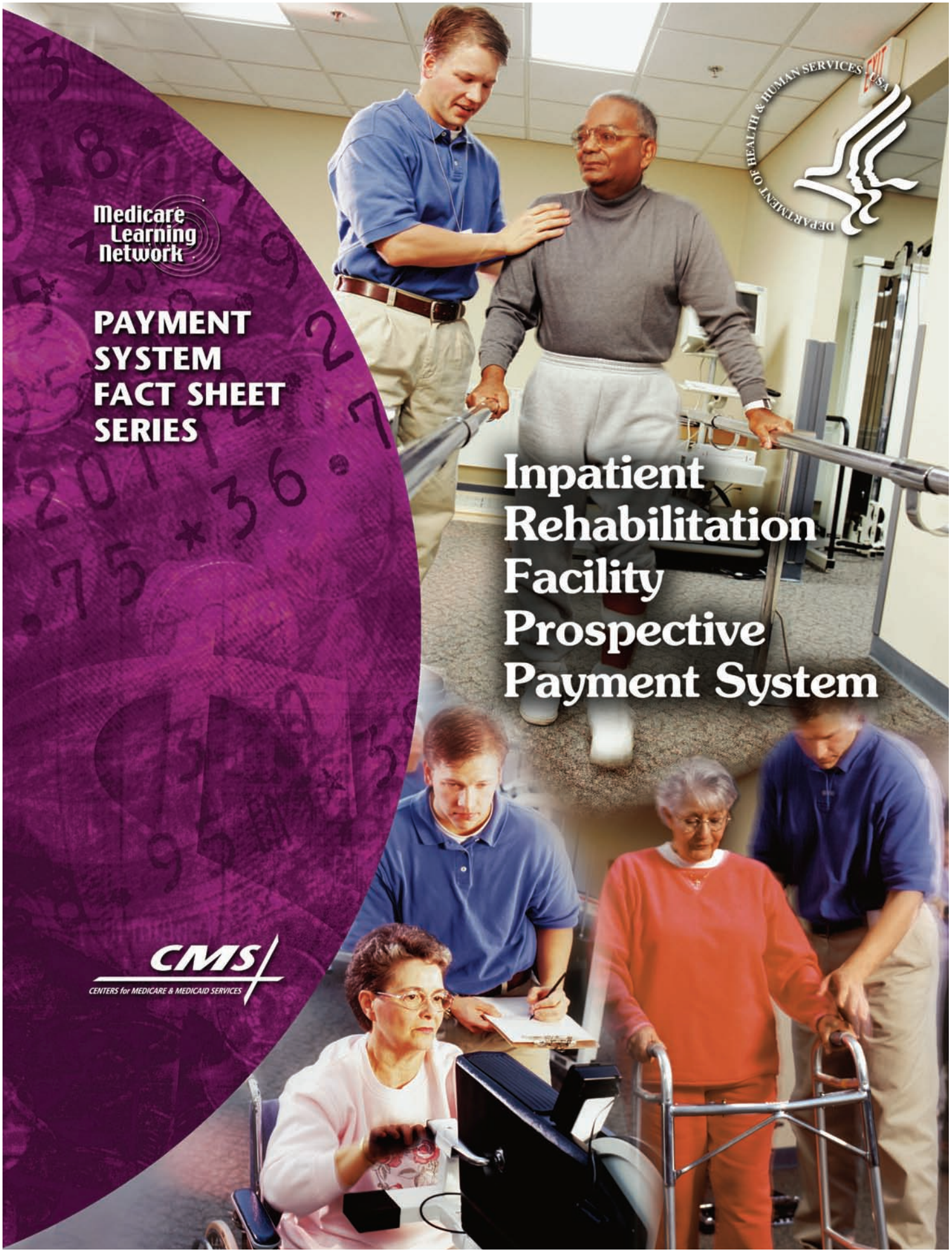
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Inpatient Rehabilitation Facility Prospective Payment System
DEPARTMENT OF HEALTH & HUMAN SERVICES USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33) modified how payment is made for **Inpatient Rehabilitation Facility (IRF)** services by creating 1886(j) of the Social Security Act (the Act), which authorized the implementation of a per-discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals—referred to as IRFs. The IRF PPS utilizes information from an IRF patient assessment instrument (PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments. The IRF PPS includes the following elements:

RATES

As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related) other than costs associated with operating approved educational activities as defined in the ***Code of Federal Regulations*** (CFR) under 42 CFR 413.75 and 413.85, bad debts, and other costs not covered under the PPS. Federal rates are adjusted to reflect:

- Patient case mix, which is the relative resource intensity that would typically be associated with each patient's clinical condition as identified through the resident assessment process:
  - Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the rehabilitation hospital;
  - Cases are further grouped into case-mix groups (CMG), which group cases that are similar according to their functional motor and cognitive scores and age;
  - Finally, cases are grouped into one of four tiers within each CMG, according to patients' comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay). Each tier adds a successively higher payment amount to the case depending on whether the costs of the comorbidity are significantly higher than other cases in the same CMG (low, medium, or high); and
  - Additional adjustments are made for interrupted stays, short stays of less than three days, short-stay transfers (defined as transfers to other institutional settings with an IRF length of stay less than the average length of stay for the CMG), and high-cost outlier cases;
- Facility characteristics:
  - Rates are adjusted to reflect geographic differences in wage rates, using the hospital wage index;
  - IRFs in rural areas (non-Metropolitan Statistical Areas) receive a 21.3 percent increase to their rates;
  - IRFs receive an increase to their rates depending on the proportion of low-income patients they treat; and
  - IRFs with residency training programs receive an increase to their rates that is based on the number of interns and residents they train compared with their average daily census. This adjustment is subject to a cap.

