Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-01-131 **Date: NOVEMBER 1, 2001**

CHANGE REQUEST 1921

SUBJECT: Additional Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

The instructions below describe the data sources that will be used to calculate IRF cost-to-charge ratios for the purpose of determining outlier payments under the IRF PPS. These instructions also contain information regarding the data that will be used in determining the adjustment for treating low income patients (LIP) under the IRF PPS and information on the payment adjustment for the late transmission of patient assessment data.

This Program Memorandum (PM) is related to the implementation of the policies and regulations discussed in the IRF PPS final rule published in the ***Federal Register*** on August 7, 2001 (66 FR 41316).

OUTLIER PAYMENTS: COST-TO-CHARGE RATIOS

This section describes the appropriate data sources for computing an overall Medicare facility-specific cost-to-charge ratio for the purpose of determining outlier payments under the IRF PPS. Intermediaries will use the latest available settled cost report and associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs or for IRFs that are distinct part units of acute care hospitals. Intermediaries will calculate updated ratios each time a subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments will not be made.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the intermediary should ensure that the underlying costs and charges are properly reported. CMS is evaluating the use of upper and lower cost-to-charge ratio thresholds (similar with the outlier policy for acute care hospitals) in the future to ensure that the distribution of outlier payments remains equitable.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the IRF PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

Calculating Medicare Cost-To-Charge Ratios For Freestanding IRFs

For freestanding IRFs, Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). For freestanding IRFs, total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III , col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101). Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

Calculating Medicare Cost-to-Charge Ratios for IRF Distinct Part Units

For IRF distinct part units, total Medicare inpatient routine and ancillary charges will be obtained from the PS&R report associated with the latest settled cost report. [If PS&R data is not available, estimate Medicare routine charges by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.] To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III , col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101). All references to Worksheets and specific line numbers should correspond with the subprovider identified as the IRF unit, i.e., the letter "T" is in the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

Calculating Medicare Cost-to-Charge Ratios for New IRFs

As stated in the final rule, new facilities may receive outlier payments even though they will not have the historical cost report information needed to compute the estimated cost that determines if a case is an outlier. Therefore, a national cost-to-charge-ratio based on the facilities location of either urban or rural will be used. Specifically, we have estimated a national cost-to-charge ratio of 0.663 for rural IRFs and 0.587 for urban IRFs. Unless otherwise notified, use these national ratios until the facility's actual cost-to-charge ratio can be computed using the first settled cost report data which will then be used for the subsequent cost report period. As stated above, these national ratios will not be retrospectively adjusted based on later data.

LIP ADJUSTMENT: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2000 for IRFs paid under the PPS

This section describes the data used to determine additional payment amounts to IRFs for their percentage of low income patients. The SSI/Medicare beneficiary data for the IRF PPS will be available electronically. Use this data to identify the disproportionate share percentage for all IRFs in your provider specific file so that you use the most current data in paying bills. The data contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. Update your provider specific file with this information by January 1, 2002.

The CMS's Division of Health Plan and Provider Data has released the following file name for you to retrieve the file from the CMS Mainframe.

File Name: ML13.@DBA2650.REHAB00.NDM

The SSI file is also available on the Internet at the following web address: www.hcfa.gov/medicare/irfpps.htm.

Use this data to determine an initial PPS payment amount and, if applicable, to determine a final outlier payment amount for IRFs with cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002. Since the disproportionate share percentage is based on a facility's cost reporting period, make a final determination of the amount of this percentage to compute the final LIP adjustment at the year-end settlement of the facility's cost report. The final LIP adjustment will

be used to retrospectively adjust the initial PPS payment amount. As explained above and in the final rule, there will be no retrospective adjustments to the data used to compute outlier payments.

Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

For more information regarding allowable Medicaid days in calculating DSH used to determine the LIP adjustment under the IRF PPS, please visit:http:www.hcfa.gov/pubforms/transmit/a996260.htm. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important specific information that is pertinent in calculating the LIP adjustment under the IRF PPS. Specifically the variables used in determining the percentage of low income patients is the same even though the adjustment formula is different for the IRF PPS.

PAYMENT ADJUSTMENT FOR LATE TRANMISSION OF PATIENT ASSESSMENT DATA

In accordance with the regulations, Medicare (Part A fee-for-service) patient assessment data must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge. Under §412.614(d)(2), if the actual transmission date is later than 10 calendar days from the mandated transmission date, the patient assessment data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

On Revenue Code line 0024, Field Locator 45 (or electronic equivalent), Service Date, when entered by the provider or CMS adjustment process, will equal the date on which the final assessment was transmitted to the CMS National Assessment Collection Database. This field is optional. Providers may, but are not required to, include this date on the bill if they expect that the assessment transmission will be 28 calendar days or more from the date of discharge thereby incurring the 25% late assessment penalty. If the provider does not complete this field and the assessment is received 28 calendar days or more from the date of discharge, CMS will utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment. Complete details of the CMS post-payment review process will be determined at a later date. We anticipate that this process will account for changes in the primary source of payment, after the patient is discharged, that may be a legitimate basis for the late transmission of Medicare patient assessment data.

The following modifications were made to the IRF PRICER to account for the future implementation of this payment adjustment:

Under the inputs to PRICER, the "payment modification flag" has been changed to "special payment indicator." This is an alpha-numeric field with valid entries of 0 – 3 currently.

The standard systems will set the payment modification flag to:

1= if the claim has Condition Code 66 entered,
2= if the assessment date is present on the revenue code line with 0024 and the assessment date is 28 calendar days or more from the date of discharge on this claim,
3= both 1 and 2 above apply, or
0= Default value

Under PRICER outputs, PRICER will now return a "penalty amount" field. When applicable, the amount in this field will equal 25% of the total payment amount computed by PRICER. The total payment amount field will be then be reduced by the penalty amount so that the final total payment amount output by PRICER will be 75% of the CMG payment due the provider. For providers receiving a blend using their facility specific rate, the penalty does not apply to this part of the payment.

Return Codes 10 – 17 will be added. They will identify claims where there was a penalty and they will mirror return codes 00 - 07 with the phrase "with penalty" added.

Interim Billing

If the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

This PM may be discarded after October 1, 2002.

These instructions should be implemented within your current operating budget.

If you have any questions regarding general payment adjustments, contact Bob Kuhl at 410-786-4597, email, bkuhl@cms.hhs.gov**.**

If you have any questions regarding the SSI/Medicare Beneficiary Data and IRF PRICER, contact Sarah Shirey at (410) 786-0187, email, sshirey@cms.hhs.gov.