CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2673	**Date: March 14, 2013**
	Change Request 8127

Transmittal 2368 , dated January 18,2013 being rescinded and replaced with Transmittal 2673, Dated March 14, 2013 to correct the formatting of the affected Sections, and include the deletion of sections 140.2.4.1 through 140.2.4.5.1 as the information was reorganized to new sections, along with minor document formatting edits. All other information remains the same.

SUBJECT: Manual Updates to Clarify IRF Claims Processing

I. SUMMARY OF CHANGES: The purpose of this CR is to update Pub. 100-04, Medicare Claims Processing Manual, chapter 3, to clarify key components of Inpatient Rehab Facility (IRF) payment policies. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

EFFECTIVE DATE: April 22, 2013
IMPLEMENTATION DATE: April 22, 2013

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/140/Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
R	3/140.1/ Medicare IRF Classification Requirements
R	3/140.1.1/Criteria That Must Be Met By Inpatient Rehabilitation Facilities
R	3/140.1.2/Additional Criteria That Must Be Met By Inpatient Rehabilitation Units
R	3/140.1.3/Verification Process Used to Determine if the Inpatient Rehabilitation Facility Met the Classification Criteria
R	3/140.1.4/New IRFs
R	3/140.1.5/Changes in the Status of an IRF Unit
R	3/140.1.6/New IRF Beds
R	3/140.1.7/Change of Ownership or Leasing
R	3/140.1.8/ Mergers
N	3/140.1.9/Retroactive Adjustments For Provisionally Excluded IRFs or IRF Beds
R	3/140.2/Payment Provisions Under IRF PPS

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/140.2.1/Phase-In Implementation
R	3/140.2.2/Payment Adjustment Factors and Rates
R	3/140.2.3/Case-Mix Groups
R	3/140.2.4/Case-Level Adjustments
D	3/140.2.4.1/Area Wage Adjustments
D	3/140.2.4.2/Rural Adjustment
D	3/140.2.4.3/Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)
D	3/140.2.4.4/Outliers
D	3/140.2.4.5/Teaching Status Adjustment
D	3/140.2.4.5.1/FTE Resident Cap
R	3/140.2.5/Facility-Level Adjustments
N	3/140.2.5.1/Area Wage Adjustments
N	3/140.2.5.2/Rural Adjustment
N	3/140.2.5.3/Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)
N	3/140.2.5.4/Teaching Status Adjustment
N	3/140.2.5.4.1/FTE Resident Cap
N	3/140.2.5.5/Outliers

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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	Transmittal: 2638	Date: January 18, 2013	Change Request: 8127

Transmittal 2368 , dated January 18,2013 is hereby rescinded and replaced with Transmittal 2673, Dated March 14, 2013 to correct the formatting of the affected Sections, and include the deletion of sections 140.2.4.1 through 140.2.4.5.1 as the information was reorganized to new sections, along with minor document formatting edits. All other information remains the same.

SUBJECT: Manual Updates to Clarify IRF Claims Processing

EFFECTIVE DATE: April 22, 2013
IMPLEMENTATION DATE: April 22, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update Pub. 100-04, Medicare Claims Processing Manual, chapter 3, to clarify key components of Inpatient Rehab Facility (IRF) payment policies. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

B. Policy: This change request (CR) manualizes a number of policy clarifications pertaining to the inpatient rehab facility (IRF) payment policies.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8127.1	Contractors shall review and be aware of the manual revisions as they concern IRF payment policies.	X	X		X	X						IRF, Hospital

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8127.2	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 sites 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 the contractor's 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		X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Anthony Hodge, 410-786-6645 or Anthony.Hodge@cms.hhs.gov , Bill Ullman, 410-786-5667 or william.ullman@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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

Table of Contents
(Rev. 2673, 03-14-13)

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Social Security Act (the Act) authorizes the implementation of a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and *inpatient* rehabilitation units *of a hospital* now jointly referred to as inpatient rehabilitation facilities (IRFs).

The IRF PPS is effective for cost reporting periods beginning on or after January 1, 2002. IRF PPS payment rates include all costs of furnishing covered IRF services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR *§§413.75 and* 413.85, bad debts, and other costs not covered under the PPS.

Effective for cost reporting periods beginning on or after October 1, 2004, the Medicare Modernization Act of 2003, Public Law 108-173, section 405(g) established that CAHs may open rehabilitation distinct part units. These IRFs will also be paid under the IRF PPS.

140.1 - Medicare IRF Classification Requirements

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system (PPS) under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Section 1886(d)(1)(B)(ii) of the Act gives the Secretary the discretion to define an IRF. The regulations at 42 CFR *§§* 412.25 and 412.29 specify the criteria for a provider *to be excluded from the inpatient prospective payment system (IPPS) specified in 42 CFR §412.1(a)(1) and instead be paid under the IRF PPS.*

A facility paid under the IRF PPS is always subject to verification that it continues to meet the criteria for exclusion from the IPPS. The fiscal intermediary (FI) or the Part A/B Medicare Administrative Contractor (MAC) provides the Regional Office (RO) with data for determining the classification status of each facility and the RO reviews the IRF's classification status each year. A determination that a facility either is or is not classified as an IRF takes effect only at the start of a facility's cost reporting period and applies to that entire cost reporting period. If a facility fails to meet the criteria necessary to be paid under the IRF PPS, but meets the criteria to be paid under the IPPS, it may be paid under the IPPS.

If a patient is admitted to a facility that is being paid under the IRF PPS, but is discharged from the facility when it is no longer being paid under the IRF PPS, then payment to the facility will be made from the applicable payment system that is in effect for the facility at the time the patient is discharged.

IRFs that are being paid under the IRF PPS need not reapply to be classified for payment under the IRF PPS each year. However, under CMS's new attestation

process, an IRF must self-attest to meeting all of the criteria, except for the criteria specified below in §140.1.1B-D, for being excluded from the IPPS and paid under the IRF PPS every 3 years. The FIs/MACs are responsible for verifying annually that each IRF meets the criteria specified below in §140.1.1B-D. IRFs are notified in writing by the ROs of the required self-attestation procedures and the time-frames for submitting the required self-attestation forms. The ROs will also notify the IRFs in writing of any other procedures and requirements that apply to them. However, the FIs and MACs are not responsible for monitoring or enforcing the IRF self-attestation procedures, which are the responsibility of the State agencies.

All IRFs must notify their FIs/MACs and ROs in writing before making any changes to their operations (i.e. increasing their bed size or square footage, moving to a new location, changing ownership, merging, or other similar changes to the ownership or operations of the facility).

