospitals.

The system applies to payments made to hospitals and units for Medicare patients served during cost-reporting periods beginning on or after January 1, 2005, using a three-year phase-in.

In this summary of the rule, we provide highlights of the rule's most significant provisions. In each section we provide an indication of the *Federal Register* (FR) page number where a more elaborate description/discussion can be found.

The various contact individuals listed in the final rule for selected areas are:

- Janet Samen 410/786-9161 (general information) and
- Phillip Cotterill 410/786-6598 and Fred Thomas 410/786-6675 (regarding the regression analysis).

Visit <http://www.cms.hhs.gov/providers/ipfpps/> for continuous updates and CMS actions related to inpatient psychiatric PPS.

Overview

The new system will change the present TEFRA-based (*Tax Equity and Fiscal Responsibility Act of 1982*) system to a new variable per diem-based system. In the final rule, CMS has made numerous changes to the proposed system. Some are in response to comments to the proposed rule, while others are the result of CMS' ongoing analysis. The updated rates in the final rule continue to be wage-index adjusted, while the labor portion of the rate has changed slightly. There continues to be a case-mix adjustment accomplished through 15 DRGs with updated codes. Similarly, there continue to be 17 comorbidity categories, although there are some changes and expansion of codes.

CMS has adopted a variable per diem adjustment for the first 21 days of the stay. The first-day weight is higher if the patient is admitted to a facility with a full-service emergency department (ED). The weights for most days decline throughout the stay to a low weight of .92 for the 22nd day. This same factor would apply to all the days over 22.

The age adjustment is also variable (across eight ranges) rather than fixed. There continues to be a rural facility adjustment. There is also a stop-loss adjustment as well as adjustments for ECT (electroconvulsive therapy), teaching, and outliers.

Sample payment calculations¹ are included later in this chapter.

¹ The labor and non-labor portions in these examples are from the final rule published in the November 15, 2004, *Federal Register*. On December 1, 2004, CMS published a Program Transmittal Change Request 3541, which includes different labor/non-labor proportions (labor \$416.11/.72247 and non-labor \$159.84/.27753) that may ultimately be included in a forthcoming *Federal Register* Correction Notice. Use of the corrected proportions will not materially affect the results of any impact analysis calculations related to the new IPPPS.

The Payment Rate, Variable Per Diem, and Emergency Department Adjustments

The revised payment rates in the final rule were developed using the FFY 2002 cost-report data and the FFY 2002 MedPAR (Medicare provider analysis and review file) payment data because these were the latest complete data available.

The final **base payment rate of \$575.95/day** includes capital and is divided into labor and non-labor portions (\$417.73 and \$158.22 respectively) (FR 66936/66982). This creates a labor proportion of 72.528 % labor and 27.472 % non-labor, which was developed using the CMS TEFRA market basket including capital (FR 66928). The payment for each day is calculated by applying the applicable adjustment factor (FR 66942), which ranges from 1.31/1.19 (1.31 applies to a full-service ED provider—see below) for the first day to .92 for the 22nd day and beyond.

After further analysis, CMS has decided that in adjusting the per diem a “variable per diem adjustment” is warranted (FR 66947). Accordingly, the tiers suggested in the proposed rule are replaced in the final rule with adjustment weights that generally decrease over the first 22 days of the stay. This means that the payment for the 22nd day represents a decrease in payment as its weight is .92. All days after the 22nd day will be paid using a .92 weight.

CMS has also decided to provide a separate payment adjustment that will be applicable to patients that are admitted to a facility that has a full-service emergency department. CMS accomplishes this adjustment by using a different weight for the first day in the variable per diem adjustment (1.31 v 1.19). This first-day factor will not apply in the situation where a patient was initially admitted to an acute hospital through its ED then readmitted to a distinct-part psychiatric unit.

The resulting rates are further adjusted by factors related to facility and patient characteristics.

Facility Characteristic Adjustments

These adjustments include an area wage adjustment, rural status adjustment, and teaching status adjustment.

Area Wage Index (AWI)

CMS will use an AWI developed from data and areas from the final acute care prereclassified area wage index for FY 2005 for the geographic adjustment to the rates (FR 66952). Implicit in this decision CMS will not be adopting the new labor market areas it adopted for the acute PPS in FY 2005. The use of the prereclassified AWI is consistent with CMS’ decisions on the other non-acute inpatient prospective payment systems. The applicable AWIs for each area are listed in a table at the end of the rule (FR 66985).

Rural Status Adjustment

Analysis by CMS continues to indicate that there are wide differences in costs between urban and rural providers, which are possibly the result of a low-volume effect. These cost differences are so great that CMS believes it warrants an adjustment. Accordingly, based on its new analysis, CMS has decided to increase the rural add-on to 17% (FR 66954) as opposed to 16% in the proposed rule.

Teaching Adjustment

In the final rule, CMS has decided to adopt its proposed teaching adjustment concept (FR 66954). The teaching adjustment will be a multiplier on the otherwise applicable per diem rate. It will function similar to the indirect medical education adjustment under the acute care PPS system.

Consistent with the proposed rule, CMS has adopted a facility-specific teaching adjustment in the final rule. The adjustment applies to the payment for the day/stay using a teaching factor (FR 66954). This adjustment is based on the ratio of the number of psychiatric interns and residents (I and R) to the average daily census (ADC) (as opposed to beds) in the psychiatric facility or unit.

The adjustment continues to be based on an exponential relationship of the I + R/ADC factor with a coefficient of .5150 (which is updated from the proposed rule). The net effect is that providers with a .10 ratio would have approximately a 5% increase in payment, while a provider with a .25 ratio would have about 10% increase in payments.

In the final rule, CMS also adopts a CAP on the I + R factor (numerator only) (FR 66955). The CAP is determined based on the I + R FTEs on the hospital's final settlement of the cost report that was most recently filed before November 15, 2004. Thus, there will be some retroactivity to the settlement for teaching payments.

Emergency Department Adjustment

Hospitals that have a full-service emergency department are eligible for a higher payment on the first day of the admission (12%) for all patients admitted to that hospital (not just those coming through the emergency room). However, patients in these eligible hospitals that are admitted directly from the emergency room to a medical/surgical bed and subsequently transferred to the psychiatric unit would not receive the higher first-day payment. Patients transferred from an emergency department to a freestanding psychiatric hospital or another general hospital would not get the higher first-day payment level.

Cost-of-living Adjustment (COLA)

After analysis of costs and the impact of various adjustments, CMS decided in the final rule that there should be an additional cost-of-living adjustment to the rates paid to hospitals in Alaska (AK) and Hawaii (HI) applied to the non-labor portion of the rate. These adjustments for AK and HI are similar to the adjustment for providers in these states in the acute care PPS and only apply to the non-labor portion of the rate. The additional payment adjustments that apply to Hawaii vary by county (FR 66982). CMS' analysis suggests that an additional payment adjustment is also warranted because of large differences in the cost of living in these areas that is not included in the base rate (FR 66957).

CMS considered but decided not to establish a COLA for California providers (FR 66958).

Patient Characteristic Adjustments

The patient-related adjustments include case complexity, comorbidity, and age.

Case Complexity Adjustment

In the final rule, CMS has adopted essentially the case complexity adjustment it proposed (FR 66936). CMS has updated/modified several of the DRGs. CMS is providing payment for all psychiatric ICD9 and

DSM codes; however, only those cases that group into the 15 DRGs will receive the DRG adjustment (FR 66937). The applicable weights range from a 1.22–.88 (FR 66938). However, if a patient falls under a psychiatric DRG that is not included in the list of 15, the hospital will be paid the base rate with other applicable adjustments.

Comorbidity Adjustment

The final rule continues the adjustment for comorbid conditions (CC). This is accomplished through a series of weights used as multipliers to the otherwise applicable rate (FR 66938). CMS has made some changes in the final rule to the CC adjustment and to the corresponding weights. Several changes of note include:

- Addition of a CC for developmental disabilities (weight 1.04).
- Deletion of the separate HIV CC, which is now combined with the broader “Infectious Disease” category (weight of 1.07).
- A slight change in the Oncology Treatment CC (weight of 1.07).

The net effect of these changes is that there are still 17 comorbidities with a range of adjustments from 1.03–1.13, but more conditions are included in some of these 17 categories.

Table 4 of the rule (FR 66940) has a comparison of the proposed and final CC codes, and Table 5 (FR 66944) has the final codes and applicable adjustments.

