§ 412.400 Basis and scope of subpart.

(a) Basis. This subpart implements section 124 of Public Law 106–113, which provides for the implementation of a per diem-based prospective payment system for inpatient hospital services of inpatient psychiatric facilities.

(b) Scope. This subpart sets forth the framework for the prospective payment system for the inpatient hospital services of inpatient psychiatric facilities, including the methodology used for the development of the Federal per diem rate, payment adjustments, implementation issues, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2005, payment for the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined payment amount applied on a per diem basis.

§ 412.402 Definitions.

As used in this subpart—

Comorbidity means all specific patient conditions that are secondary to the patient’s primary diagnosis and that coexist at the time of admission, develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

Federal per diem base rate means the payment based on the average routine operating, ancillary, and capital-related cost of 1 day of hospital inpatient services in an inpatient psychiatric facility.

Federal per diem payment amount means the Federal per diem base rate with all applicable adjustments.

Fixed dollar loss threshold amount means a dollar amount which, when added to the Federal payment amount for a case, the estimated costs of a case must exceed in order for the case to qualify for an outlier payment.

Inpatient psychiatric facilities means hospitals that meet the requirements as specified in §§ 412.22, 412.23(a), 482.60, 482.61, and 482.62, and units that meet the requirements as specified in §§ 412.22, 412.25, and 412.27.

Interrupted stay means a Medicare inpatient is discharged from an inpatient psychiatric facility and is admitted to any inpatient psychiatric facility within 3 consecutive calendar days following discharge. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of the third day.

New graduate medical education program means a medical education program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after November 15, 2004.

Outlier payment means an additional payment beyond the Federal per diem payment amount for cases with unusually high costs.

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility also referred to as primary diagnosis. Principal diagnosis is also referred to as primary diagnosis.

Qualifying emergency department means an emergency department that is staffed and equipped to furnish a comprehensive array of emergency services and meeting the definitions of a dedicated emergency department as specified in § 489.24(b) of this chapter and the definition of “provider-based status” as specified in § 413.65 of this chapter.

Rural area means for cost reporting periods beginning January 1, 2005, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2006, an area as defined in § 412.62(1)(i)(II). For discharges occurring on or after July 1, 2006, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

Urban area means for cost reporting periods beginning on or after January 1, 2005, with respect to discharges occurring during the period covered by
such cost reports but before July 1, 2006, an area as defined in §412.62(f)(1)(ii). For discharges occurring on or after July 1, 2006, urban area means an area as defined in §412.64(b)(1)(ii)(A) and §412.64(b)(1)(ii)(B).

§412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(a) General requirements. (1) Effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished in to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient psychiatric facility fails to comply fully with these conditions, CMS may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient psychiatric facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient psychiatric facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment system as specified in §412.1(a)(1).

(b) Inpatient psychiatric facilities subject to the prospective payment system. Subject to the special payment provisions of §412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in §412.22. In order to be excluded from the hospital inpatient prospective payment system as specified in §412.1(a)(1), a psychiatric hospital must meet the criteria set forth in §§412.23(a), 482.60, 482.61, and 482.62 and psychiatric units must meet the criteria set forth in §412.25 and §412.27.

(c) Limitations on charges to beneficiaries—(1) Prohibited charges. Except as permitted in paragraph (c)(2) of this section, an inpatient psychiatric facility may not charge a beneficiary for any service for which payment is made by Medicare, even if the facility’s cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) Permitted charges. An inpatient psychiatric facility receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this chapter and for items or services as specified under §489.20(a) of this chapter.

(d) Furnishing of inpatient hospital services directly or under arrangement. (1) Subject to the provisions of §412.422, the applicable payments made under this subpart are payment in full for all inpatient hospital services, as specified in §409.10 of this chapter. Hospital inpatient services do not include the following:

(i) Physicians’ services that meet the requirements of §415.102(a) of this chapter for payment on a fee schedule basis.

(ii) Physician assistant services, as specified in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as specified in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as specified in section 1861(gg) of the Act.

(v) Qualified psychologist services, as specified in section 1861(ii) of the Act.

(vi) Services of a certified registered nurse anesthetist, as specified in section 1861(bb) of the Act and defined in §410.69 of this subchapter.

(2) CMS does not pay providers or suppliers other than inpatient psychiatric facilities for services furnished to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, except for services described in paragraphs (d)(1)(i) through (d)(1)(vi) of this section.

(3) The inpatient psychiatric facility must furnish all necessary covered services to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, either directly or under arrangements (as specified in §409.3 of this chapter).
§ 412.405 Reporting and recordkeeping requirements. All inpatient psychiatric facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements as specified in §§ 412.27(c), 413.20, 413.24, and 482.61 of this chapter.