140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation *Facilities*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

An inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) is excluded from the IPPS and is eligible for payment under the IRF PPS if it meets all of the criteria listed below. Note that in order for an individual IRF claim to receive Medicare payment under the IRF PPS, it must meet all of the IRF coverage requirements in 42 CFR 412.622(a)(3), (4), and (5), as further clarified in Chapter 1, Section 110 of the Medicare Benefit Policy Manual (Pub. 100-02).

A. The IRF must have (or be part of a hospital that has) a provider agreement under 42 CFR Part 489 to participate in Medicare as a hospital.

B. During *the* most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI*/MAC*) the *IRF must have* treated an inpatient population that met or exceeded the following percentages:

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

C. List of Medical Conditions:

1. Stroke.

2. Spinal cord injury.

3. Congenital deformity.

4. Amputation.

5. Major multiple trauma.

6. Fracture of femur (hip fracture).

7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

9. Burns.

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course *(as defined below)* of outpatient therapy services or services in other less intensive rehabilitation settings, but have the potential to improve with more intensive rehabilitation.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course *(as defined below)* of outpatient therapy services or services in other less intensive rehabilitation settings, but *would* have the potential to improve with more intensive rehabilitation.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major 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 that have not improved after the patient has participated in an appropriate, aggressive, and sustained course *(as defined below)* of outpatient therapy services or services in other less intensive rehabilitation settings, but *would* have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

13. Knee or hip joint replacement, or both, during a hospitalization immediately preceding the *IRF* stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

Definition of "an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings"

For the medical conditions specified above in subsections 10, 11, and 12, an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI/MAC's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI/MAC has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI/MAC considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI/MAC with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. The outpatient therapy services (or services in other less intensive settings) must immediately precede the IRF admission or result from a systemic disease activation immediately before admission.

The FI*/MAC* has the discretion to review documentation to assure that *the patient* has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or *from the therapy services provided* in another less intensive setting and *include these* in the patient's *medical record at the IRF* (in a section for prior records). CMS believes that these prior records will be used by therapists and others caring for the patient in the IRF, *and* will also be available to *the* FI*/MAC* staff who review the medical records for compliance with the requirements specified above in §140.1.1B-*D*.

D. Comorbidities.—A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis. A patient with a comorbidity may be counted as part of the inpatient population that counts towards the required applicable percentage specified above in §140.1.1B-D if:

1. The patient is admitted for inpatient rehabilitation for a medical condition that is not one of the conditions specified above in sub-section 140.1.1C.

2. The patient has a comorbidity that falls in one of the medical conditions specified above in sub-section 140.1.1C; and

3. The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IRF PPS.

E. For the first cost reporting period during which a facility first begins being paid under the IRF PPS as a "new" IRF, a facility seeking to be paid under the IRF PPS must provide a written certification to the FI/MAC that the inpatient population it intends to serve meets the requirements specified above in §140.1.1B-D. However, if CMS discovers that the facility did not actually meet the requirements specified above in §140.1.1B-D during any cost reporting period for which the facility provided such written certification of its intent to meet the requirements in §140.1.1B-D, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.9.

F. The *IRF* has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program. *This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.*

G. The IRF has in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

H. The IRF furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

I. The IRF has one physician who serves as director of rehabilitation and who—

(1) Provides services to the IRF hospital or its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

If an IRF serves both inpatients and outpatients, the time spent by the director in performing administrative duties for the entire facility counts toward the direction

requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

J. The IRF has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

K. The IRF uses a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans. The IRF must also ensure that team conferences are held at least once per week to determine the appropriateness of treatment.

140.1.2 - *Additional Criteria That Must Be Met By Inpatient Rehabilitation Units*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

In addition to the requirements specified above in §140.1.1, an inpatient rehabilitation unit must meet the additional criteria in paragraphs A through M below in order to be excluded from the IPPS and be paid instead under the IRF PPS.

A. The inpatient rehabilitation unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the IPPS.

B. The inpatient rehabilitation unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. The inpatient rehabilitation unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. The record must indicate the dates of the admission and discharge for patients of the unit. The IRF must also have a process in place to ensure that each patient's medical record at the IRF meets the hospital conditions of participation in 42 CFR Part 482 and all of the documentation requirements specified in 42 CFR §412.622 (a)(3), (4), and (5). Further guidance on the IRF documentation requirements is available in chapter 1, section 110 of the Medicare Benefit Policy Manual (Pub. 100-02). The inpatient rehabilitation unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the inpatient rehabilitation unit, as described further in chapter 1, section 110.1.1 of the Medicare Benefit Policy Manual (Pub. 100-02).

D. If state law provides special licensing requirements for rehabilitation units, the inpatient rehabilitation unit must be licensed in accordance with the applicable requirements.

E. The hospital's utilization review plan must include separate standards for the type of care offered by the inpatient rehabilitation unit.

F. The beds assigned to the inpatient rehabilitation unit must be physically separate from (i.e., not co-mingled with) beds not included in the unit. This means that patients from other parts of the hospital may not be treated in the beds assigned to the inpatient rehabilitation unit.

G. The hospital must have enough beds not excluded from the IPPS to permit the provision of adequate cost information. The FI/MAC has discretion as to how to apply generally accepted accounting principles when making this analysis.

H. The inpatient rehabilitation unit and the hospital in which it is located must be serviced by the same FI/MAC.

I. The inpatient rehabilitation unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. The accounting system of the hospital in which the inpatient rehabilitation unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

Compliance with the criteria in items H, I, and J above may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the FI/MAC, that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion from the IPPS, if approved, applies.

K. The cost report for the hospital must include the costs of the inpatient rehabilitation unit, covering the same fiscal period as the hospital, and use the same method of cost apportionment as the hospital.

L. As of the first day of the first cost reporting period for which all other exclusion requirements are met, the inpatient rehabilitation unit must be fully equipped, staffed, and must be capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the IPPS.

The criteria specified in paragraphs A through M above are used to determine whether a part of a hospital qualifies for exclusion from the IPPS. An excluded unit must be established as a separate cost entity for cost reporting purposes.