Patient Age Adjustment

The proposed rule included an age adjustment that was a flat 13% add-on adjustment for patients who were 65 years of age and older. Based on comments and further analysis, CMS has decided in the final rule to adopt a variable adjustment that changes with the age of the patient. Under this concept, the range of the adjustments is broadened. For example, patients who are 50 (but less than 55) would receive a 2% add-on, while patients 80 and older would receive a 17% add-on (FR 66946). The eight ranges of adjustment (FR 66983) are as follows:

<45	No adjustment
45≤50	1.01
50≤55	1.02
55≤60	1.04
60≤65	1.07
65≤70	1.10
70≤75	1.13
75≤80	1.15
≤80	1.17

Specifically, the payment of an individual over 50 but less than 55 years of age would receive a 2% add-on to the otherwise applicable payment accomplished by a 1.02 adjustment factor applied to the payment.

ECT (Electroconvulsive Therapy)

As rumored, CMS' analysis supports an additional adjustment when patients receive ECT services during their stay (in other words, separate from the base per diem payments). The payment will be separate and outside the otherwise applicable payments. The payment will be \$247.96 per treatment (FR 66951 and FR 66982). This payment will be adjusted for wage differences in the same manner that the per diem payment is adjusted (and COLA-adjusted for Hawaii and Alaska). CMS used the hospital OPPS unadjusted claims data for its analysis in developing the IPPPS ECT payment. Providers will be required to code the ECT service on the bill (procedure 90870 and revenue code 901) along with the number of units the patient received (FR 66951). Payments will be based on "per treatment."

Physician Recertification

CMS has decided to retain the current recertification requirement at the 18th day following admission to the IPF (FR 66964). CMS had proposed reducing this time to the 10th day.

CMS considered but will **not** implement the following:

Gender

While CMS' analysis continues to indicate that there is about a 2% difference between the cost of treating females versus males, it believes that this differential does not warrant a payment adjustment (FR 66950).

Involuntarily Committed Patients

Based on analysis of relative costs, CMS has decided not to implement a payment adjustment for patients who are involuntarily committed to an IPF (FR 66951).

Other Payment Provisions

Transition Period

CMS has adopted its proposed three-year transition period. For cost-reporting periods beginning on or after January 1, 2005, providers will have 75% of their payment in year 1 based on the present TEFRA system and 25% PPS. Thereafter, the blends would be 50%/50% for year 2; and 25%/75% for year 3. In year 4 and thereafter, facilities will be paid 100% at the federal PPS rate (FR 66964). Accordingly, for the initial three years, hospitals/units will be operating under two payment systems—albeit for different proportions of their payments. CMS reemphasizes that there will be no 100% opt-in to the IPPPS.

How you calculate actual payments is as follows. For a particular patient, first calculate the per-case TEFRA payment for the patient (operating and capital) and multiply by 75%. Then calculate the payment for the same patient under the PPS methodology and multiply by 25% (federal portion in year 1). Add these two amounts together to determine the actual payment for that case.

Implementation Issues for Facilities with a Fiscal Year Beginning January 1, 2005

Medicare will pay hospitals with a fiscal year beginning January 1 based on the hospital's current TEFRA payment level (determined from the previous year's cost report). There will be no disruption in cash-flow to hospitals during this period.

Beginning on or about April 4, 2005, facilities will begin having claims paid based on the PPS formula. Hospitals with a fiscal year beginning January 1, 2005, will be paid according to their current TEFRA payment level during the January to March period; however, all claims submitted during this time period will be paid according to the new system when processed in April. This means that it is important to code these claims with all the necessary information required under the new PPS. These claims should document comorbidities, diagnosis/DRG, age, and any ECT treatments. Any difference between the TEFRA payment amount paid to the hospital during the January to March period and the actual claims during that period calculated under new PPS will be reconciled—either through adjustment to the hospital payments during the rest of the year or at the time of settlement at the end of the year.

Interrupted Stays

CMS is concerned that under a variable per diem system there would be an incentive to discharge and readmit patients to obtain the higher payment adjustment from the earlier days of the stay, twice. In response to comments, the final rule defines an interrupted stay as one in which the patient is discharged from an IPF and returns to the same—or any other IPF—within three consecutive calendar days. In this situation, the patient will be regarded as having one continuous hospitalization (FR 66962).

Outlier Pool and Adjustment

The final rule adopts an outlier payment calculated on a per-case or discharge basis. It updates and increases the outlier cost threshold to \$5,700 (FR 66960). Qualifying cases will receive 80% of the cost of cases through the 9th day of the stay and 60% thereafter (FR 66962). This represents a change of one day from the proposed rule, which CMS asserts is based on its change to a variable per diem adjustment. The outlier pool continues at an estimated 2.0% of total payments.

In adopting this policy, CMS links the definition of the cost-to-charge ratio (CCR) to its inpatient acute care PPS definition. As such, a provider's adjustment for outliers will be based on its actual CCR for the period in which the discharge occurred. Thus, final outlier payments will be subject to retroactive settlement (FR 66962). CMS also identifies the specific cost-report lines that would be used to determine CCRs.

Stop-Loss Payments

In response to comments, CMS is instituting in the final rule a stop-loss payment that guarantees that each facility will receive total payments under the IPF PPS portion of its payment that are no less than 70% of its payments under TEFRA (FR 66964). The stop-loss will apply only during the transition period. As such, a facility's payments under the IPPPS portion of its payments will be adjusted to 70% of what it would have received under TEFRA. The stop-loss applies to the PPS portion *only*. The impact of the stop-loss declines each year as follows:

$$\text{Year 1: } 25\% \times .7 = 17.5 + 75\% = 92.5\%$$

$$\text{Year 2: } 50\% \times .7 = 35.0 + 50\% = 85.0\%$$

$$\text{Year 3: } 75\% \times .7 = 52.5 + 25\% = 77.5\%$$

Coding

In the final rule, CMS clarifies its policy and approach to coding in response to comments on the subject. In the proposed rule, CMS inadvertently omitted the ICD 9-CM instructions pertaining to the "code first"

diagnosis codes. CMS now reminds providers of the “Instructional Notations” in ICD 9, which explain the “code first” concept (FR 66945).

Essentially “code first” places an emphasis on sequencing diagnosis codes and requires that the underlying disease (etiology) be coded first (principal diagnosis) with the code the note is applied to being coded second. This concept guides the principal and secondary diagnoses. In addition, there are code first notes under selected codes, which guide their order of presentation. Essentially, causal conditions are coded before manifestations (effects).

New Providers

Once the PPS begins, new providers that open will be placed 100% on the new, fully prospective system (with no transition). A new provider is a provider of inpatient psychiatric hospital services otherwise meeting the criteria whose first cost-reporting period as an IPF begins on or after January 1, 2005 (FR 66966).

Settlement

Currently under TEFRA, the hospital’s intermediary establishes a TEFRA payment rate based on the previous year’s cost report and pays that amount throughout the year. At the end of the year based on the hospital’s cost report, the intermediary calculates the hospital’s actual costs. If they are below the projected costs, the hospital would be required to pay back the difference. If the intermediary underpaid based on the facility’s real costs (up to their TEFRA cap), the hospital would receive an additional payment. This same process will be used during the transition. Therefore, the TEFRA portion (75% in year 1) will be estimated based on the hospital’s previous year’s cost and the hospital will be paid that amount during the year; however, at the end of the year this amount may increase or decrease based on the hospital’s actual costs for the year.

Outlier, stop-loss, and teaching payments will be estimated during the year and finalized after the close of the hospital’s fiscal year during the settlement process.

In the Future

Future Updates

The rule will not update the federal per diem rate (\$575.95) for 18 months after the effective date of January 1, 2005. Therefore, beginning on July 1, 2006, and in subsequent years, the federal per diem will be updated for the subsequent 12-month period using the excluded hospital with capital market-basket increase in order to reflect the price of goods and services used by IPFs. The present (final) market basket uses the 1997-based weights for goods and services to update the labor share and obtain the update for the ratio (FR 66928/66982).

Future Refinements/Research

CMS plans to conduct ongoing monitoring and research on various payment elements.

This research will include the Case Mix Assessment Tool (CMAT), which CMS described in the proposed rule. In the final rule, CMS responded to a wide range of comments on the proposed CMAT (FR 66967). The CMAT as modified is being reviewed by the Executive Office of Management and Budget. Thereafter, it will be pilot-tested and potentially edited before use in their research.

Plans are to relate the data obtained in the CMAT to claims and cost-report data before deciding what to implement nationally and what changes to make to the data collected that would determine potential future payment system adjustments or other changes. CMS' response to comments did not preclude ways to electronically collect the data necessary for the payment system (or CMAT-type data).

CMS is clearly interested in collecting data that will help it refine the payment system, understand relationships among variables, or contribute to development of outcome measures.

