SECTION 1: INTRODUCTION AND BACKGROUND INFORMATION

The purpose of this manual is to guide the user in completing the Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI), which is required by the Centers for Medicare & Medicaid Services (CMS) as part of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). The IRF-PAI is used to gather data to determine the payment for each Medicare Part A fee-for-service patient admitted to an inpatient rehabilitation unit or hospital. The completion of the IRF-PAI is required for every Medicare Part A fee-for-service patient discharged on or after the IRF PPS implementation day of January 2, 2002. The completion of the IRF-PAI is also required for every Medicare Part C (Medicare Advantage) patient discharged on or after October 1, 2009 (see the fiscal year 2010 IRF PPS final rule (74 FR 39762) for more information).

NOTE: This manual is a guide and revisions will be made as the IRF PPS is refined. These revisions may include, but are not limited to, changes resulting from research supporting the IRF PPS, legislation, regulation and refinements. Please refer to the following web site to obtain the most recent updates: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html

BACKGROUND

- Medicare statute was originally enacted in 1965 providing for payment for hospital inpatient services based on the reasonable costs incurred in treating Medicare beneficiaries.
- The statute was amended in 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA), which placed limits on deliverable costs per discharge.
- Social Security Amendments of 1983 established a Medicare inpatient prospective payment system (IPPS) for the operating costs of an inpatient hospital stay. The following hospitals and hospital units are excluded from the IPPS:
    - Children's Hospitals
    - Psychiatric Hospitals
    - Long-term Care Hospitals
    - Rehabilitation Hospitals
    - Distinct part Psychiatric and Rehabilitation units of IPPS hospitals and critical access hospitals ; and
    - Cancer Hospitals
- TEFRA payments remained in effect for inpatient rehabilitation hospitals and distinct part rehabilitation units from 1982 - 2001. TEFRA payments are based upon costs incurred during a base period, which resulted in inequities in payment between older and newer facilities.
- The desire to control the rapid growth of rehabilitation facilities and eliminate inequities in Medicare payments led to Congressional action:
    - Balanced Budget Act (BBA) of 1997
    - Balanced Budget Refinement Act (BBRA) of 1999
        - Provisions for implementation of an Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
        - IRF PPS was implemented on January 1, 2002

- Research began on the development of an IRF PPS:
  - 1984: the FIM™ instrument was developed to address functional status measurement
  - 1987: RAND and the Medical College of Wisconsin investigated an IRF PPS
    - Diagnoses alone explained little of variance in cost
    - Functional status explained more of total costs for rehabilitation patients
  - 1993: Functional Related Groups (FRGs) concept developed by N. Harada and colleagues at VA Medical Center in Los Angeles as possible basis for rehabilitation prospective payment
  - 1994: FRGs concept refined and applied by M. Stineman and colleagues from the University of Pennsylvania to large rehabilitation database for use as a patient classification system
  - 1994: RAND commissioned to study the stability of the FRGs and their performance related to cost rather than length of stay.
  - 1997: RAND finds:
    - FRGs remained stable over time.
    - FRGs explained 50% of patient costs and 65% of facility costs.
    - FRGs could be used as a case mix methodology to establish an IRF PPS.
  - 1997: Prospective Payment Assessment Commission (ProPAC) reports to Congress:
    - Implement IRF-PPS as soon as possible.
    - FIM-FRGs could be an appropriate basis for the IRF PPS.
  - 1997: CMS published the criteria for the IRF PPS.
- As a result, the Secretary of Health and Human Services:
  - Established Case Mix Groups (CMGs) and the method to classify patients within these groups.
  - Required IRFs to submit data to establish and administer the IRF PPS.
  - Provided a computerized data system to group patients for payment.
  - Provided software for data transmission.
  - Recommended that the Medicare hospital claim form contain appropriate CMG codes to support an IRF PPS.
- 2001: CMS established a patient assessment instrument following a comparison study of two proposed instruments.
- 2001: Final Rule for the IRF PPS was published.
- In order to be excluded from the IPPS and paid instead under the IRF PPS, an IRF is required to meet all applicable requirements in 42 Code of Federal Regulations 412.25 and 412.29.
- In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Social Security Act (the Act), the IRF claim must meet the requirements in 42 Code of Federal Regulations 412.622(a)(3), (4), and (5).
- 2012: Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for Inpatient Rehabilitation Facilities (IRFs). Please see below link to text of Section 3004 of the ACA.

- Section 3004 of the ACA requires the Secretary to publish, by no later than October 1, 2012, the selected quality measures that must be reported by IRFs. The ACA requires that CMS use nationally endorsed quality measures, but also allows CMS to specify measures that are not already endorsed if a feasible and practical measure in the area determined appropriate by the Secretary has not been endorsed.