If a hospital wishes to have a unit excluded from the IPPS for a cost reporting period, it must notify its FI/MAC, no later than 5 months prior to the start of that cost reporting period, of the following: (1) the particular areas that it has designated as the unit, and (2) the square footage and number of beds in the unit. The FI/MAC or RO will inform the IRF of the proper procedures. The hospital's notification of its intent to have a unit excluded from the IPPS must be sent to the FI/MAC at the same time that it is sent to the RO, and it must identify the designated space for the excluded unit through the use of room numbers and/or bed numbers. The RO will then determine, based on information obtained from the State Survey Agency and the

hospital's FI/MAC, whether the unit qualifies for exclusion from the IPPS. If the RO rejects the hospital's request to have the unit excluded from the IPPS, it will notify the FI/MAC, CMS, and the hospital prior to the start of the hospital's next cost reporting period. If the RO approves the hospital's request to have the unit excluded from the IPPS, it will notify the hospital prior to the start of the hospital's next cost reporting period, and will also notify the FI/MAC of the unit's exclusion from the IPPS and of the unit's new provider identification number.

The hospital must self-attest that it meets all of the applicable criteria for having a unit that is excluded from the IPPS. This self-attestation is subject to verification by the RO, the State Agency, and the FI/MAC.

After the initial classification as an IRF, changes in the amount of space occupied by the unit, or in the number of beds in the unit, are allowed to be made one time during a cost reporting period if the hospital notifies its Medicare contractor and the RO in writing of the planned change at least 30 days before the date of the change. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the remainder of that cost reporting period.

140.1.3 - *Verification Process Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

A. Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period. In general, the RO and FI/MAC will use data from the most recent, consecutive, and appropriate 12-month time period (as defined by CMS) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and FI/MAC will notify the facility of the time period that will be used. The RO and FI/MAC will begin reviewing data 4 months prior to the start of the facility's next cost reporting period.

The compliance review periods are determined based on the following:

1. Guidelines for Determining Compliance Review Periods For IRFs With Cost Reporting Periods That Start Between July 1, 2004 and October 31, 2004.

Data prior to July 1, 2004 will not be used to determine an IRF's compliance with the requirements in §140.1.1B-D. Thus, for IRFs with cost reporting periods beginning on or after July 1, 2004 and before November 1, 2004, less than 12 months of data will be used in their first compliance review period after July 1, 2004. Refer to the first 5 rows of the Table of Compliance Review Periods (below) for an illustration of this.

2. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Differs Across Two Cost Reporting Periods

When a cost reporting period starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods, the compliance percentage is calculated using either of the following two methods. The IRF must have a patient population in each of the two portions of time in order to use either of the two methods described below.

(A) The IRF must meet the applicable compliance percentage threshold in each of the two portions of the compliance review period separately, as illustrated in the example below.

The following is an example of how this first method would be applied:

The compliance review period for an IRF that has a cost reporting period from July 1, 2005 through June 30, 2006 is March 1, 2005 to February 28, 2006.

The IRF must meet a compliance threshold of 50 percent for the cost reporting period of July 1, 2004 to June 30, 2005.

The IRF must meet a compliance threshold of 60 percent for the cost reporting period of July 1, 2005 to June 30, 2006.

In this example, the first portion of the compliance review period (from March 1, 2005 to June 30, 2005) is part of the IRF's cost reporting period that started on July 1, 2004 and ends on June 30, 2005. The second portion of the compliance review period (from July 1, 2005 to February 28, 2006) is part of the IRF's cost reporting period that starts on July 1, 2005 and ends on June 30, 2006.

Therefore,

For the portion of the compliance review period from March 1, 2005 to June 30, 2005, the compliance percentage threshold that the IRF must meet is 50 percent.

For the portion of the compliance review period from July 1, 2005 to February 28, 2006, the compliance percentage threshold that the IRF must meet is 60 percent.

If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005 to June 30, 2005 portion of the compliance review time period, or the compliance percentage threshold of 60 percent for the July 1, 2005 to February 28, 2006 portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005 to February 28, 2006.

(B) The FI/MAC computes one weighted average compliance percentage for the entire 12-month compliance review period. The resulting weighted

average compliance percentage will be used to determine if the facility met the compliance threshold requirements in §140.1.1B-D.

The following is an example of how this second method would be applied:

The compliance review period for an IRF that has a cost reporting period from August 1, 2005 to July 31, 2006 is April 1, 2005 to March 31, 2006. However, the compliance review period is divided into two portions: April 1, 2005 to July 31, 2005 and August 1, 2005 to March 31, 2006.

In the following hypothetical example, 45 percent of the cases met at least one of the medical conditions listed above in §140.1.1C from April 1, 2005 to July 31, 2005, and 80 percent of the cases met at least one of the medical conditions listed in §140.1.1C from August 1, 2005 to March 31, 2006. The weighted average compliance percentage from the two portions of time must be calculated as follows for compliance review periods beginning on or after January 1, 2013.

4/12 = 0.333 which is rounded to 0.33
8/12 = 0.666 which is rounded to 0.67

0.33 X 45% = 0.1485
0.67 X 80% = 0.5360

0.1485 + 0.5360 = 0.6845 which is rounded to 68%

Based on this result of 68 percent from the weighted average calculation, it will be determined that the IRF met the compliance percentage threshold for the compliance review period starting on April 1, 2005.

3. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Is the Same for the Entire Compliance Review Period

To minimize the level of effort required by Medicare contractors and IRFs, contractors must review one continuous 12-month period if the compliance percentage threshold is the same throughout the entire compliance review period for all compliance review periods beginning on or after January 1, 2013.

4. Guidelines for Determining the Compliance Review Period of a Facility Classified as a New IRF. According to the regulations in §412.25(c), a new IRF can only begin being paid under the IRF PPS at the start of a cost reporting period. If the IRF begins treating patients prior to the start of a cost reporting period, it may receive payment under the IPPS until the start of the next cost reporting period, at which point it can begin receiving payment under the IRF PPS if it meets all of the applicable requirements in §412.25 and §412.29. A new IRF will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2012 and is a new IRF, its compliance review period would start on

July 1, 2012 and end on February 28, 2013. Thus, a facility classified as a new IRF will have an initial compliance review period that is 8 months in length, in order to allow the RO and FI/MAC a 4-month time period to make and administer a compliance determination.

5. Guidelines for Determining an IRF's Compliance When the IRF Expands its Bed Capacity. Effective October 1, 2011, as long as an IRF meets all of the applicable requirements in §412.25(b) and 412.29(c)(2), it may add new beds one time, at any time, during a cost reporting period. The IRF must provide written certification that the inpatient population it intends to serve (including the patients served in the new beds) meets the requirements in §412.29(b). In addition, the new IRF beds will be included in the compliance review calculations under §412.29(b) from the time that they are added to the IRF.

6. Guidelines for Determining the Compliance Review Period of a Facility That Changes Its Cost Reporting Period. A facility that changes its cost reporting period will have a new compliance review period that is based on its new cost reporting period. For example, if an IRF changes the start of its cost reporting period from July 1, 2011 to October 1, 2011, then the start date of its compliance review period will also change from March 1, 2011 to June 1, 2011. Excessive changes to cost reporting periods are not permitted.