§ 412.405 Preadmission services as inpatient operating costs under the inpatient psychiatric facility prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services if the inpatient operating costs are for—

(a) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary’s inpatient admission, and during the calendar day immediately preceding the date of the beneficiary’s inpatient admission, to the inpatient psychiatric facility that meet the following conditions:

(1) The services are furnished by the inpatient psychiatric facility or by an entity wholly owned or wholly operated by the inpatient psychiatric facility. An entity is wholly owned by the inpatient psychiatric facility if the inpatient psychiatric facility is the sole owner of the entity. An entity is wholly operated by an inpatient psychiatric facility if the inpatient psychiatric facility has exclusive responsibility for conducting and overseeing the entity’s routine operations, regardless of whether the inpatient psychiatric facility also has policymaking authority over the entity.

(2) The services are diagnostic (including clinical diagnostic laboratory tests).

(3) The services are nondiagnostic when furnished on the date of the beneficiary’s inpatient admission, the services are nondiagnostic when furnished on the calendar day preceding the date of the beneficiary’s inpatient admission, and the hospital does not demonstrate that such services are unrelated to the beneficiary’s inpatient admission, and are not one of the following:

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

(b) The preadmission services are furnished on or after June 25, 2010.

[75 FR 50415, Aug. 16, 2010]

§ 412.422 Basis of payment.

(a) Method of payment. (1) Under the inpatient psychiatric facility prospective payment system, inpatient psychiatric facilities receive a predetermined Federal per diem base rate for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The Federal per diem payment amount is based on the Federal per diem base rate plus applicable adjustments as specified in § 412.424.

(3) During the transition period, payment is based on a blend of the Federal per diem payment amount as specified in § 412.424, and the facility-specific payment rate as specified in § 412.426.

(b) Payment in full. (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as specified in subpart G of part 409 of this chapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient psychiatric facility, but not the cost of an approved medical education program as specified in § 413.75 through § 413.85 of this chapter.

(2) In addition to the Federal per diem payment amounts, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.80 of this chapter.

[69 FR 66977, Nov. 15, 2004; 70 FR 19728, Apr. 1, 2005]

§ 412.424 Methodology for calculating the Federal per diem payment amount.

(a) Data sources. (1) To calculate the Federal per diem base rate (as specified in paragraph (b) of this section for inpatient psychiatric facilities, as specified in paragraph (b) of this section, CMS uses the following data sources:

(2) The best Medicare data available to estimate the average inpatient operating and capital-related costs per day made as specified in part 413 of this chapter.

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(i) Patient and facility cost report data capturing routine and ancillary costs.

(ii) An appropriate wage index to adjust for wage differences.

(iii) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities.

(b) Determining the average per diem cost of inpatient psychiatric facilities for FY 2002. CMS determines the average inpatient operating, ancillary, and capital-related per diem cost for which payment is made to each inpatient psychiatric facility, using the available data described in paragraph (a) of this section.

(c) Determining the Federal per diem base rate for cost reporting periods beginning on or after January 1, 2005 through June 30, 2006—(1) General. Payment under the inpatient psychiatric facility prospective payment system is based on a standardized per diem cost method described in paragraph (b) of this section. The adjusted cost per day is adjusted in accordance with paragraphs (c)(2) through (c)(5) of this section.

(2) Update of the average per diem cost. CMS applies the increase factor described in paragraph (a)(2)(iii) of this section to the updated average per diem cost to the midpoint of the January 1, 2005 through June 30, 2006, under the update methodology described in section 1886(b)(3)(B)(i) of the Act.

(3) Budget neutrality. (i) CMS adjusts the updated average per diem cost so that the aggregate payments in the first 18 months (for January 1, 2005 through June 30, 2006) under the inpatient psychiatric facility prospective payment system are estimated to equal the amount that would have been made to the inpatient psychiatric facilities under part 413 of this chapter if the inpatient psychiatric facility prospective payment system described in this subpart were not implemented.

(ii) CMS evaluates the accuracy of the budget-neutrality adjustment within the first 5 years after implementation of the inpatient psychiatric facility prospective payment system. CMS may make a one-time prospective adjustment to the Federal per diem base rate to account for significant differences between the historical data on cost-based TEFRA payments (the basis of the budget-neutrality adjustment at the time of implementation) and estimates of TEFRA payments based on actual data from the first year of the prospective payment system.

(d) Determining the Federal per diem payment amount. The Federal per diem payment amount is the product of the Federal per diem base rate established under paragraph (c) of this section, the facility-level adjustments applicable to the inpatient psychiatric facility, patient-level adjustments and other policy adjustments applicable to the case.

(1) Facility-level adjustments. (i) Adjustment for wages. CMS adjusts the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as defined in §412.402.
(ii) Rural location. CMS adjusts the Federal per diem base rate for inpatient psychiatric facilities located in a rural area as defined in §412.402.

