

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**News Flash** – In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the [“mailing list for referral agents”](#) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: MM8127 **Revised**

Related Change Request (CR) #: CR 8127

Related CR Release Date: January 18, 2013

Effective Date: April 22, 2013

Related CR Transmittal #: R2673CP

Implementation Date: April 22, 2013

**Note:** This article was revised on March 18, 2013, to reflect a revised Change Request (CR) that corrects formatting in the CR. The Transmittal Number, CR release date, and web address of the CR also changed. All other information remains the same.

## Manual Updates to Clarify Inpatient Rehabilitation Facility (IRF) Claims Processing

### Provider Types Affected

This MLN Matters® Article is intended for physicians and providers (including Inpatient Rehabilitation Facilities (IRFs)) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for inpatient rehabilitation services to Medicare beneficiaries.

### Provider Action Needed

Change Request (CR) 8127, from which this article is taken, updates the "Medicare Claims Processing Manual," Chapter 3 (Inpatient Hospital Billing), to clarify key components of Inpatient

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

Rehabilitation Facility (IRF) claims processing. These changes are intended only to clarify the existing policies and there are no system or policy changes.

## Background

---

The changes that CR8127 makes to the manual are clarifications of existing policy. The entire manual revision is attached to CR8127. Key manual changes of interest to IRFs are summarized as follows:

### Medicare IRF Classification Requirements

A facility paid under the IRF Prospective Payment System (PPS) is always subject to verification that it continues to meet the criteria for exclusion from the Inpatient PPS (IPPS). Your FI or MAC provides the Centers for Medicare & Medicaid Services (CMS) 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.

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 in the revised manual Section 140.1.1C. See CR8127 for a list of these criteria.

### Additional Criteria for Inpatient Rehabilitation Units

Inpatient rehabilitation units must also meet additional criteria to be paid under the IRF PPS. These criteria are detailed in Section 140.1.2 of the revised manual, as attached to CR8127.

### Verification Process Used to Determine if IRF Meets Classification Criteria

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), 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. For complete details of the verification process, see the revised Section 140.1.3 of the manual, which is attached to CR8127.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

### New IRFs

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 certification requirements. 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.

### Changes in the Status of an IRF Unit

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.

### New IRF Beds

Any IRF beds that are added to an existing IRF must meet all applicable State Certificates 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.

### Change of Ownership or Leasing

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 (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.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

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.

### **Mergers**

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.

### **Full Time Equivalent (FTE) Resident Cap**

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.

### **Outliers**

The Social Security Act provides the Secretary of Health and Human Services 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 Case-Mix Group (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.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

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

## Additional Information

The official instruction, CR8127 issued to your FI, carrier, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2673CP.pdf> on the CMS website. As mentioned above, you can find the updated "Medicare Claims Processing Manual," Chapter 3 (Inpatient Hospital Billing) as an attachment to this CR.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

**News Flash - Flu Season is Here** - Flu season is here but it is not too late to protect your patients against the flu. The [Centers for Disease Control and Prevention](#) (CDC) recommends that everyone 6 months of age and older get a yearly flu vaccine. As the occurrence of the flu continues to be reported around the country, remember, every office visit is an opportunity to check your patients' vaccination status and encourage a yearly flu vaccine for those that have not yet taken action to protect themselves and their loved ones from the flu. Vaccination is especially important for those at high risk for flu-related complications (please refer to the [People at High Risk](#) web page). Additionally, research shows that a strong provider recommendation for yearly flu vaccination increases a patient's willingness to get vaccinated themselves.

Getting vaccinated is just as important for health care personnel, like you, for many reasons. You can get sick with the flu and spread it to your family, colleagues and patients without knowing or having symptoms. Be an example by getting your flu vaccine and know that you're helping to reduce the spread of flu in your community.

Note: The influenza and pneumococcal vaccines and their administration fees are covered Part B benefits. Influenza and pneumococcal vaccines are NOT Part D-covered drugs.

*For More Information:*

- CMS has posted the 2012-2013 [Seasonal Influenza Vaccines Pricing](#) list. You may also refer to the [MLN Matters® Article MM8047](#), "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."
- Please visit the [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations](#) web pages for more information on coverage and billing of the flu and pneumococcal vaccines and their administration fees.
- While some providers may offer the flu vaccine, those who don't can help their patients locate a vaccine provider within their local community. The [HealthMap Vaccine Finder](#) is a free, online service where users can find nearby locations offering flu vaccines.
- The [CDC](#) website offers a variety of provider resources for the 2012-2013 flu season.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.