The table below entitled "Table of Compliance Review Periods" provides examples of compliance review periods associated with various cost reporting periods.

Examples of Compliance Review Periods. For a facility that has been classified as an IRF, but is not a "new" IRF as defined below in §140.1.4, the following table provides examples of the compliance review periods associated with different cost reporting periods.

Examples of Compliance Review Periods

Start Date of the Cost Reporting Period for Which a Facility Will (or Will Not) be Classified (or Retain Classification) as an IRF	***Compliance Review Period: (Admissions or Discharges During)***	***# of Months in Review Period***	***Compliance Percentage Threshold***
07/01/2005	*07/01/2004 - 02/28/2005*	*8*	*50%*
08/01/2005	*07/01/2004 - 03/31/2005*	*9*	*50%*
09/01/2005	*07/01/2004 - 04/30/2005*	*10*	*50%*
10/01/2005	*07/01/2004 - 05/31/2005*	*11*	*50%*

11/01/2005	*07/01/2004 - 06/30/2005*	*12*	*50%*
07/01/2006	*03/01/2005 - 02/28/2006*	*12*	*03/01/2005 to 06/30/2005: 50 %* *07/01/2005 to 02/28/2006: 60 %*
08/01/2006	*04/01/2005- 03/31/2006*	*12*	*04/01/2005 to 07/31/2005: 50 %* *08/01/2005 to 03/31/2006: 60 %*
09/01/2006	*05/01/2005- 04/30/2006*	*12*	*05/01/2005 to 08/31/2005: 50 %* *09/01/2005 to 04/30/2006: 60 %*
10/01/2006	*06/01/2005- 05/31/2006*	*12*	*06/01/2005 to 09/30/2005: 50 %* *10/01/2005 to 05/31/2006: 60 %*
11/01/2006	*07/01/2005- 06/30/2006*	*12*	*07/01/2005 to 10/31/2005: 50 %* *11/01/2005 to 06/30/2006: 60 %*
12/01/2006	*08/01/2005- 07/31/2006*	*12*	*08/01/2005 to 11/30/2005: 50%* *12/01/2005 to 07/31/2006: 60%*

For cost reporting periods beginning on or after July 1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs, as described in section 140.3.4 above), the compliance review period will be one continuous 12-month time period beginning 4 months before the start of a cost reporting period and ending 4 months before the beginning of the next cost reporting period.

B. Types of Data Used to Determine Compliance with the Classification Criteria

1. Starting on July 1, 2004, the FI/MAC will use the verification procedures specified below in subsection C which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records" or subsection D which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population" to verify that an IRF has complied with the requirements specified above in §140.1.1B-D.

2. The verification procedure specified below in subsection C (that is, verification using the IRF-PAI data) will only be used if the FI/MAC has verified that the IRF's Medicare Part A fee-for-service inpatient population is at least 50 percent of the IRF's total inpatient population. Effective for compliance review periods beginning on or after October 1, 2009, FI/MACs must include the IRF's Medicare Part C (Medicare Advantage) inpatient population, along with the IRF's Medicare Part A fee-for-service inpatient population, in determining whether at least 50 percent of the IRF's total inpatient population is made up of Medicare patients.

3. General Guideline Regarding Submission of a List of the Inpatients in Each IRF: In order to verify that an IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient populations (combined) reflect the IRF's total inpatient population, the FI/MAC in writing will instruct the IRF to send the FI/MAC, by a specific date, a list showing the hospital patient number of each inpatient IRF admission during the IRF's 12-month compliance review period. Note that the term "hospital patient number" used throughout this section

refers to a unique patient identifier used internally within the hospital for patient identification and record-keeping purposes. For each inpatient on the list, the IRF must include the payer the IRF can bill, or has billed, for treatment and services furnished to the inpatient. If an inpatient on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient on the list, the IRF must include the IRF admission and discharge dates.

Exception to the General Guideline: The Secretary of Health and Human Services can declare a Public Health Emergency under section 319 of the Public Health Service Act or another appropriate statute, and the President can declare either a National Emergency under the National Emergencies Act or a Major Disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, or other appropriate law. In accordance with such declarations, certain regulations or operational policies may be waived in specific geographic areas for limited and defined periods of time. If applicable, in accordance with the waiver provisions, the IRF may be permitted to admit patients (referred to in this section as national emergency or disaster inpatients) who otherwise would be admitted to another inpatient setting. The national emergency or disaster inpatients will not be included as part of the IRF's total inpatient population when the IRF's compliance with the requirements specified in §140.1.1B-D is determined by the FI/MAC reading a sample of medical records. Therefore, when the IRF submits the list of hospital patient numbers stipulated above in section 140.1.3B3, the IRF will identify each national emergency or disaster inpatient by placing either the capital letter "E" or "D" after the patient's unique internal hospital identification number. The FI/MAC will verify the information and, if appropriate, exclude these patients from the list of inpatients used to select a sample of medical records. The IRF should appropriately document in the medical record sufficient information to identify an inpatient as a national emergency or disaster inpatient.

4. The FI/MAC will use the list of hospital patient numbers to determine the IRF's total inpatient population during the IRF's compliance review period. The FI/MAC will then determine whether the compliance percentage threshold differs or is the same throughout the IRF's compliance review period.

If the compliance percentage threshold differs during the compliance review period (i.e., if it is 50 percent for one portion of the period and 60 percent for the other portion), then the FI/MAC must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service patients for both time periods. For example, the FI/MAC will consider the portion of the period in which the compliance percentage threshold is 50 percent and the portion of the period in which the compliance percentage threshold is 60 percent independently and determine if the IRF's total inpatient population consists of at least 50 percent Medicare Part A fee-for-service patients in each of the two time periods.

If, however, the compliance percentage threshold is the same throughout the IRF's compliance review period (i.e., 60 percent throughout the period), then the FI/MAC must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service or Medicare Part C

(Medicare Advantage) patients (beginning on or after October 1, 2009) for the entire 12-month period.

In addition to the above processes, the FI/MAC has the discretion to sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) population (beginning on or after October 1, 2009) is representative of the IRF's total inpatient population.

A determination by the FI/MAC, in accordance with the preceding methodologies, that the IRF's inpatient population for the compliance review period consisted of at least 50 percent Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients (beginning on or after October 1, 2009) means that the FI/MAC can use the procedure stipulated below in subsection C to presumptively determine if the IRF met the compliance threshold as specified above in §140.1.1B-D.