Calculation of Estimated Payments

NOTE: The labor and non-labor portions in these examples are from the final rule published in the November 15, 2004, *Federal Register*. On December 1, 2004, CMS published a Program Transmittal Change Request 3541, which includes different labor/non-labor proportions (labor \$416.11/.72247 and non-labor \$159.84/.27753) that may ultimately be included in a forthcoming *Federal Register* Correction Notice. Use of the corrected proportions will not materially affect the results of any impact analysis calculations related to the new IPPPS.

PPS Payment Example # 1

Payments under the final inpatient psychiatric facility (IPF) prospective payment system will be determined by adjusting the per diem base amount by the appropriate wage index and applicable IPF prospective payment system payment adjustments and adding any applicable outlier amounts. An example of how to calculate payment under the IPF prospective payment system follows.

Example: Jane Doe, a 78-year-old female, is admitted to a psychiatric unit within an acute general hospital located in Richmond, Virginia, which has a full-service emergency department. The patient was admitted to this hospital's unit directly. The hospital is a teaching facility with a teaching adjustment of 1.07. Ms. Doe presents with signs and symptoms indicating a primary diagnosis of Major Depressive Disorder (ICD-296.33, DRG-430). Her medical history includes Uncontrolled Type 1 Diabetes with Ophthalmic manifestations (ICD-250.53) and Chronic Renal Failure (ICD-585). Ms. Doe remains in the hospital for 11 days. This patient also received 4 ECT treatments.

Example of Payment Calculation

Steps to Determine the Per Diem Payments

Federal Base Prospective Payment Rate

Calculate Wage-adjusted federal base rate	
Labor portion of the Federal base rate: (FR 66982)	\$417.73
Apply wage index factor from Addendum B1 for Richmond Virginia (0.9397 x \$417.73) (FR 67006)	\$392.54
Non-labor of the federal base rate: (FR 66982)	\$158.22
Calculate total wage-adjusted federal base rate: (\$392.54 + \$158.22)	\$550.76

Apply Facility-level Adjusters

Teaching adjustment	1.07
Rural adjustment	-----
COLA	-----

Apply Patient-level Adjusters

DRG adjustment for DRG 430	1.00
Age adjustment	1.15
Comorbidity adjusters	
Diabetes	1.05
Chronic renal failure	1.11

Total PPS Patient Adjustment Factor (1.00 x 1.15 x 1.05 x 1.11): 1.3403

Calculate PPS wage, patient, and facility adjusted federal per diem:
(\$550.76 x 1.07 x 1.3403) \$789.86

Apply Variable Per Diem Adjustments

Day 1: (1.31 x \$789.86)	\$1034.72
Day 2: (1.12 x \$789.86)	884.64
Day 3: (1.08 x \$789.86)	853.05
Day 4: (1.05 x \$789.86)	829.35
Day 5: (1.04 x \$789.86)	821.45
Day 6: (1.02 x \$789.86)	805.66
Day 7: (1.01 x \$789.86)	797.76
Day 8: (1.01 x \$789.86)	797.76
Day 9: (1.00 x \$789.86)	789.86
Day 10: (1.00 x \$789.86)	789.86
Day 11: (0.99 x \$789.86)	781.96

Total PPS payments for Jane Doe's IPF Stay \$9,186.07

ECT Payment

ECT rate	\$247.96
Wage-adjusted rate [(\$247.96 x .72528) x .9397]	169.00
Non-labor rate (\$247.96 x .27472)	68.12
ECT rate (\$169.00 + 68.12)	237.12
# of Procedures	4
Addition ECT payment	\$948.48

Total Patient Payments

(\$9,186.07 + \$948.48) **\$10,134.55**

PPS Payment Example # 2: This example is identical to Example #1, except for the following four changes: the hospital is located in rural Virginia, it does not have a full-service ED, it does not have a teaching program, and the patient did not receive any ECT treatments.

Example of Payment Calculation

Steps to Determine the Per Diem Payments

Federal Base Prospective Payment Rate

Calculate Wage-adjusted federal base rate:	
Labor portion of the Federal base rate (FR 66982)	\$417.73
Apply wage index factor from Addendum B1 for Rural Virginia (0.8479 x \$417.73) (FR 67014)	\$354.19
Non-labor of the federal base rate (FR 66982):	\$158.22
Calculate total wage-adjusted federal base rate: (\$354.19 + \$158.22)	\$512.41

Apply Facility-level Adjusters

Teaching adjustment	-----
Rural adjustment	1.17
COLA	-----

Apply Patient-level Adjusters

DRG adjustment for DRG 430	1.00
Age adjustment	1.15
Comorbidity adjusters	
Diabetes	1.05
Chronic renal failure	1.11

Total PPS Patient Adjustment Factor (1.00 x 1.15 x 1.05 x 1.11): 1.3403

Calculate PPS wage, patient, and facility adjusted federal per diem: (\$512.41 x 1.17 x 1.3403)	\$803.54
-------------------------------------------------------------------------------------------------	----------

Apply Variable Per Diem Adjustments

Day 1: (1.19 x \$803.54)	\$956.21
Day 2: (1.12 x \$803.54)	899.96
Day 3: (1.08 x \$803.54)	867.82
Day 4: (1.05 x \$803.54)	843.72
Day 5: (1.04 x \$803.54)	835.68
Day 6: (1.02 x \$803.54)	819.61
Day 7: (1.01 x \$803.54)	811.58
Day 8: (1.01 x \$803.54)	811.58
Day 9: (1.00 x \$803.54)	803.54
Day 10: (1.00 x \$803.54)	803.54
Day 11: (0.99 x \$803.54)	795.50

Total PPS payments for Jane Doe's IPF Stay \$9,248.74

ECT Payment

ECT rate	-----
Wage-adjusted rate	-----
Non-labor rate	-----
ECT rate	-----
# of Procedures	-----
Addition ECT payment	-----

Total Patient Payments \$9,248.74

Example Outlier Payment Computation

Example: John Smith was hospitalized at a non-teaching IPF facility in Richmond, Virginia, for 11 days. His total allowable billed charges for the 11 days were \$25,000. The prospective payment amount (per diem payments plus adjustments) was \$9,186.

To determine whether this case qualifies for outlier payments, it is necessary to compute the cost of the case by multiplying the facility's overall cost-to-charge ratio of .72 by the allowable charge of \$25,000. In this case, the total allowable costs for Mr. Smith's case are \$18,000 (\$25,000 x .72). Because the IPF is a non-teaching urban facility, the fixed-dollar threshold is adjusted by the wage index 0.9397.

Steps to Calculate the Proposed Outlier Payment

Calculate the Fixed-Dollar Loss Threshold

Fixed-dollar threshold		\$5,700
Wage-adjusted labor share (.72528 x \$5,700) x .9397	\$ 3,885	
Non-Labor Share (0.27472 x \$5,700)	1,566	
Adjusted fixed dollar threshold (\$3,885 + \$1,566)	5,451	

Calculate Eligible Outlier Costs

Hospital costs	\$18,000
Adjusted fixed-dollar threshold	5,451
Prospective payment system adjusted payment	9,186
Eligible for outlier costs (\$18,000 - \$5,451 - \$9,186)	3,363

Calculate the Loss-sharing Ratio Amount

Per diem outlier costs (\$3,363 / 11 days)		\$ 306
Loss-sharing ratio (days 1 through 9) (\$306 x .80 x 9 days)	\$ 2,203	
Loss-sharing ratio (days 10 and 11) (\$306 x .60 x 2 days)	367	

Total Outlier Payment Amount

(\$2,203 + \$367)	\$ 2,570
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Example Stop-Loss Calculation

Hospital Inflated Target Rate	\$14,500.00
Hospital Medicare Discharges FYE 12/31/05	1,100
Applicable Wage-index-adjusted National CAP	\$15,000.00
Hospital Routine and Ancillary Medicare Capital Payments from FYE 12/31/05 Cost Report	\$1,000,000
Hospital IPPPS Payments FYE 12/31/05	\$9,900,000
Hospital Psych Operating Costs FYE 12/31/05 from Cost Report	\$14,000,000

An estimate of the hospital's stop-loss payment for FYE 12/31/2005 is as follows:

(1)	Estimated TEFRA operating payments:	
	a) Target rate x 1,100 = \$15,950,000	
	b) Cost per CR = \$14,000,000	
	c) Applicable national cap = \$16,500,000 (\$15,000 x 1,100)	
	TEFRA payment would be cost (since provider's cost is lowest)	\$14,000,000
(2)	Plus: TEFRA capital payments	\$1,000,000
(3)	Total estimated TEFRA payments	\$15,000,000
(4)	x 70% stop loss %	\$10,500,000
(5)	Less: IPPPS payments	\$9,900,000
(6)	Estimated annual short-fall/stop loss	\$600,000
(7)	x 25% first-year blend	x .25
(8)	Estimated first stop-loss payment	\$150,000

Rate and Adjustment Factors

Per Diem Rate:

Federal Per Diem Base Rate	\$575.95
Labor Share (0.72528)*	\$417.73*
Non-labor Share (0.27472)*	\$158.22*

*NOTE: The labor and non-labor portions in these charts are from the final rule published in the November 15, 2004, *Federal Register*. On December 1, 2004, CMS published a Program Transmittal Change Request 3541, which includes different labor/non-labor proportions (labor \$416.11/.72247 and non-labor \$159.84/.27753) that may ultimately be included in a forthcoming *Federal Register* Correction Notice. Use of the corrected proportions will not materially affect the results of any impact analysis calculations related to the new IPPPS.