Federal rates are updated annually:

- To reflect inflation in the cost of goods and services used to produce IRF services, using a market basket index that is calculated for IRFs, Long-Term Care Hospitals, and Inpatient Psychiatric Facilities (facilities originally excluded from the Acute Inpatient PPS);
- To reflect changes in local wage rates, using the hospital wage index; and
- Through rulemaking that, by law (Section 1886(j) of the Act), must be provided for publication in the ***Federal Register*** on or before the August 1 that precedes the October 1 start of each new Federal fiscal year.

CLASSIFICATION CRITERION

In order to be excluded from the Acute Inpatient PPS specified in 42 CFR 412.1(a)(1) and instead be paid under the IRF PPS, an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital must meet the requirements for classification as an IRF stipulated in subpart B of 42 CFR part 412.

One criterion specified at 42 CFR 412.23(b)(2) that Medicare uses for classifying a hospital or unit of a hospital as an IRF is that a minimum percentage of a facility's total inpatient population must meet at least one of 13 medical conditions listed in 42 CFR 412.23(b)(2)(ii). This minimum percentage is known as the "compliance threshold." The compliance threshold was 75 percent prior to the Centers for Medicare & Medicaid Services (CMS) issuing a final rule on May 7, 2004, which revised 42 CFR 412.23(b)(2). As 42 CFR 412.23(b)(2) previously stipulated that the compliance threshold was 75 percent, the regulatory requirement was commonly referred to as the "75 percent rule." Beginning July 1, 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) stipulated that the compliance threshold should be set no higher than 60 percent. Thus, we now refer to this regulatory requirement as the "60 percent rule."

The Medicare, Medicaid, and SCHIP Extension Act of 2007 also stipulated that comorbidities that meet certain criteria as specified in 42 CFR 412.23(b)(2)(i) must continue to be used to determine the compliance threshold, as they have been since the May 7, 2004 final rule.

The 13 medical conditions that qualify for the 60 percent rule, as specified in the May 7, 2004 final rule, are:

- Stroke;
- Congenital deformity;
- Major multiple trauma;
- Fracture of femur (hip);
- Spinal cord injury;
- Amputation;
- Brain injury;
- Burns;
- Neurological disorders including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease;

  For the three qualifying conditions listed below, the severity/complexity can vary significantly; for this reason, additional clinical criteria have been established to require evidence that other less intensive treatments have been attempted before admission to the IRF:
- Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living;
- Systemic vasculidities with joint inflammation resulting in significant functional impairment of ambulation and other activities of daily living;
- Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more weight bearing joints (elbow, shoulders, hips, or knees but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living; and

  For the final qualifying condition, patient characteristics have been identified which would add complexity in a way that would justify IRF level care:
- Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
  - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission;
  - The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; or
  - The patient is age 85 or older at the time of admission to the IRF.

Compliance Percentage

A provider's compliance percentage is the percentage of its total inpatient population that met at least one of the medical conditions listed at 42 CFR 412.23(b)(2)(ii). The Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) uses data from a specific time period known as the compliance review period to calculate a compliance percentage. The compliance review periods associated with different cost reporting periods are specified in a detailed table that can be found in the 75 percent rule Program Transmittals, which can be accessed at **http://www.cms.hhs.gov/Transmittals** on the CMS website. The FI or A/B MAC computes a percentage by either:

- **The Presumptive Method**—Using a CMS software program that analyzes the IRF PPS impairment group, etiologic, or comorbidity ICD-9-CM codes on the IRF PAIs that the provider submitted to CMS during a specific compliance review time period; or
- **A Review of Medical Records**—Analyzing a random sample of medical records that represent inpatients the IRF treated during the compliance review time period.

Although the FI or A/B MAC may determine that the provider met an applicable compliance threshold by using the presumptive method, the FI or A/B MAC still has the discretion to also use a random sample of medical records to calculate a compliance percentage. A compliance percentage calculated by the FI or A/B MAC analyzing a random sample of medical records will always supersede a compliance percentage calculated by using the presumptive method. Also, the FI or A/B MAC must use the random sample medical record method to calculate the compliance percentage when the compliance percentage using the presumptive method fails to meet the applicable compliance threshold.

The FI or A/B MAC is responsible for notifying the appropriate CMS Regional Office (RO) of the results. Based on this information, the RO is responsible for determining the provider's classification status prior to the start of the provider's next cost reporting period. The classification status of a provider as an IRF must be determined at the beginning of its cost reporting period and is effective for the entire cost reporting period. When a provider is not classified as an IRF, it is not eligible to be paid under the IRF PPS and may instead be paid under the Acute Inpatient PPS or, if applicable, the payment system Medicare uses to pay Critical Access Hospitals provided that it meets all of the requirements to be paid under one of these other payment systems.

To find additional information about the IRF PPS, visit **http://www.cms.hhs.gov/InpatientRehabFacPPS** on the CMS website.

Medicare Contracting Reform (MCR) Update
In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at **http://www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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