5. The FI/MAC will inform the RO if an IRF fails to send the list showing the hospital patient number associated with each inpatient IRF admission during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. Further, the FI/MAC will inform the RO if the list of hospital patient numbers does not show the payer or payers or the admission and discharge dates for each hospital patient number on the list. The RO will notify the IRF that failure to send the FI/MAC the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D and the facility will no longer be eligible for payment under the IRF PPS.

C. Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records (The Presumptive Methodology)

1. To determine if a facility has presumptively complied with the criteria specified above in §140.1.1B-D, the CMS will enable the FI/MAC to access the CMS' IRF-PAI data records. Specifically, each FI/MAC will be allowed to access only the IRF-PAI information submitted by IRFs that submit claims to that FI/MAC. In order to ensure that the software that matches each IRF to a particular FI/MAC is constantly updated, the FI/MAC must electronically send the RO a table that has at least the following title and column headings:

FI/MAC List Of IRF Provider Numbers (Specify The FI/MAC's Name)

The Name of Each IRF That Submits Claims To This FI/MAC	*IRF Provider Number*	*IRF Cost Reporting Period*

After checking the FI/MAC's list of IRFs for completeness and, as necessary, communicating with the FI/MAC to ensure the accuracy of the information, the RO will forward the FI/MAC's list of IRFs to the CMS contractor that maintains the IRF-PAI database. The CMS contractor that maintains the IRF-PAI database will then, if necessary, update the IRF-PAI database software used to presumptively verify compliance with the requirements specified in §140.1.1B-D. The FI/MAC must coordinate with their CMS RO to obtain access to the software system. The FI/MAC will provide the RO with user information from all FI/MAC staff that are required to access the IRF-PAI data records.

2. When the FI/MAC accesses the IRF-PAI data records, the FI/MAC will be able to generate an IRF compliance review report using the IRF-PAI information from the IRFs on the FI/MAC's list. The software that the FI/MAC uses to generate the IRF compliance review report will automatically use the specific ICD-9-CM and impairment group codes that are listed in Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html, to determine if a particular IRF is presumptively in compliance with the requirements specified in §140.1.1B-D. Prior to generating the IRF compliance review report, the FI/MAC must allow the IRF to decide whether the IRF compliance review report will be generated using the IRF-PAI data records of patients who were admitted during the IRF's compliance review period (even if they were discharged outside of the compliance review period), or the IRF-PAI data records of patients who were discharged during the IRF's compliance review period (even if they were admitted outside of the compliance review period).

Below are the sections of the IRF compliance review report with example data:

IRF Compliance Review Report

State	*Provider Number*	*Provider Name*	*Cost Report Start Date*	*Compliance Review Period*
Any State	*IRF Number*	*Best Rehab*	*08/01/2008*	*04/01/2007 To 03/31/2008*

Submitted Assessments	*Eligible Assessments*	*Percent*
100	*60*	*60%*

The submitted assessments section identifies all of the IRF-PAI data records that the IRF submitted to the IRF-PAI database during the compliance review period.

The eligible assessments are the assessments submitted during the compliance review period that match one of the codes in Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html. The cost report start date shown is the start of the facility's next cost reporting period.

3. If an IRF's inpatient Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined) (beginning on or after October 1, 2009) are at least 50 percent of its total inpatient population and the presumptive methodology (described above) indicates that the IRF met or exceeded the requirements specified in §140.1.1B-D, then the IRF is presumed to have met the requirements specified above in §140.1.1B-D. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B-D, the RO and FI/MAC still have the discretion to instruct the IRF to send to the RO or FI/MAC specific sections of the medical records of a random sample of inpatients, or specific sections of the medical records of inpatients identified by other means by the CMS or the FI/MAC.

4. Each FI/MAC must submit a report to the appropriate CMS RO (with a copy to the CMS Central Office) on at least a quarterly basis that shows each IRF's status with respect to compliance with the requirements specified above in §140.1.1B-D.

5. Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html, will be used to determine presumptive compliance with the requirements specified above in §140.1.1B-D.

D. Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility's Total Inpatient Population (Medical Review Methodology)

1. The FI/MAC must use the IRF's total inpatient population to verify that the IRF has met the requirements specified above in §140.1.1B-D if:

(i) the IRF's Medicare population (including Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients, effective October 1, 2009) is not at least 50 percent of its total inpatient population; or

(ii) the FI/MAC is unable to generate a valid IRF compliance review report using the IRF-PAI database methodology specified previously; or

(iii) the FI/MAC generates an IRF compliance review report, based on the use of the presumptive methodology, which demonstrates that the IRF has not met the requirements specified above in §140.1.1B-D.

If the IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) comprise less than 50 percent of the IRF's total inpatient population, or the FI/MAC otherwise

determines that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) are not representative of the overall IRF inpatient population, or the FI/MAC is unable to generate a valid report using the presumptive methodology, the presumptive determination is that the IRF did not meet the requirements specified above in §140.1.1B-D.

2. As previously stated above, the FI/MAC will instruct the IRF to send the FI/MAC a list showing the hospital patient number of each inpatient that the IRF admitted during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. The list of hospital patient numbers must include the payer(s) and admission and discharge dates that correspond with the inpatients whose hospital patient numbers are shown on the list. The FI/MAC will then use generally accepted statistical sampling techniques to obtain a random sample of inpatients from the list. The random sample of inpatients drawn from the list must be sufficiently large to ensure that the FI/MAC can determine, with at least 95 percent confidence, whether the IRF's compliance percentage is below the required compliance threshold (i.e., not in compliance) or at or above the required compliance threshold (i.e., in compliance).

For example, suppose that the required compliance threshold for an IRF to be in compliance with the requirements specified above in §140.1.1B-D is 60 percent. The FI/MAC reviews a random sample of claims from IRF A and estimates that IRF A's compliance percentage is 58 percent. Suppose that the standard deviation that the FI/MAC calculates for IRF A's random sample of IRF claims is plus or minus 4 percentage points, so that the 95 percent confidence interval in this particular example is between 54 percent and 62 percent (with 58 percent as the midpoint). In this case, the IRF is considered to be in compliance with the 60 percent rule, since 60 percent is within the 95 percent confidence interval. To verify whether the IRF is in fact in compliance with the requirements specified above in §140.1.1B-D, the FI/MAC may need to draw a larger random sample of the IRF's inpatients. For example, a larger random sample of IRF A's inpatients might have reduced the standard deviation to plus or minus 1 percentage point, which would have led the 95 percent confidence interval to be between 57 percent and 59 percent. This would have demonstrated with 95 percent confidence that the IRF was not in compliance with the requirements specified above in §140.1.1B-D (because the entire 95 percent confidence interval was below the required compliance threshold of 60 percent).