Facility Adjustments:

Rural Adjustment Factor	1.17
Teaching Adjustment Factor	0.5150
Wage Index	Same as IPPS

Cost-of-living Adjustments (COLAs):

Alaska	1.25
Hawaii	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

Patient Adjustments:

ECT - Per Treatment	\$247.96
Labor portion	\$179.84**
Non-labor portion	\$68.12**

**NOTE: The labor and non-labor portions in these charts are from the final rule published in the November 15, 2004, *Federal Register*. On December 1, 2004, CMS published a Program Transmittal Change Request 3541, which includes different labor/non-labor proportions (see per diem rates above) that may ultimately be included in a forthcoming *Federal Register* Correction Notice. Use of the corrected proportions will not materially affect the results of any impact analysis calculations related to the new IPPPS.

Variable Per Diem Adjustments:

	Adjustment Factor
Day 1 — Facility without a 24/7 full-service emergency department	1.19
Day 1 — Facility with a 24/7 full-service emergency department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
After Day 21	0.92

Age Adjustments:

Age (in years)	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

DRG/Weights (FR 66938/66983)

Final IPF Prospective Payment System DRGs

DRG	Description	Adjustment Factor
12	Degenerative Nervous System Disorders	1.05
23	Nontraumatic Stupor and Coma	1.07
424	Procedure with Principal Diagnosis of Mental Illness	1.22
425	Acute Adjustment Reaction	1.05
426	Depressive Neurosis	0.99
427	Neurosis, Except Depressive	1.02
428	Disorders of Personality	1.02
429	Organic Disturbances	1.03
430	Psychosis	1.00
431	Childhood Disorders	0.99
432	Other Mental Disorders	0.92
433	Alcohol/Drug Use Leave Against Medical Advice	0.97
521	Alcohol/Drug Use with Comorbid Conditions	1.02
522	Alcohol/Drug Use or without Comorbid Conditions	0.98
523	Alcohol/Drug Use without Rehabilitation	0.88

Comorbidities/Weights (FR 66944/66984)

Diagnosis Codes for Comorbidity Categories

Description of Comorbidity	ICD-9-CM Code	Adjustment Factor
Developmental Disabilities	317,318.0,318.1,318.2, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheotomy	51900 through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 6363, 6373, 6383, 6393, 66932, 66934, 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 585, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 WITH either V58.0 OR V58.1	1.07
Uncontrolled Type I 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 Diseases	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, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884 and V461	1.12
Artificial Openings-Digestive and Urinary	56960 through 56969, 9975, V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100,73000 through 73009, 73010 through 73019, 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

4. Making PPS Work in Your Organization

Checklists to Use Today

This section includes checklists to help each member of your team think through all the things that can be done today to help your organization transition to the new Medicare inpatient psychiatric prospective payment system. The materials are meant to be used as guides only. Although NAPHS is not responsible for the technical accuracy of forms or materials developed by others, we present these as a service to help you customize tools that will meet the needs of your organization. Use the information to help you prepare handouts and forms for your own medical staff meetings, clinical planning sessions, or staff trainings.

Our thanks to our members and friends for their generous sharing of materials and information.

What CEOs and Administrators Need to Know

- ***Talk to your staff to help them prepare for the transition to inpatient psychiatric PPS.***
Smooth implementation will require a well-informed, multi-disciplinary team of administrators and clinicians working together.
 - ✓ **Meet with coding, billing, administrative, and clinical staffs** to inform them about the inpatient psychiatric PPS final rule and to develop a plan for coordinating all aspects of implementation.
 - ✓ **Be sure your team understands the way you currently make decisions about staffing.**
Appropriate staffing is at the foundation of the provision of quality psychiatric care and is an important driver of cost.
 - ✓ **Review your clinical services and strategic plan.** What do you project as your case mix? Are you considering adding or closing programs? What are the mission-driven or market forces that will impact your services?
- ***Understand where your clinical programs are today.***
 - ✓ **Assess your current case mix** (such as the number of Medicare patients with medical problems). This will help you evaluate how the change in Medicare payment rates will affect your organization.
 - ✓ **Know your most frequent discharge psychiatric DRGs.**
 - ✓ **Know your Medicare average length of stay.**
 - ✓ **Know the percent of Medicare patients you care for who fall within the new age categories outlined in the final rule.**

- ***Review current systems to ensure that you will capture the type of information you will need for inpatient PPS, especially the factors affecting PPS rates.***

For example, one of the variables affecting PPS rates will be medical comorbidities. However, because this did not affect TEFRA rates, facilities have not always coded all diagnoses. Also, different primary psychiatric diagnoses will be paid at different rates.

- ✓ **Review your process for documenting and coding primary psychiatric diagnoses** (and medical comorbidities).

What Chief Financial Officers Need to Know

- ***Understand your reimbursement and cost structure.***

This will help you understand how you are being reimbursed now and how that money is being distributed within your organization.

- ✓ **Know your facility's current Medicare TEFRA limit.** Are you operating under or over that limit?
- ✓ **Know your current cost per day and the components of that cost.**
- ✓ **Review your overall cost structure** (both direct and indirect costs).
- ✓ **Understand the basis on which you allocate overhead and why.**
- ✓ **Manage costs and revenue during the transition period and beyond.**

- ***Be able to answer the following questions:***

- ✓ What portion of your inpatient volume is Medicare-related?
- ✓ What is your case mix? (elderly/disabled, DRGs, level of co-morbidity)
- ✓ What are the key drivers of cost (staffing, pharmacy, lab, overhead, teaching)?
- ✓ What will they be under the new PPS?
- ✓ Are your current array of services and case mix financially sustainable?
- ✓ Are there changes you can make to improve financial performance and still sustain the clinical and organizational missions?

What Coders Need to Know

- ***Understand the top challenges facing coders.***

This will prepare you to assist your organization in meeting the overall challenges of moving to a new payment system. It will also help you to assist in educating your medical and clinical staff about ways in which documentation can be improved. Check to see that your organization can address the following top coding issues:

- ✓ **Have a current ICD-9-CM listing.** Be certain that your reference materials are up-to-date. See “Resources” in the back of this guide for links to useful publications.
- ✓ **Understand how the DSM-IV TR correlates with the ICD-9-CM.** ICD-9-CM codes will be the basis for payment under the inpatient psychiatric prospective payment system. Consider providing a training session for an upcoming medical staff meeting to present the crosswalk.
- ✓ **Manifestation codes.** Be aware that coding guidelines require the physical condition to be coded first.
- ✓ **Check carefully for comorbidities.** Payment is based on the comorbidities documented in the record.
- ✓ **The highest specificity is essential.** The IPPPS is designed to gather information on the specific patient characteristics. Be certain your coders are prepared to identify and code appropriately. Medicare rejects unspecified diagnoses.
- ✓ **Understand documentation issues.** It’s essential to know what to look for. Use the forms and resources in this document to learn more.
- ✓ **Be certain to list all diagnoses—even ones that are not reimbursed.** Over time, CMS will continue to look at—and revise—the lists of diagnoses covered. Only by having access to accurate information about actual diagnoses will future updates and changes reflect the true needs of patients.
- ✓ **Check to be certain that your software is listing diagnoses correctly on claims.**
- ✓ **DRG issues.** The inpatient psychiatric prospective payment system differs from other DRG systems because it is based on a limited number of codes. This is important to know when choosing software. Encoding companies need to understand this, or you will need to work with them to get what you need.
- ✓ **Use your coding experience to benefit the organization.** Your knowledge and technical skills will be critical to ensuring that your facility receives appropriate reimbursement.
- ✓ **Anticipate future changes.** Look for the ICD-10, which is compatible with DSM-IV, to be implemented within the next few years. You may want to have this pending change in mind in discussions (or informal contracts) with software vendors so you will be able to make the transition in a cost-effective manner.