(iii) Teaching adjustment. CMS adjusts the Federal per diem base rate by a factor to account for indirect teaching costs.

(A) An inpatient psychiatric facility’s teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the inpatient psychiatric facility divided by the facility’s average daily census.

(B) Residents with less than full-time status and residents rotating through the inpatient psychiatric facility for less than a full year will be counted in proportion to the time they spend in the inpatient psychiatric facility.

(C) Except as described in paragraph (d)(1)(iii)(D) of this section, the actual number of current year full-time equivalent residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the inpatient psychiatric facility’s most recently filed cost report filed with its fiscal intermediary before November 15, 2004 (base year).

(D) If the inpatient psychiatric facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (d)(1)(iii)(C) of this section may be adjusted using the method described in §413.79(e)(1) and (ii) of this chapter.

(E) 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.

(iv) Inpatient psychiatric facilities located in Alaska and Hawaii. CMS adjusts the non-labor portion of the Federal per diem base rate to reflect the higher cost of living of inpatient psychiatric facilities located in Alaska and Hawaii.

(v) Adjustment for IPF with qualifying emergency departments. (A) CMS adjusts the Federal per diem base rate to account for the costs associated with maintaining a qualifying emergency department. A qualifying emergency department is staffed and equipped to furnish a comprehensive array of emergency services (medical and psychiatric) and meets the requirements of §§489.24(b) and 413.65 of this chapter.

(B) Where the inpatient psychiatric facility is part of an acute care hospital that has a qualifying emergency department as described in paragraph (d)(1)(v)(A) of this section and an individual patient is discharged to the inpatient psychiatric facility from that acute care hospital, CMS would not apply the emergency adjustment.

(2) Patient-level adjustments. The inpatient psychiatric facility must identify a principal psychiatric diagnosis as specified in §412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the diagnosis-related group assignment associated with the principal diagnosis, as specified by CMS.

(i) Age. CMS adjusts the Federal per diem base rate to account for patient age based on age groupings specified by CMS.

(ii) Diagnosis-related group assignment. The inpatient psychiatric facility must identify a principal psychiatric diagnosis as specified in §412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the CMS inpatient psychiatric facility prospective payment system recognized diagnosis-related group assignment associated with each patient’s principal diagnosis.

(iii) [Reserved]

(iv) Comorbidities. CMS adjusts the Federal per diem base rate by a factor to account for certain comorbidities as specified by CMS.

(v) Variable per diem adjustments. CMS adjusts the Federal per diem base rate by factors as specified by CMS to account for the cost of each day of inpatient psychiatric care relative to the cost of the median length of stay.

(3) Other adjustments. (i) Outlier payments. CMS provides an outlier payment if an inpatient psychiatric facility’s estimated total cost for a case exceeds a fixed dollar loss threshold amount for an inpatient psychiatric facility as defined in §412.402 plus the Federal payment amount for the case.

(A) The fixed dollar loss threshold amount is adjusted for the inpatient psychiatric facility’s adjustments for wage area, teaching, rural locations,
and cost of living adjustment for facilities located in Alaska and Hawaii.

(B) The outlier payment equals a percentage of the difference between the IPF’s estimated cost for the case and the adjusted threshold amount specified by CMS for each day of the inpatient stay.

(C) For discharges occurring in cost reporting periods beginning on or after January 1, 2005, outlier payments are subject to the adjustments specified at §§412.84(i) and 412.84(m) of this part, except that national urban and rural median cost-to-charge ratios would be used instead of statewide average cost-to-charge ratios.

(ii) Stop-loss payments. CMS will provide additional payments during the transition period, specified in §412.426(a)(1) through (3), to an inpatient psychiatric facility to ensure that aggregate payments under the prospective payment system are at least 70 percent of the amount the inpatient psychiatric facility would have received under reasonable cost reimbursement had the prospective payment system not been implemented.

(iii) Special payment provision for interrupted stays. If a patient is discharged from an inpatient psychiatric facility and is admitted to the same or another inpatient psychiatric facility within 3 consecutive calendar days following the discharge, the case is considered to be continuous for the purposes listed below. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of day 3.

(A) Determining the appropriate variable per diem adjustment, as specified in paragraph (d)(2)(v) of this section, applicable to the case.

(B) Determining whether the total cost for a case meets the criteria for outlier payments, as specified in paragraph (d)(3)(1)(C) of this section.

(iv) Payment for electroconvulsive therapy treatments. CMS provides an additional payment to reflect the cost of electroconvulsive therapy treatments received by a patient during an inpatient psychiatric facility stay in a manner specified by CMS.

§412.426 Transition period.

(a) Duration of transition period and composition of the blended transition payment. Except as provided in paragraph (d) of this section, for cost reporting periods beginning on or after January 1, 2005 through January 1, 2008, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in §412.424(d) and a facility-specific payment as specified under paragraph (b).