If the compliance percentage threshold differs within the compliance review period (i.e., is 50 percent for a portion of the compliance review period and 60 percent for the other portion of the period), then a random sample of inpatients will be drawn from each of the two time periods separately.

The use of generally recognized statistical sampling principles may result in a determination that it would be inappropriate to use a sample to determine the facility's compliance percentage. If a random sample is not appropriate in a particular case, then the FI/MAC will use the IRF's entire inpatient population to determine the IRF's compliance percentage. In addition, if the IRF had 100 or fewer inpatients during the compliance review period, then the FI/MAC must use

the IRF's total inpatient population (consisting of both Medicare and non-Medicare inpatients) to determine the IRF's compliance percentage.

Prior to selecting the random sample of inpatients, the FI/MAC must allow the IRF to decide if the IRF wants the sample to contain either the patients who were admitted during the IRF's compliance review period (even if some of those patients were discharged outside of the compliance review period) or the patients discharged during the IRF's compliance review period (even if some of those patients were admitted outside of the compliance review period).

If the FI/MAC uses a random sample of the IRF's inpatient population (rather than the IRF's total inpatient population) to determine the IRF's compliance percentage, then the FI/MAC must ensure that an adequate sample size is used to determine (with at least a 95 percent statistical level of confidence) whether or not the IRF has met the requirements in §140.1.1B-D. In some cases, this will require the FI/MAC to expand the size of the random sample of inpatients selected from a particular IRF.

The FI/MAC will instruct the IRF to send it copies of specific sections of the medical records for all of the inpatients to be used in the compliance review. The FI/MAC has the discretion to decide which specific sections of the medical records to obtain, provided that the requested medical record sections contain enough information to allow the FI/MAC's reviewers to determine the medical condition(s) for which each inpatient received treatment in the IRF. In addition to submitting the requested sections of the medical records, the IRF has the discretion to send the FI/MAC other clinical information regarding these same inpatients.

3. The FI/MAC will examine the medical record sections and any other information submitted by the IRF to determine if the IRF meets the requirements specified above in §140.1.1B-D. To determine if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the FI may use the ICD-9-CM and impairment group codes specified in Appendix B and Appendix C of the most recent IRF Compliance Rule Specification Files (which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html) for general guidance. However, the FI/MAC is not permitted to use these codes to make a final determination as to whether or not the specific inpatient required intensive rehabilitation services for treatment of one or more of the medical conditions specified in §140.1.1C. The determination of whether a specific inpatient required intensive rehabilitation services for treatment of a condition can only be determined through careful review of that inpatient's unique clinical characteristics and circumstances, as reflected in the inpatient's medical record.

4. In general, when the FI/MAC is using a sample of medical records to determine compliance with the requirements in §140.1.1B-D, the FI/MAC always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the results of the presumptive methodology described previously. In other words, the compliance percentage that is determined using the medical

review methodology described in this section will supersede the compliance percentage that was determined for the same compliance review period using the presumptive methodology. To ensure that the compliance review process is similar for all IRFs, the FI/MAC must have written policies that describe the reasons for using a random sample of medical records to determine an IRF's compliance percentage when the presumptive methodology has shown that the IRF met the compliance threshold.

5. The FI/MAC will inform the RO if an IRF fails to provide information in accordance with the requirements specified above in subsection D2. The RO will notify the IRF that failure to provide the FI/MAC with the information in accordance with the requirements specified above in subsection D2 will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D.

E. By the 15th day of each month, the FI/MAC responsible for determining the compliance percentage for each IRF using either of the methods specified above in §§140.1.3C or 140.1.3D will submit a report to CMS via e-mail. Instructions regarding the format of the report, how to complete the report, and where to send it are specified on the IRF PPS website at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html.

F. The FI/MAC must verify that the requirements specified above in §140.1.1B-E and §140.1.2 G-K were met.

G. The State Agency will determine whether the criteria specified above in §140.1.1F-K and §140.1.2 Q were met.

140.1.4 - *New IRFs*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

A new IRF must provide written certification that the inpatient population it intends to serve will meet the requirements in §140.1.1B-D above. The written certification is effective for the first full 12-month cost reporting period that occurs after the IRF begins being paid under the IRF PPS, and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the IRF begins being paid under the IRF PPS and the start of the IRF's first full 12-month cost reporting period.

As described in section 140.1.9 below, retroactive adjustments may be made for any period during which the hospital has self-attested to meeting the requirements specified in §140.1.1B-D, but is shown not to have actually met these requirements during that period.

140.1.5 - *Changes in the Status of an IRF Unit*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

For purposes of payment under the IRF PPS, the status of an IRF unit may be changed from not excluded from the IPPS to excluded from the IPPS only at the start of a cost reporting period. If an IRF unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of the hospital's next cost reporting period.

The status of an IRF unit may be changed from excluded from the IPPS to not excluded from the IPPS at any time during a cost reporting period, but only if the hospital notifies the FI/MAC and the RO in writing of the change at least 30 days before the date of the change. In addition, the hospital must maintain the information needed to accurately determine which costs are and are not attributable to the IRF unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the remainder of that cost reporting period.

140.1.6 - *New IRF Beds*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any time during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified.

New IRF beds are included in the compliance review calculations for determining compliance with §140.1.1B-D above from the time that they are added to the IRF.

140.1.7 - *Change of Ownership or Leasing*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

If an IRF hospital (or a hospital that has an IRF unit) undergoes a change of ownership or leasing, as defined in 42 CFR §489.18, the IRF hospital (or IRF unit of a hospital) retains its excluded status and will continue to be paid under the IRF PPS before and after the change of ownership or leasing if the new owner(s) of the IRF hospital (or the hospital with an IRF unit) accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be purchased outside of the purchase of its host hospital.

If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to the Medicare program to operate a new IRF, under the requirements for new IRFs in §140.1.4 above.

If, after the change of ownership or leasing, the IRF does not continue to meet all of the requirements for payment under the IRF PPS, then the IRF loses its excluded status and will be paid instead under the IPPS.

140.1.8 - *Mergers*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the IRF PPS before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be merged with another entity outside of the merger with its host hospital.

If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may re-apply to the Medicare program to operate a new IRF under the requirements for new IRFs in §140.1.4 above.