- **Resources**

The new PPS will require your staff to understand ICD-9-CM coding. Among resources available to assist in staff training are:

- *ICD-9-CM CD Rom Version*. This product contains the complete official version of the International Classification of Diseases, Ninth Revision, Clinical Modification (Volumes 1, 2, 3, and Guidelines), compiled by the National Center for Health Statistics and the Centers for Medicare and Medicaid Services. The ICD-9-CM CD-ROM contains all changes issued through October 1, 2004. This CD-ROM supersedes all previous issues. This product can be purchased from the Government Printing Office (GPO), stock number 017-022-01573-1, cost \$25. Earlier versions may also still be available. For details, see <http://www.cms.hhs.gov/paymentsystems/icd9/cdrom.asp>.
- *ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2003*. These guidelines are available as a pdf file at <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>. You can also find extensive background and references related to ICD-9-CM through the CMS Web site at <http://www.cms.hhs.gov/paymentsystems/icd9/default.asp#guidelines> or <http://www.cms.hhs.gov/medlearn/icd9code.asp>.
- *ICD-9-CM Coding Handbook 2005, With Answers* by Faye Brown is the most widely used publication for teaching ICD-9-CM to entry-level and experienced coders. It is designed for self-study and reference. The 445-page publication is available for purchase with answers (\$89—Catalog No. WS-148020). Go to the American Hospital Association’s “Online Store” at <http://www.ahaonlinestore.com> to order.
- *Clinical Coding Workout: Practice Exercises for Skill Development, 2004 Edition, with answer key* (Product No. AC201504; ISBN/ISSN: 1-58426-065-3). Published by the American Health Information Management Association (AHIMA), this 512-page workbook provides practical information and skill-development exercises for assigning codes from ICD-9-CM, CPT, and HCPCS Level II. Order for \$90 from the AHIMA Catalog at <https://imis.ahima.org/orders>.

What Physicians Need to Know

- *Physician certification (and recertification) is essential for every admission.*

Be certain that your organization has a simple form to facilitate appropriate documentation.

- *Proper diagnosis and coding is central to the IPPPS.*

- ✓ **Recognize and code for psychiatric diagnosis and medical co-morbidity.** Unless information is clearly documented in the medical record, proper payment will not be received under the inpatient psychiatric PPS.
- ✓ **Detail matters.** Coders can't assume something that has not been documented by the physician. The OIG considers this a problematic area because coders are not physicians. Physicians *must* specify conditions—particularly those that would not be obvious to the average observer.
- ✓ **Increased documentation supports medical necessity.** Be sure your documentation is:
 - complete
 - consistent
 - clinically accurate.
- ✓ **If something is not documented, it didn't happen.** Incomplete documentation will not only affect reimbursement today, but in the future. Over time, CMS will continue to look at—and revise—the lists of diagnoses covered. Only by having access to accurate information about actual diagnoses will future updates and changes reflect the true needs of patients.
- ✓ **Documenting your time with patients will help your coders to know what evaluation and management codes are appropriate.** For example, one facility includes on its forms a place to indicate how many minutes the physician spends with the patient in each category (e.g. on a physician's progress note, there is space to indicate the total time in minutes spent with the patient as well as the total minutes spent in counseling).
- ✓ **Psychotherapy documentation:** Documentation should substantiate the necessity for the psychotherapy—especially for longer sessions and/or continued treatment. The reason for the encounter, pertinent themes discussed, interventions used, risk factors, and progress/regression should be documented, along with changes in treatment plan, diagnosis, or medications. Last, the duration of the session must be documented so that it may be properly coded.

What the Interdisciplinary Clinical Team Needs to Know.

- ***You can help your facility meet the challenges of PPS.***
 - ✓ Discuss with the entire team the goal of providing an array of high-quality, financially sustainable clinical services to support and enhance the mission of the hospital and meet community needs.
 - ✓ Status quo may not be an option. Do you need to add, expand, or close clinical programs? How will these decisions be made?
 - ✓ Use your knowledge of change theory to help staff members anticipate and plan for changes that may be necessary.
 - ✓ Review all aspects of your current active treatment program. How do assessment, treatment planning, program delivery, and documentation work together to support criteria for medically necessary care?
 - ✓ Review the staffing requirements for the provision of your active treatment program.
 - ✓ Review your organization's policies and procedures related to transfer and/or readmission relative to the interrupted stay provisions of the PPS rule.
 - ✓ Review your organization's policies and procedures related to treatment of comorbid conditions. What are your capabilities and limits in treating medically compromised patients? Be sure medical comorbidities that are being actively treated are identified and documented in the medical record.
 - ✓ Operationalize an efficient system for assuring that physician certification and recertification documentation is included in the medical record.
- ***Be aware of regulatory and accreditation requirements your organization must meet—as well as your own organizational mission and value statements.***

You need to keep all regulations in mind at once to be able to develop and maintain an effective clinical program. These include the requirements of:

- ✓ Medicare special Conditions of Participation
- ✓ Accreditation bodies (e.g. JCAHO, CARF, etc.)
- ✓ Local coverage determination (LCD) policies from your fiscal intermediary
- ✓ State licensure
- ✓ Your organization's own mission and value statements

Useful Forms

- *Use the following ideas and forms to customize materials for your organization.*

Please keep in mind that there is no single form or approach that is most appropriate. The following examples are provided only as guidance to help you think about the types of resources that may be most useful for your own organization.

The following pages include forms that address the following things:

- Physician certification
- Physician recertification
- A listing of psychiatric DRG and ICD-9 codes (developed by SSM Health Care/Behavioral Health Services)
- ICD-9-CM codes for medical comorbidity (developed by SSM Health Care/Behavioral Health Services)

Forms for Physician Certification and Physician Recertification

The requirements for physician certification and recertification are detailed in the November 15, 2004, final rule on inpatient psychiatric PPS. See Chapter 3 in this toolkit for more specific information (and page references in the final rule).

The following two forms were developed by SSM Healthcare Behavioral Health Services to assist in documentation of physician certification and recertification. Forms were printed 10 to a page on labels so that they could be readily attached to the medical record.

Physician Certification of Medical Necessity

I certify that inpatient psychiatric hospital admission is medically necessary for treatment which can be expected to improve the patient's condition/symptomatology.

Signed _____ Date _____

Physician Re-certification of Medical Necessity

I certify that inpatient psychiatric services furnished since the previous certification or re-certification were and continue to be necessary for treatment which could reasonably be expected to improve the patient's condition/symptomatology.

Signed _____ Date _____

At Butler Hospital, a similar statement on physician recertification is included directly at the bottom of the treatment planning form to ensure that physicians will provide the necessary documentation for each patient.

Psychiatric DRG and ICD-9 Codes

Because IPPPS payment allows for adjustment based on patient diagnoses, it is important to understand how psychiatric DRGs are related to ICD-9 codes. The resource section of this toolkit includes a variety of references (including the ICD-9-CM reference books), which you should have on your reference shelf.

In addition, facilities may want to consider “condensed” forms and reference sheets to help make these textbooks come alive for your clinical staff.

Example: The following page provides an example of a form developed by SSM Healthcare Behavioral Health Services.

Keep in mind that if a patient falls under a psychiatric DRG that is not included in the list of 15, the hospital will be paid the base rate with other applicable adjustments.

Adjustment Factor = 1.22

DRG 424 O.R. Procedure w/ Principal Diagnoses of Mental Illness

294. Persistent Mental Disorders due to conditions classified elsewhere
 310. Nonpsychotic Mental Disorders due to Brain Damage
 317. Mild Mental Retardation
 318. Moderate/Severe/Profound Mental Retardation
 758.0 Down's Syndrome
 797. Senility w/o Psychosis

Adjustment Factor = 0.99

DRG 431 Childhood Mental Disorders

307.52 Pica
 307.6 Enuresis
 307.7 Encopresis
 312. Disturbance of Conduct
 313. Disturbance of Emotions Specific to Childhood & Adolescence
 314. Hyperkinetic Syndrome of Childhood
 315. Specific Delays in Development
 784.61 Alexia and Dyslexia
 784.79 Other Symbolic Dysfunction

Adjustment Factor = 1.07

DRG 023 Nontraumatic Stupor & Coma

348.4 Cerebral Edema / compression
 780.01 Coma / Vegetative states

Adjustment Factor = 1.05

DRG 425 Acute Adjustment Reaction & Psychosocial Dysfunction

293. Delirium
 300. Anxiety / Panic Disorders
 308. Stress Reactions
 780.1 Hallucinations
 799.2 Nervousness
 V71.01 Obs. of Adult Antisocial Behavior.

