CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2157	**Date: February 11, 2011**
	Change Request 7072

Transmittal 2089, dated November 12, 2010, is being rescinded and replaced by Transmittal 2157 dated February 11 2011 to modify business requirements 7072.1.2 to update the provider range, and 7072.1.3 to update the ANSI and Remittance Advice Remark Code. The Effective and Implementation dates have not been changed. All other information remains the same.

SUBJECT: Implementation of edits for the Emergency Department (ED) adjustment policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. SUMMARY OF CHANGES: Section 124 of the Medicare, Medicaid, and SCHIP (State Children"s Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented January 2005. One aspect of the IPF PPS included an ED adjustment policy.

Recently, the Office of Inspector General, drafted a report, entitled "Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During Calendar Years 2006 and 2007" (A-01-09-00504). Based on findings in this report, CMS is implementing edits for ED adjustments where the costs for the emergency department services are already covered by another Medicare payment.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/190.16/IPF PPS System Edits

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is

not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	2157	Date: February 11, 2011	Change Request: 7072

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SUBJECT: Implementation of Edits for the Emergency Department (ED) Adjustment Policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

Effective Date: **April 1, 2011**

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented January 2005. One aspect of the IPF PPS included an ED adjustment policy.

Recently, the Office of Inspector General, drafted a report, entitled "Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During Calendar Years 2006 and 2007", (A-01-09-00504). Based on findings in this report, CMS is implementing edits for ED adjustments where the costs for the emergency department services are already covered by another Medicare payment.

B. Policy: As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7072.1	FISS shall identify claims that do not qualify for the ED adjustment by examining an incoming IPF claim against history claims.						X				
7072.1.1	FISS shall reject incoming claims when the Provider Transaction Access Numbers (PTANs) have an "S" or "M" in the third location, on the incoming IPF PPS claim and the following conditions exist: • The Point of Origin code on the IPF PPS is not "D". • The admission date of the incoming IPF PPS claim equals the discharge date of an Acute Care hospital or Critical Access Hospital (CAH). • The IPF PPS claim is a transfer from the same hospital to that hospital's IPF unit.						X				
7072.1.2	FISS shall reject incoming claims when the Provider Transaction Access Numbers (PTANs) are in the range of XX-0001 – XX-0999 or XX-1300 – XX-1399 on the incoming IPPS or CAH claim and the following conditions exist: • The discharge date of the incoming Acute Care hospital or Critical Access Hospital (CAH) claim equals the admission date of the history IPF PPS claim. • The IPF PPS claim is a transfer from the same hospital to that hospital's IPF PPS unit. • The Point of Origin code on the IPF PPS is not "D".						X				
7072.1.3	When FISS shall reject the incoming claim, FISS shall utilize a reason code narrative asking the provider to correct Point of Origin code to "D" on the IPF PPS claim using ANSI code 125 and Remittance Advice Remark Code MA42.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7072.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations: N\A

V. CONTACTS

Pre-Implementation Contact(s):
Fred Rooke at fred.rooke@cms.hhs.gov or 410-786-6987
Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 410-786-0187
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

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

Section B: ***For Medicare Administrative Contractors (MACs)*****:**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

190.16 - IPF PPS System Edits

(Rev. 2157, Issued: 02-11-11, Effective: 04-01-11, Implementation: 04-04-11)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines.
- The length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.
- *Value Code 75 is allowed from contractor entry and not allowed from Provider entry. Also, Providers are not allowed to alter this information.*
- *The ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit with the application of the correct Point of Origin code "D" on the IPF PPS claim.*

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

CWF shall ensure that:

- *Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the same IPF within 3 days).*
- *Value Code 75 is present on claims when there is an interrupted stay resulting from a discharge at another IPF (the beneficiary has returned to the different IPF within 3 days).*