(1) For cost reporting periods beginning on or after January 1, 2005 and on or before January 1, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after January 1, 2006 and on or before January 1, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.

(3) For cost reporting periods beginning on or after January 1, 2007 and on or before January 1, 2008, payment is based on 25 percent of the facility-specific payment and 75 percent is based on the Federal per diem payment amount.

(4) For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the Federal per diem payment amount.

(b) Calculation of the facility-specific payment. The facility-specific payment is equal to the estimated payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility’s Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

(c) Treatment of new inpatient psychiatric facilities. New inpatient psychiatric facilities, are facilities that under present or previous ownership or
both have their first cost reporting period as an IPF beginning on or after January 1, 2005. New IPFs are paid based on 100 percent of the Federal per diem payment amount.

(69 FR 66977, Nov. 15, 2004; 70 FR 16729, Apr. 1, 2005, as amended at 71 FR 27087, May 9, 2006)

§ 412.428 Publication of Updates to the inpatient psychiatric facility prospective payment system.

CMS will publish annually in the Federal Register information pertaining to updates to the inpatient psychiatric facility prospective payment system. This information includes:

(a) A description of the methodology and data used to calculate the updated Federal per diem base payment amount.

(b)(1) For discharges occurring on or after January 1, 2005 but before July 1, 2006, the rate of increase factor, described in §412.424(a)(2)(iii), for the Federal portion of the inpatient psychiatric facility’s payment is based on the excluded hospital with capital market basket under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(2) For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the inpatient psychiatric facility’s payment is based on the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket.

(3) For discharges occurring on or after January 1, 2005 but before October 1, 2005, the rate of increase factor, described in §412.424(a)(2)(iii), for the reasonable cost portion of the inpatient psychiatric facility’s payment is based on the 1997-based excluded hospital market basket under the updated methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(4) For discharges occurring on or after October 1, 2005, the rate of increase factor for the reasonable cost portion of the inpatient psychiatric facility’s payment is based on the 2002-based excluded hospital market basket.

(c) The best available hospital wage index, and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.

(d) Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.

(e) Describe the ICD-9-CM coding changes and DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system regulations.

(f) Update the electroconvulsive therapy adjustment by a factor specified by CMS.

(g) Update the national urban and rural cost to charge ratio median and ceilings. CMS will apply the national cost to charge ratio to—

(1) New inpatient psychiatric facilities that have not submitted their first Medicare cost report.

(2) Inpatient psychiatric facilities whose operating or capital cost to charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean.

(3) Other inpatient psychiatric facilities for which the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital cost to charge ratio or both.

(h) Update the cost of living adjustment factor if appropriate.

(69 FR 66977, Nov. 15, 2004, as amended at 71 FR 27087, May 9, 2006)

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

(a) General rule. Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient psychiatric facility receives payment under this subpart for inpatient operating cost and capital-related costs for each inpatient stay following submission of a bill.

(b) Periodic interim payments (PIP). (1) Criteria for receiving PIP.

(i) An inpatient psychiatric facility receiving payment under this subpart may receive PIP for Part A services under the PIP method subject to the provisions of §413.64(h) of this chapter.

(ii) To be approved for PIP, the inpatient psychiatric facility must meet the qualifying requirements in §413.64(h)(3) of this chapter.

(iii) A hospital that is receiving periodic interim payments also receives
payment under this subpart for applicable services furnished by its excluded psychiatric unit.

(iv) As provided in §413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary’s best judgment as to whether payment can be made under the PIP method without undue risk of resulting in an overpayment to the provider.

(2) Frequency of payment. For facilities approved for PIP, the intermediary estimates the annual inpatient psychiatric facility’s Federal per diem prospective payments, net of estimated beneficiary deductibles and coinsurance, and makes biweekly payments equal to 1⁄26 of the total estimated amount of payment for the year. If the inpatient psychiatric facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of the biweekly period of service as specified in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) Outlier payments. Additional payments for outliers are not made on an interim basis. Outlier payments are made based on the submission of a discharge bill and represents final payment subject to the cost report settlement specified in §§412.84(i) and 412.84(m).

(e) Accelerated payments—(1) General rule. Upon request, an accelerated payment may be made to an inpatient psychiatric facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient psychiatric facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient psychiatric facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient psychiatric facility’s preparation and submittal of bills to the intermediary beyond the normal billing cycle.

(2) Approval of accelerated payment. An inpatient psychiatric facility’s request for an accelerated payment must be approved by the intermediary and CMS.

(3) Amount of accelerated payment. The amount of the accelerated payment is computed as a percent of the net payment for unbilled or unpaid covered services.

(4) Recovery of accelerated payment. Recovery of the accelerated payment is made by recoupment as inpatient psychiatric facility bills are processed or by direct payment by the inpatient psychiatric facility.