Adjustment Factor = 1.05

DRG 012 Degenerative Nervous System Disorders

046. CNS Slow Virus Infections (Kuru, Jakob-Creutzfeldt Disease)
 094. Paresis, Neurosyphilitic conditions
 330. Cerebral Degenerations of Childhood
 331. Cerebral Degeneration (Alzheimer's, Pick's)
 332.1 Secondary Parkinsonism
 333. Extrapyramidal Disease & Movement Disorders
 335. Anterior Horn Cell disease
 336.0 Syringomyelia
 358. Myasthenia Gravis
 379.45 Argyll Robertson Pupil
 438. Late Effects of Cerebrovascular Disease (Cognitive/Speech/Language Deficits, Paralytic syndromes)

Adjustment Factor = 1.03

DRG 429 Organic Disturbances & Mental Retardation

290. Dementias (senile, vascular)
 293. Transient Mental Disorders due to conditions classified elsewhere

Adjustment Factor = 1.02

DRG 428 Disorders of Personality & Impulse Control

300.14 Multiple Personality Disorder
 301. Personality Disorders
 307.1 Anorexia Nervosa
 312.31 Pathologic Gambling
 312.32 Kleptomania
 312.39 Impulse Control disorder, other

Adjustment Factor = 1.02

DRG 521 Alcohol/Drug Abuse or Dependence w/ CC

291. Alcohol Induced Mental Disorders
 292. Drug Induced Mental Disorders
 303. Alcohol Dependence Syndromes
 304. Drug Dependence
 305. Nondependent Abuse of Drugs
 790.3 Excessive Blood Alcohol Level

Adjustment Factor = 1.02

DRG 427 Neuroses except Depressive

300. Anxiety, Dissociative and Somatoform Disorders
 306. Physiological Malfunction Arising from Mental Factors
 307.53 Psychogenic Rumination/Vomiting/Pain
 309. Adjustment Reactions

Adjustment Factor = 1.00

DRG 430 Psychoses

295. Schizophrenic Disorders
 296. Episodic Mood Disorders
 297. Delusional Disorders
 298. Other Nonorganic Psychoses

Adjustment Factor = 0.99

DRG 426 Depressive Neuroses

300.4 Neurotic Depression
 301.12 Chronic Depressive Personality Disorder
 309.0 Brief Depressive Reaction
 309.1 Prolonged Depressive Reaction
 311 Depressive Disorder NEC

Adjustment Factor = 0.98

DRG 522 Alcohol/Drug Abuse Or Dependence w/Rehabilitation Therapy w/o CC

Same ICD-9-CM codes as DRG 521, in conjunction with the following procedures:
 94. Alcohol/Drug Rehabilitation/Detox

Adjustment Factor = 0.97

DRG 433 Alcohol/Drug Abuse or Dependence—Left Against Medical Advice

Adjustment Factor = 0.92

DRG 432 Other Mental Disorder Diagnoses

298.2 Reactive Confusion
 302. Sexual and Gender Identity Disorders
 306.8 Psychogenic Disorder, other
 307.0 Stammering/Stuttering
 307.3 Stereotyped Movements
 307.4 Nonorganic Sleep Disorders
 307.5 Eating Disorder other & unspecified
 780.5 Sleep Disturbances
 V71.09 Observe Mental Condition, other

Adjustment Factor = 0.88

DRG 532 Alcohol/Drug Use without Rehabilitation

ICD-9-CM Codes for Medical Comorbidity

Being able to document any medical comorbidities is essential—even ones that are not reimbursed. Over time, CMS will continue to look at—and revise—the lists of diagnoses covered. Only by having access to accurate information about actual diagnoses will future updates and changes reflect the true needs of patients.

Facilities may want to make information on comorbidities available to staff in an easy-to-use format.

Example: To help its clinicians, SSM Health Care developed the following form on medical comorbidities, which they reproduce as a double-sided tri-fold publication on colored stock.

Adjustment Factor = 1.13

Coagulation Factor Deficits

- 286. Congenital Disorders & Von Willebrand's Disease

Adjustment Factor = 1.13

Severe Protein Calorie Malnutrition

- 260. Kwashiorkor
- 261. Nutritional Marasmus
- 262. Other Severe Protein-calorie Malnutrition

Adjustment Factor = 1.12

Eating and Conduct Disorders

- 307.1 Anorexia Nervosa
- 307.50 Eating Disorder, Unspecified
- 312.03 Undersocialized Conduct Disorder, Aggressive Type, Severe Degree
- 312.33 Pyromania
- 312.34 Intermittent Explosive Disorder

Adjustment Factor = 1.12

COPD

- 491.21 Obstructive Chronic Bronchitis, w/ (Acute) Exacerbation
- 494.1 Bronchiectasis w/ Acute Exacerbation
- 510.0 Empyema w/ Fistula
- 518.83- Acute and Chronic Respiratory Failure
- 518.84
- V461 Dependence on Respirator

Adjustment Factor = 1.11

Renal Failure, Acute

- 584. Acute Renal Failure
- 636.3 Renal Failure following Labor and Delivery, Abortion, Postpartum
- 637.3 - Condition or Complication
- 639.3 - Traumatic Anuria (Crush syndrome)

Adjustment Factor = 1.11

Renal Failure, Chronic

- 403... Hypertensive Renal Disease, w/ Renal Failure
- 404... Hypertensive Heart and Renal Disease, w/ Renal Failure
- 585. Chronic Renal Failure
- 586. Renal Failure, Unspecified
- V45.1 Postsurgical Renal Dialysis Status
- V56. Dialysis and Dialysis Catheter Care

Adjustment Factor = 1.11

Cardiac Conditions

- 391.0 - Acute Rheumatic Fever w/ Heart Involvement
- 402.01 - Malignant Hypertensive Heart Disease w/ Heart Failure and/or Renal Failure
- 404.03 Heart Failure and/or Renal Failure
- 416.0 Primary Pulmonary Hypertension
- 421. Acute and Subacute Endocarditis

Adjustment Factor = 1.11

Poisoning

- 965.00 - Poisoning by Opiates and Related Narcotics
- 965.09 Narcotics
- 965.4 Poisoning By Aromatic Analgesics
- 967.0 - Poisoning By Sedatives and Hypnotics
- 967.9
- 968.0 - Poisoning By Other CNS Depressants and Anesthetics
- 968.9 Depressants and Anesthetics
- 969.0 - Poisoning By Psychotropic Agents
- 969.9
- 977.0 Poisoning By Other and Unspecified Drugs and Medicinal Substances
- 980.0 - Toxic Effect of Alcohol
- 980.9
- 983.0 - Toxic Effect of Corrosive Aromatics, Acids, and Caustic Alkalis
- 983.9
- 986. Toxic Effect of Carbon Monoxide
- 989. Toxic Effect of Other Substances, Chiefly Nonmedicinal as to Source

Adjustment Factor = 1.10

Gangrene

- 440.24 Atherosclerosis of native arteries of Extremities, w/ Gangrene
- 785.4 Gangrene

Adjustment Factor = 1.09

Severe Musculoskeletal and Connective Tissue Diseases

- 696.0 Psoriatic Arthropathy
- 710.0 Systemic Lupus Erythematosus
- 730. Osteomyelitis

Adjustment Factor = 1.08

Artificial Openings—Digestive and Urinary

- 569.60 - Colostomy and Enterostomy
- 569.69 Complications
- 997.5 Urinary Complications, NEC
- V44.1 - Status of Gastrostomy, Ileostomy, Colostomy, Other Artificial Opening of Gastrointestinal Tract, Nephrostomy; Ureterostomy; Urethroostomy)
- V44.6

Adjustment Factor = 1.06

Tracheotomy

- 519. - Tracheostomy w/ Complications
- 519.09
- V44.0 Tracheostomy Status

Adjustment Factor = 1.07

Oncology Treatment

- 140.0 - 239.9 AND EITHER
- V58.0 Radiotherapy
- V58.1 Chemotherapy

Adjustment Factor = 1.07**Infectious Disease**

010.	Primary Tuberculous Infection
020.	Plague
030.	Leprosy
040.	Other Bacterial Diseases
041.0	Streptococcus
041.1	Staphylococcus
042.	Human Immunodeficiency Virus (HIV) disease
045.	Acute Poliomyelitis
046.	Slow Virus Infection of CNS
047.	Viral Meningitis
048.	Other Enterovirus Diseases of CNS (Boston Exanthem)
049.	Other Non-arthropod-borne Viral Diseases of CNS
050.	Smallpox
051.	Cowpox and Paravaccinia
052.	Chickenpox
053.	Herpes Zoster
054.40	- Herpes Simplex
054.49	
055.	Measles
056.	Rubella
057.	Other Viral Exanthemata
060.	Yellow Fever
070.	Viral Hepatitis
071.	Rabies
072.	Mumps
073.	Ornithosis
074.	Specific Diseases due to Coxsackie Virus
075.	Infectious Mononucleosis
076.	Trachoma
077.0	Inclusion Conjunctivitis
078.2	Sweating Fever
078.3	Cat-scratch Disease
078.4	Foot and Mouth Disease
078.5	Cytomegaloviral Disease
078.6	Hemorrhagic Nephrosonephritis
078.7	Arenaviral Hemorrhagic Fever
078.81	Epidemic Vertigo
078.82	Epidemic Vomiting Syndrome
078.88	Other Specified Diseases due to Chlamydiae

