



**News Flash** – On January 1, 2012, standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These electronic health care transactions include, among others, claims processing, eligibility inquiries, and remittance advice. Unlike the current Version 4010/4010A1, Version 5010 accommodates the International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes, and must be in place first before the changeover to ICD-10. The transition to ICD-10 is dependent on a successful Version 5010 implementation. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate Version 5010 testing and implementation time. Failure to prepare now for these changes may result in rejection of claims or other transactions and delays in claim reimbursement.

**Important Dates to Remember:**

- January 1, 2011 – Payers and providers should begin external testing of Version 5010 for electronic claims.
- January 1, 2012 – All electronic claims must use Version 5010
- October 1, 2013 – Transition to ICD-10-CM (diagnoses codes) and ICD-10-PCS (procedures codes)

**Keep Up to Date on Version 5010 and ICD-10.** Please visit the websites at <http://www.cms.gov/icd10> and <http://www.cms.gov/Versions5010andD0/> for the latest news and sign up for Version 5010 and ICD-10 e-mail updates!

MLN Matters® Number: MM7076

Related Change Request (CR) #: 7076

Related CR Release Date: August 13, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R2026CP

Implementation Date: October 4, 2010

## **Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for Fiscal Year (FY) 2011**

### **Provider Types Affected**

This article is for IRFs submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### **Provider Action Needed**

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This article is based on Change Request (CR) 7076 which provides updated rates used to correctly pay IRF PPS claims for FY 2011. Be sure your billing staff is aware of these changes.

## Background

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On August 7, 2001, the Centers for Medicare & Medicaid services (CMS) published in the Federal Register, a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge Federal rates for Federal FY 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886(j)(3)(C) of the Act.

The FY 2011 IRF PPS Update Notice published on July 22, 2010, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF PRICER software package will be released prior to October 1, 2010 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2010 through September 30, 2011.

### **PRICER Updates: For IRF PPS FY 2011 (October 1, 2010 – September 30, 2011)**

- The standard Federal rate is \$13,860;
- The fixed loss amount is \$11,410;
- The labor-related share is 0.75271;
- The non-labor related share is 0.24729;
- Urban national average Cost-to-Charge Ratio (CCR) is 0.489;
- Rural national average CCR is 0.620;
- The Low Income Patient (LIP) Adjustment is 0.4613, which represents no change from FY 2010;
- The Teaching Adjustment is 0.6876, which is no change from FY 2010; and
- The Rural Adjustment is 1.1840, which is also the same as FY2010.

Note also that for atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit Health Insurance PPS (HIPPS) Rate/ Case-Mix Group (CMG) Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient

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is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, CMS instructs IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).

## Additional Information

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If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR7076) issued to your Medicare MAC and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2026CP.pdf> on the CMS website.

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