140.1.9 - Retroactive Adjustments for Provisionally Excluded IRFs or IRF Beds

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

For cost reporting periods beginning on or after October 1, 1991, if a new IRF (or new beds that are added to an existing IRF) are paid under the IRF PPS for an initial cost reporting period during which the hospital has self-attested to meeting the requirements specified above in §140.1.1B-D, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period do not meet the requirements specified above in §140.1.1B-D, CMS adjusts payments to the hospital retroactively in accordance with the procedure specified below.

A. If an IRF hospital, IRF unit, or group of new IRF beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the requirements specified above in §140.1.1B-D, but does not actually meet the requirement for that cost reporting period, CMS adjusts Medicare payments to the hospital retroactively in accordance with paragraph C below.

B. In the case of a unit to which new beds have been added, the requirement in §140.1.1B-D above is applied to the entire unit, including both new and existing beds. If the entire unit is able to meet the requirement, the previously existing unit and the

added beds are presumed to meet the requirement separately and no payment adjustment as specified below in paragraph C is made. If the unit as a whole does not meet the requirement specified above in §140.1.1B-D, the hospital must furnish the FI/MAC or the State Agency, as specified by the RO, the information needed to determine whether the requirement specified in §140.1.1B-D above was met by the established portion of the unit (that is, the previously existing unit) and by the newly added beds, considered separately. If the hospital is not able to demonstrate that the established portion of the unit met the requirement, then that portion of the facility will not be classified as an IRF for the following cost reporting period. Retroactive adjustments may apply.

If the added beds are shown to have met the requirement specified above in §140.1.1B-D, then those beds are eligible to be included as part of the unit's classification as an IRF for the following cost reporting period. If the added beds did not meet the requirement, the FI/MAC adjusts its payment to the unit retroactively in accordance with paragraph C below and the added beds will not be included as part of the unit classified as an IRF for the following cost reporting period.

If the hospital does not have the records needed to discriminate between the performance of the previously existing unit and that of the added beds, or for other reasons does not furnish the information requested by the FI/MAC or State Agency, neither the previously existing unit nor the added beds will be classified as an IRF for the following cost reporting period. In that case, the FI/MAC adjusts its payment to the entire unit retroactively in accordance with paragraph C below.

C. The FI/MAC adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the IRF hospital, IRF unit, or new IRF beds during the period of provisional exclusion, and the amount that would have been paid if the IRF hospital, IRF unit, or new IRF beds had not been excluded from the IPPS. The FI/MAC then takes action to recover the resulting overpayment, or corrects the underpayment to the hospital.

140.2 - Payment Provisions Under IRF PPS

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs). The IRF PPS incorporates per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system.

IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre- admission services *that is described in section 40.3 of this chapter (Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-04),* but *instead* are subject to *a* 1-day payment window (24-hour rule) for pre- admission services.

Beneficiary liability operate*s* the same as under the current Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system. Even if Medicare payments

are below *the* cost of care for a patient under *the IRF PPS*, the patient cannot be billed for the difference.

Below are the annual rate update Change Requests (CRs) for the applicable Fiscal Years
(FYs):

FY 2013 – CR 7901
FY 2012 – CR 7510
FY 2011 – CR 7076
FY 2010 – CR 7029 *(legislative adjustment of FY 2010 market basket increase factor)*
FY 2010 – CR 6607
FY 2009 – CR 6166
FY 2008 – CR 5694
FY 2007 – CR 5273
FY 2006 – CR 4037
FY 2005 – CR 3378
FY 2004 – CR 2894
FY 2003 – CR 2250

Change Requests can be accessed through the following CMS Transmittals Web site:
http://www.cms.hhs.gov/Transmittals/01_Overview.asp

140.2.1 - *Phase-In Implementation*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Under the BBA, the Federal fiscal year in which a facility's cost reporting period begins determines which transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during Federal fiscal year 2001. The second transition period percentages are applicable to cost reporting periods beginning during Federal fiscal year 2002, that is, periods beginning on or after October 1, 2001, and before October 1, 2002. For cost reporting periods beginning during Federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted Federal prospective payment.

Since CMS is implementing the IRF PPS for discharges that occur during the IRF's cost reporting period that begins on or after January 1, 2002, IRFs are phased directly into the second transition period, where payment will be based on 66 2/3 percent of the PPS payment and 33 1/3 percent of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to January 1, 2002.

In addition, §305 of the BIPA 2000 states facilities may elect to be paid 100 percent PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their FI no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the Medicare FI for the facility. The FI must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other

means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

140.2.2 - *Payment Adjustment Factors and Rates*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Act sets forth the methodology for establishing the payment rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and other factors the Secretary deems necessary to ensure that payment most accurately reflects cost.

For the initial period of *the IRF* PPS, beginning on or after January 1, 2002, all payment rates and associated rules were published in the "Federal Register" on August 7, 2001. For each succeeding fiscal year, the rates will be published in the "Federal Register" on or before August 1 of the year preceding the affected fiscal year.

140.2.3 - *Case-Mix Groups*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities were used to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. In addition to the first two digits of the CMG indicating the RIC, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age improves the explanatory power of the CMGs if some groups are split based on this variable. Lastly, comorbidites were found to substantially increase the average cost of *a case in* specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

140.2.4 - *Case-Level Adjustments*

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Payment is based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. For case level adjustments, more than one case level adjustment may apply to the same case. For ease of understanding, the case level discussion is presented below in the same order that is used to assess whether or not they apply. For example, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for interrupted stay cases and the payment will be based on the initial assessment. For example, if a Medicare beneficiary is discharged on February 1, 2001, and is readmitted on February 3, the case would be considered an interrupted stay and only one CMG payment will be made based on the initial assessment. However, if the Medicare beneficiary was readmitted on February 4, then it would not be considered an interrupted stay. A separate DRG payment will not be made to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, a DRG payment can be made if the beneficiary does not return to the same IRF on the same day as they were discharged. If a case is determined to be an interrupted stay, other adjustments may apply to this payment amount. For example, the case still may meet the definition of a transfer case described below.

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. *Cases* that expire with a length of stay of 3 days or less, will also be classified to CMG 5001.

Separate CMGs will also be made for cases that expire with a length of stay greater than 3 days. To improve the explanatory power of the groups, four additional CMGs were created to account for cases that expire. CMG 5101 is used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09 and the length of the stay is greater than 3 days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

140.2.5 - *Facility-Level Adjustments*
(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for *facilities* located in rural areas, an adjustment for treating low-income patients and an adjustment for teaching facilities. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can be determined to qualify for these additional payments only after all other facility-level adjustments are computed. Thus, for ease of understanding, the discussion of these facility-level and outlier adjustments are presented in the same order that is used to assess their applicability.