078.89 Other Specified Diseases due to Viruses (Epidemic cervical myalgia; Marburg disease; Tanapox)

079.5 Retrovirus Unspecified

Adjustment Factor = 1.04**Developmental Disabilities**

317. Mild Mental Retardation

 IQ 50-70

318.0 Moderate Mental Retardation

 IQ 35-49

318.1 Severe Mental Retardation

 IQ 20-34

318.2 Profound Mental Retardation

 IQ under 20

319. Unspecified Mental Retardation

Adjustment Factor = 1.03**Drug and/or Alcohol Induced Mental Disorders**

291.0 Alcohol Withdrawal Delirium

292.0 Drug Withdrawal

292.2 Pathological Drug Intoxication, resulting in brief psychotic states

303.00 Acute Alcoholic Intoxication in Alcoholism, Unspecified

 Drinking Behavior

304.00 Opioid Type Dependence, unspecified use

Adjustment Factor = 1.05**Uncontrolled Type I Diabetes-Mellitus w/ or w/o Complications**

250.02	Type Two Diabetes Mellitus w/o mention of Complication, Uncontrolled [non-insulin dependent]	250.73	Type One Diabetes Mellitus w/ Peripheral Circulatory Disorders, Uncontrolled
250.03	Type One Diabetes Mellitus w/o mention of Complication, Uncontrolled	250.83	Type One Diabetes Mellitus w/ other Specified Manifestations, Uncontrolled
250.12	Type Two Diabetes Mellitus w/ Ketoacidosis, Uncontrolled	250.92	Type Two Diabetes Mellitus w/ Unspecified Complication, Uncontrolled
250.13	Type One Diabetes Mellitus w/ Ketoacidosis, Uncontrolled	250.93	Type One Diabetes Mellitus w/ Unspecified Complication, Uncontrolled
250.22	Type Two Diabetes Mellitus w/ Hyperosmolar Coma, Uncontrolled		

250.23 Type One Diabetes Mellitus w/ Hyperosmolar Coma, Uncontrolled

250.32 Type Two Diabetes Mellitus w/ other Coma, Uncontrolled

250.33 Type One Diabetes Mellitus w/ other Coma, Uncontrolled

250.42 Type Two Diabetes Mellitus w/ Renal Manifestations, Uncontrolled

250.43 Type One Diabetes Mellitus w/ Renal Manifestations, Uncontrolled

250.52 Type Two Diabetes Mellitus w/ Ophthalmic Manifest, Uncontrolled

250.53 Type One Diabetes Mellitus w/ Ophthalmic Manifest, Uncontrolled

250.62 Type Two Diabetes Mellitus w/ Neurological Manifest, Uncontrolled

250.63 Type One Diabetes Mellitus w/ Neurological Manifest, Uncontrolled

250.72 Type Two Diabetes Mellitus w/ Peripheral Circulatory Disorders, Uncontrolled

5. About the Authors and Acknowledgements

About the Authors

National Association of Psychiatric Health Systems

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Its members are behavioral healthcare provider organizations, including 400 specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, partial hospital services, behavioral group practices, and other providers of care. The association was founded in 1933.

T. Giovanis & Company (Health Policy and Regulatory Consultants)

Established in 1990, T. Giovanis & Company is a health policy and regulatory consulting firm located between Baltimore, MD, and Washington, DC. The firm provides broad-based policy, advocacy, and regulatory consulting services and has had engagements with clients in about half the states. The company is experienced in rate system design, reimbursement, and advocacy. Founder and President Theodore Giovanis, FHFMA, CHFP, has more than 30 years' experience in government relations, health policy development, and management of healthcare organizations. He has been involved in the development of many Medicare regulatory and legislative policy changes, including the creation of the Medicare Geographic Classification Review Board and the payment system for Certified Registered Nurse Anesthetists. Mr. Giovanis assists many organizations in developing and executing strategies to capitalize on or respond to government-initiated laws and regulations. He is a recognized expert in Medicare and Medicaid regulation and has been an expert witness in numerous court cases.

Steven M. Mirin, M.D. (Best Practice Management)

Steven M. Mirin, M.D., is a strategic partner with Best Practice Management Inc., a national healthcare consulting firm. From 1997 through 2002, Dr. Mirin served as medical director of the American Psychiatric Association (APA) in Washington, D.C. In this role, he oversaw the association's activities shaping the financing and delivery of mental health care. Before going to APA, Dr. Mirin was president and psychiatrist-in-chief of McLean Hospital in Belmont, Massachusetts—an affiliate of the Massachusetts General Hospital and a teaching hospital of the Harvard Medical School, where Dr. Mirin was a professor of psychiatry. At McLean he oversaw the hospital's clinical care, research and training programs, hospital operations and facilities. Dr. Mirin is a Distinguished Life Fellow of the APA, a Fellow of the American College of Psychiatrists, a member of numerous professional organizations, and the recipient of numerous awards. He was a member of the National Advisory Council of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and chair of the Governing Council of the Section on Psychiatric and Substance Abuse Services of the American Hospital Association. He is currently a consultant to the Alcohol and Drug Abuse Research Center at McLean and lecturer on psychiatry at Harvard Medical School. A well-known author and editor of nine books or monographs and more than 140 professional papers, he was the co-founder and co-editor-in-chief of the *Harvard Review of Psychiatry*.

Linda Martins, RHIA

Ms. Martins has been with Butler Hospital in Providence, RI, for the past 20 years in the Health Information and Reimbursement/Compliance Departments. She has been involved with behavioral health coding and documentation issues for the past 10 years. Ms. Martins has an associates degree in health information technology and a baccalaureate degree in business administration from Fisher College, Boston, MA. She is currently pursuing a master's degree in healthcare administration from Salve Regina University, Newport, RI. She received her certification in Registered Health Information Technology (RHIT) in 1997 and recently received her certification in Registered Health Information Administration (RHIA). She has also served as education director and president of the Rhode Island Health Information Management Association (RIHIMA), an affiliate of AHIMA.

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Project Team

Theodore Giovanis, FHFMA, CHFP, President and Founder, T. Giovanis & Company
Steven M. Mirin, M.D., Organizational Consultant; Strategic Partner, Best Practice Management Inc.
Mark J. Covall, Executive Director, National Association of Psychiatric Health Systems
Linda Martins, RHIA, Butler Hospital, Providence, RI
Kathleen McCann, R.N., D.N.Sc., Director of Clinical Services, National Association of Psychiatric Health Systems
Carole Szpak, Director of Operations and Communications, National Association of Psychiatric Health Systems

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Dan Mullins, Chair, Ardent Health Services, TN
Gregory Bowers, Maine Medical Center, ME
Marie Caffey, Langley Porter Psychiatric Hospital & Clinics, CA
Alan Eaks, Aurora Chicago Lakeshore, IL
Michele L. Gougeon, McLean Hospital, MA
Bob Halinski, Universal Health Services, Inc., PA
Mary Hanrahan, New York Presbyterian Hospital, NY
Jack Kent, Sheppard Pratt Health System, MD
Harold Schwartz, M.D., Institute of Living: Hartford Hospital, CT
Trace Swartzfager, St. Dominic-Jackson Memorial Hospital, MS
Anil Godbole, M.D., ex officio, Advocate Behavioral Health Council, IL
Dennis P. King, ex officio, Spring Harbor Hospital; MaineHealth, ME

6. Resources

Telephone Training Conferences and Compact Discs

As a companion to this *Toolkit for Action*, the National Association of Psychiatric Health Systems is sponsoring a series of trainings throughout 2005 (including regional conferences as well as interactive telephone conference calls) on various aspects of the creation and implementation of the new inpatient psychiatric prospective payment system.

Regional One-Day Leadership Conferences

- Chicago January 28, 2005
- Atlanta February 22, 2005

For a brochure and registration form, see www.naphs.org or call 202/393-6700, ext. 107.

Targeted Two-Hour Telephone Trainings

Throughout 2005, NAPHS will offer a wide variety of low-cost trainings to help facilities educate specific audiences about the move to inpatient psychiatric PPS. Each two-hour telephone training is designed to help your staff understand and prepare your organization for change. While the calls are specifically intended to help members with inpatient psychiatric PPS, many of the calls will also be of benefit to organizations re-evaluating their clinical programming overall.

Join the calls live.....or purchase compact discs (CDs) after the calls. The telephone conference format allows you to have as many staff as you wish on the call for a single registration per telephone line of \$150 for NAPHS members (or \$225 for non-members).

Complete registration and ordering information is available at www.naphs.org under "Training" or call 202/393-6700, ext. 104, for information.

- December 7, 2004. Preparing Your Organization for the Move to Inpatient Psychiatric Prospective Payment: An Introduction to the Final Rule [Compact disc now available: \$125 for NAPHS members; \$175 for non-members]
- TBA. "Ask-The-Expert" About Staffing Within Behavioral Health Inpatient Programs [\$125 for NAPHS members; \$175 for non-members]
- TBA. "Coding for Medicare Inpatient Psychiatric PPS"
- TBA. "What Physicians Need to Know About Inpatient Psychiatric PPS"
- Others to be announced. Check www.naphs.org frequently for news of the latest offerings.

2005 Annual Meeting—Special Session on Inpatient Psychiatric PPS

A special Sunday session on inpatient psychiatric PPS will be featured at the April 17–19, 2005, NAPHS Annual Meeting in Washington, DC. For complete annual meeting details, see <http://www.naphs.org/AnnMeeting/index.html> or call 202/393-6700, ext. 104.

Resources

Federal Register

For the November 15, 2005, final rule, see:

http://www.access.gpo.gov/su_docs/fedreg/a041115c.html (under Centers for Medicare and Medicaid Services)

CMS Information on PPS

For links to background on Medicare’s move to inpatient psychiatric prospective payment, see:

<http://www.cms.hhs.gov/providers/ipfpps/>

Transmittal 384

Subject: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

CMS Manual System (Pub. 100-04 Medicare Claims Processing)

Date: December 1, 2004 (change request 3541)

http://www.cms.hhs.gov/manuals/pm_trans/R384CP.pdf

CMS MedLearn Web Site

The Centers for Medicare and Medicaid Services makes training materials available on a wide range of Medicare issues. Access the online Medicare Learning Network at

<http://www.cms.hhs.gov/medlearn>. From this site, you can search for details on specific con-

cerns. For example, a search for detailed information on ICD-9 codes is available at

<http://www.cms.hhs.gov/medlearn/icd9code.asp>.

CMS Report to Congress

For the 2002 Report to Congress, see:

<http://www.cms.hhs.gov/providers/ipfpps/rptcongress.pdf>

Coding References

The new PPS will require your staff to understand ICD-9-CM coding. Among resources available are:

- *ICD-9-CM CD Rom Version*. This product contains the complete official version of the International Classification of Diseases, Ninth Revision, Clinical Modification (Volumes 1, 2, 3, and Guidelines), compiled by the National Center for Health Statistics and the Centers for Medicare and Medicaid Services. The ICD-9-CM CD-ROM contains all changes issued through October 1, 2004. This CD-ROM supersedes all previous issues. This product can be purchased from the Government Printing Office (GPO), stock number 017-022-01573-1, cost \$25. Earlier versions may also still be available. For details, see <http://www.cms.hhs.gov/paymentsystems/icd9/cdrom.asp>.

- *ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2003*. These guidelines are available as a pdf file at <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>. You can also find extensive background and references related to ICD-9-CM through the CMS Web site at <http://www.cms.hhs.gov/paymentsystems/icd9/default.asp#guidelines> or <http://www.cms.hhs.gov/medlearn/icd9code.asp>.
- *ICD-9-CM Coding Handbook 2005, With Answers* by Faye Brown is the most widely used publication for teaching ICD-9-CM to entry-level and experienced coders. It is designed for self-study and reference. The 445-page publication is available for purchase with answers (\$89—Catalog No. WS-148020). Go to the American Hospital Association’s “Online Store” at <http://www.ahaonlinestore.com> to order.
- *Clinical Coding Workout: Practice Exercises for Skill Development, 2004 Edition, with answer key* (Product No. AC201504; ISBN/ISSN: 1-58426-065-3). Published by the American Health Information Management Association (AHIMA), this 512-page workbook provides practical information and skill-development exercises for assigning codes from ICD-9-CM, CPT, and HCPCS Level II. Order for \$90 from the AHIMA Catalog at <https://imis.ahima.org/orders>.

Consultants and Other Resources

T. Giovanis & Company

Providing health policy and regulatory consultation, including consultation on the reimbursement, financial, and documentation and coding implications of inpatient psychiatric prospective payment.

Contact: Theodore Giovanis, FHFMA, CHFP
 P.O. Box 130
 Highland, MD 20777
 Phone: 301/854-2496
 E-mail: TNGiovanis@aol.com
 Web: www.tgiovanis.com

Steven M. Mirin, M.D.

Strategic Partner, Best Practice Management Inc.

Providing organizational consulting on the financial, strategic, and clinical implications of prospective payment for psychiatric hospitals and units.

Contact: Steven M. Mirin, M.D.
 384 Catarina Heights
 Concord, MA 01742-4752
 Phone: 978/369-0515
 E-mail: smirin@earthlink.net

Creative Socio-Medics Corporation

A long-time sponsor of NAPHS and a leading supplier of unique software solutions for the behavioral healthcare industry, Creative Socio-Medics Corporation of Islip, NY, has more than 600 clients using its Avatar product line throughout the nation. Avatar is composed of electronic medical records, practice management, managed care, and public health solutions. Creative is proud of its clients who are NAPHS members, including Butler Hospital, Ridgeview Institute, North Shore Health System, and The Retreat. Creative is also dedicated to the inpatient PPS initiative by the federal government.

Contact: Ron Marge, AVP Sales & Marketing
Creative Socio-Medics
3500 Sunrise Highway, Suite D122, Great River, NY 11739
Email: rmarge@csmcorp.com
Phone: 800/421-7503, ext. 2026
Web: www.csmcorp.com

KB Behavioral Health Care Consultants, Inc.

KB Behavioral Health Care Consultants, Inc., (KB) has specialized for more than 20 years in Medicare and Medicaid requirements for behavioral health; CMS compliance survey preparation and corrective action; partial hospitalization and psychiatric outpatient program review; operations design, development, evaluation and improvement; Medicare fiscal intermediary and carrier audit, denial & appeals processes; strategy and business planning; organizational development; documentation, policies, procedures, forms; attorney-client privileged analysis; and education and training seminars.

Contact: Kathy Bolmer, Ph.D., President
1228 Lupine Hills Drive, Vista, CA 92081
Phone: 661/803-5414
Fax: 760/727-0508
Email: boltal@csiway.com

Greater New York Hospital Association

This organization is available to provide financial impact analysis of the PPS.

Contact: Karen S. Heller, Executive Director, THEORI
Phone: 212/506-5408
Web: www.theori.org, www.gnyha.org

National Association of Psychiatric Health Systems

For details on PPS trainings, see www.naphs.org or call 202/393-6700, ext. 107 or ext. 104.

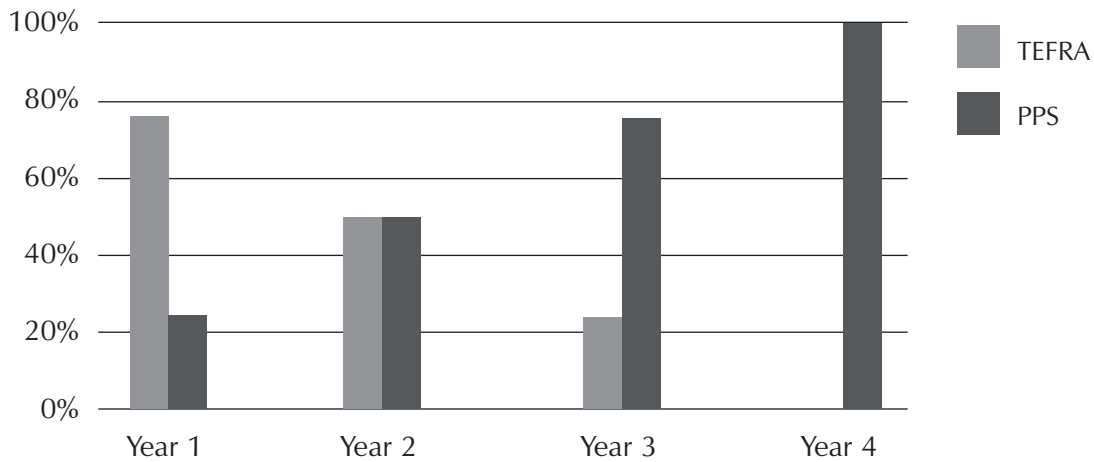
7. Appendix

You may find illustrations helpful to explain PPS concepts at-a-glance. Here are examples of some ways to describe how PPS works.

The Transition from TEFRA to PPS

The transition will occur over a three-year period.

MIX OF TEFRA AND PPS PAYMENTS DURING TRANSITION



Prospective Payment Is Based on a Number of Factors Related to the Individual Patient and the Facility Itself

Adjustments to the base rate include patient-specific factors as well as facility-specific factors.