140.2.5.1 - Area Wage Adjustments
(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

To adjust payments for area wage differences, CMS first identifies the labor-related portion of the prospective payment rates which is published annually in the **Federal Register**. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. CMS uses the inpatient acute care hospital wage data to compute the wage indices on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under §§1886(d)(8) or (d)(10) of the Act and without applying the "rural floor" under §4410 of the BBA. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare part B, because these services are not covered under the IRF PPS. For IRF PPS discharges occurring before October 1, 2005, IRFs are divided into labor market areas where urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget.

For IRF PPS discharges occurring on or after October 1, 2005, the IRF PPS adopts new labor market area definitions based upon the new statistical area definitions issued by the Office of Management and Budget (OMB) in OMB Bulletin No. 03-04, June 6, 2003. OMB Bulletin No. 03-04 includes new definitions of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, more commonly referred to as Core-Based Statistical Areas (CBSAs). CBSA-based designations reflect the most recent available geographic classifications and more accurately reflect current labor markets. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs. CMS uses the county-based areas for <u>all</u> MSAs in the Nation, including those in New England. Adopting county-based labor market areas for the entire country creates consistency and stability in the Medicare payment program because all of the labor market areas, including New England, are defined using the same system (that is, counties), rather than different systems in different areas of the country, and minimizes program complexity. CMS uses the Metropolitan Divisions where applicable under the new CBSA-based labor market area definitions to determine urban areas. Micropolitan Areas are treated as rural labor market areas under the IRF PPS. To calculate the statewide rural wage index for each State, CMS combines all of the counties in a State outside of designated urban areas *along with*

all Micropolitan Areas. The wage indices applicable to IRF PPS discharges occurring on or after October 1, 2005 are published annually in the **Federal Register**.

140.2.5.2 - Rural Adjustment

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-*urban* area.

For FY 2006 and FY 2007, a hold harmless policy applies to IRFs that meet the definition of rural in FY 2005 in §412.602 and become urban under the FY 2006 CBSA-based designations. The IRFs that meet the criteria described in the previous sentence will qualify for an adjustment to their payments in FY 2006 and FY 2007 equal to some portion of the 19.14 percent rural adjustment effective in FY 2005. This adjustment is in addition to the one-year blended wage index described above for discharges occurring on or after October 1, 2005 and on or before September 30, 2006.

140.2.5.3 – Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate, a file will be updated annually (usually each October/November).

Patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111), which includes both Condition Code 04 and the CMG code from the IRF PAI, to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for Fiscal Year 2007 and

beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

IRFs that received LIP payments during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

Informational Only Claim Elements:

- Covered 111 TOB
- Condition Code 04
- Medicare Fee-for-Service is the primary payer
- There is no MSP
- Beneficiary's Medicare HICN
- For claims prior to October 1, 2011, report the Revenue Code 0024 line containing CMG A9999 and, instead of inputting the transmission date of the IRF-PAI in the service date field (as is required for FFS claims), input the discharge date as a default for these informational only claims. The discharge date is required on informational only claims to reduce reporting burden for IRFs who may be submitting "old" informational only claims.

NOTE: Effective January 1, 2011, do not report the service date for the revenue code 0024 line. Instead, use occurrence code 50 in place of the service date to report the default discharge date for informational only claims**.**

- Effective October 1, 2011, report the Revenue Code 0024 line containing the CMG from the IRF-PAI and the transmission date of the IRF-PAI in the occurrence code 50 and date field (as is required for FFS claims).

- All other required claim elements

The SSI/Medicare beneficiary data for IRF PPS is available to *FIs and MACs* electronically and 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. FIs will use this information to update their provider specific file. The files are located at the following CMS Web site address:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the FI settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The FI uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference

between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation) is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan

approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, CMS recognizes the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes
Type of Day	Description	Eligible Title XIX Day
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under	No.

140.2.5.4 - Teaching Status Adjustment

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

The teaching status adjustment is a facility level adjustment made to the Federal per discharge base rate to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education. The adjustment is made on a claim basis as an interim payment, with final payment in full for the cost reporting period made through the cost report. Any difference between the interim payments and the actual teaching status adjustment amount computed in the cost report are adjusted through lump sum payments/recoupments when the cost report is filed and later settled. The adjustment is based on the IRF's "teaching variable," which is the ratio of the number of FTE residents training in the IRF (subject to the FTE resident cap described below) to the IRF's average daily census (ADC).

140.2.5.4.1 - FTE Resident Cap

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, not the number of residents teaching institutions can hire or train. The FTE resident cap is identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. The cap is the number of FTE residents that trained in the IRF during a "base year."

An IRF's FTE resident cap is determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. IRFs that first began training residents after November 15, 2004 will initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

For other types of Medicare providers (including long-term care hospitals) that have been training residents and are currently converting to IRFs, the fiscal intermediary will determine an FTE resident cap for purposes of the IRF teaching status adjustment, applicable beginning with the new IRF's payments under the IRF PPS based on the FTE count of residents during the predecessor facility's most recent cost reporting period ending on or before November 15, 2004. If the predecessor facility did not begin training residents until after November 15, 2004, the facility would initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)), may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

Once established, the FTE resident cap for the teaching status adjustment for the new IRF will be subject to the same rules and adjustments as any IRF's FTE resident cap. CMS will monitor this policy closely to ensure that it is not being inappropriately manipulated.

IRFs are not permitted to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. Residents with less than full- time status and residents floating through the rehabilitation hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IRF (for example, a resident on a full-time, 3-month rotation to the IRF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS IME adjustment is allowed to be counted for purposes of the teaching status adjustment for the IRF PPS.

The denominator used to calculate the teaching status adjustment under the IRF PPS is the IRF's average daily census (ADC) from the current cost reporting period. If a rehabilitation hospital or unit has more FTE residents in a given year than in the base

year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If a rehabilitation hospital or unit were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility hires and trains).

Effective for cost reporting periods beginning on or after October 1, 2011, the IRF FTE resident caps may be temporarily adjusted to reflect interns and residents added because of another IRF's closure or the closure of another IRF's residency training program. An IRF is only eligible for the temporary cap adjustment if training the additional interns and residents would cause the IRF to exceed its FTE resident cap. In addition, an IRF that closes a medical residency training program must agree to temporarily reduce its FTE cap before other IRFs can receive temporary adjustments to their caps for training the IRF's interns and residents. IRFs may qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011 if they are already training interns and residents displaced by IRF closures or residency training program closures that occurred prior to October 1, 2011.

140.2.5.5 - Outliers

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. CMS calculates the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, CMS calculates the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the Federal Register.