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Learn about these Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) topics:

- Background
- IRF PPS elements
- Payment updates
- IRF Quality Reporting Program (QRP)
- Resources

**BACKGROUND**

Social Security Act (SSA) § 1886(j) created an IRF services per-discharge prospective payment system. Medicare pays inpatient rehabilitation hospitals and inpatient rehabilitation units, collectively known as IRFs.

Medicare bases the IRF PPS payments on information in the IRF-Patient Assessment Instrument (IRF-PAI). The IRF-PAI has patient clinical, demographic, and other information, which helps classify patients into payment groups based on clinical characteristics and expected resource needs. Medicare also uses information from the IRF-PAI to monitor the quality of care and apply facility-level adjustments.

**NOTE:** October 1, 2019, Medicare removed the Functional Independence Measure (FIM™) Instrument and associated Function Modifiers from the IRF-PAI.

42 Code of Federal Regulations (CFR) § 412.622(c), requires IRFs to determine whether a physician qualifies as a rehabilitation physician (that is, a licensed physician with specialized training and experience in inpatient rehabilitation).

**IRF PPS ELEMENTS**

The IRF PPS includes:

- Rates
- Classification criteria
- Reasonable and necessary criteria

**Rates**

Under the PPS, IRFs get a pre-determined payment for goods and services furnished during each Medicare patient’s stay in the IRF. Federal rates reflect all patient-care costs in the IRF, including routine, ancillary, and capital costs. The Federal rates exclude costs associated with operating approved educational activities defined in 42 CFR § 413.75 and § 413.85, bad debts, and other costs PPS does not cover. Medicare adjusts Federal rates to reflect:

- Patient case mix (the relative resource intensity typical for each patient’s clinical condition identified by the patient assessment process):
Medicare groups cases into Rehabilitation Impairment Categories, according to the primary IRF admitting condition.

Medicare further groups the cases into case-mix groups (CMGs), according to their functional motor and cognitive scores and age.

- Beginning October 1, 2019, an unweighted motor score determines a patient’s CMG placement. Each of the 18 items making up the score has an equal weight of 1. The Centers for Medicare & Medicaid Services (CMS) removed GG0170A1, roll left to right, from the motor score.

Medicare groups cases into one of four tiers within each CMG according to patient comorbidities (conditions secondary to the principal admitting diagnosis). Each tier adds a higher case-payment amount.

Medicare makes additional adjustments for interrupted stays, short stays less than 3 days, short-stay transfers (transfers to another institutional setting with an IRF length of stay [LOS] less than the average CMG LOS), and high-cost outlier cases.

**Facility Characteristics**

- Medicare uses the hospital wage index to adjust rates to reflect geographic differences in wage rates.
- IRFs get a rate increase based on the proportion of low-income patients they treat.
- IRFs with residency training programs get a rate increase based on the number of interns and residents they train compared to their average daily census. This adjustment is subject to a cap.

The Federal government updates rates annually:

- To reflect inflation in furnishing IRF goods and services using a market basket index calculated for free-standing and hospital-based IRFs
- To reflect changes in local wage rates

**Classification Criteria**

- To get payment under the IRF PPS and exclude it from the Acute Care Hospital Inpatient PPS designation specified in 42 CFR § 412.1(a)(1), an entity must meet the IRF classification requirements in Subpart B of 42 CFR Part 412.
- 42 CFR § 412.29(b) requires that a minimum percentage of a facility’s total inpatient population must need treatment in an IRF for one or more of 13 medical conditions. This is known as the compliance threshold.
- The compliance threshold was 75 percent (the “75 percent rule”) before 2004 when CMS revised the classification criteria.
- Since, 2006, CMS sets the compliance threshold no higher than 60 percent.

CMS also includes comorbidities, if they meet certain criteria in 42 CFR § 412.29(b)(1), in calculating the compliance threshold.
The 13 medical conditions qualifying under the 60 percent compliance threshold are:

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
   - 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 appropriate, aggressive, and sustained outpatient therapy services or services in other less-intensive rehabilitation settings immediately before the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation
11. Systemic vasculitides with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after appropriate, aggressive, and sustained outpatient therapy services or services in other less-intensive rehabilitation settings immediately before the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but 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 appropriate, aggressive, and sustained outpatient therapy services or services in other less-intensive rehabilitation settings immediately before the inpatient rehabilitation admission but 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 an acute hospitalization immediately before the inpatient rehabilitation stay and meeting one or more of the following specific criteria:

- The patient had bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately before the IRF admission
- The patient is extremely obese with a Body Mass Index of at least 50 at the time of IRF admission
- The patient is age 85 or older at the time of IRF admission

**Compliance Percentage**

- An IRF’s compliance percentage is the percentage of the total inpatient population that needs treatment in an IRF for one or more of the previous 13 medical conditions.
- Medicare Administrative Contractors (MACs) use data from a specific period (the compliance-review period) to calculate the compliance percentage.
- Since January 1, 2013, each compliance-review period (except in the case of a new IRF), is one continuous 12-month 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.

MACs compute a percentage using:

- **Presumptive Method**: MACs use CMS software to analyze the IRF PPS impairment group codes and etiologic diagnosis and comorbidity codes. These are International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes on the IRF-PAIs submitted to CMS. If an IRF fails the presumptive methodology, MACs must perform mini reviews of arthritis cases to ensure they meet regulatory requirements for inclusion in the IRF’s presumptive method compliance percentage (beginning October 1, 2015).

- **Review of Medical Records**: Analyzes a random sample of medical records representing IRF inpatients during the compliance-review period.

While your MAC may use the presumptive method to determine if you meet an applicable compliance threshold, it can review a random sample of medical records if it believes this is a more accurate way of calculating your compliance percentage. A compliance percentage calculated by a MAC reviewing a random sample of medical records always replaces a compliance percentage calculated using the presumptive method.

MACs must use the random sample medical record method to calculate the compliance percentage when:

- The facility’s presumptive compliance percentage is less than the applicable compliance threshold
- The facility’s Medicare population is less than half of its total patient population
MACs must submit results to the appropriate CMS Regional Office (RO). The RO determines an IRF’s classification status before the start of the next cost reporting period. This classification status is effective for the entire cost reporting period.

If the RO does not classify a provider as an IRF, the provider is not eligible for payment under the IRF PPS. Medicare may pay the provider under the Acute Care Hospital Inpatient PPS or other applicable payment system if the provider meets requirements.

**Reasonable and Necessary Criteria**

**SSA § 1862(a)(1)** coverage requirements determine whether individual IRF claims meet reasonable and necessary criteria:

- A pre-admission screening, reviewed and approved by a rehabilitation physician before an IRF admission
- A post-admission physician evaluation verifying the patient’s pre-admission screening information is unchanged or documenting any changes

**NOTE:** Beginning October 1, 2018, the post-admission physician evaluation counts as one of the three required face-to-face rehabilitation physician visits in the first week of the IRF stay.

- An individualized patient plan of care
- An interdisciplinary approach to IRF care with interdisciplinary team meetings held at least once per week throughout the IRF stay

**NOTE:** Beginning October 1, 2018, the rehabilitation physician may lead the interdisciplinary team meetings remotely without additional documentation requirements.

- Clarifies IRF admission requirements by specifying a patient must:
  - Need the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy); one of the therapies must be physical therapy or occupational therapy
  - Generally, need an intensive rehabilitation therapy program specifically furnished in IRFs
  - Be reasonably expected to actively participate in and benefit from intensive IRF services
  - Need close medical supervision by a physician for managing medical conditions to support participation in an intensive rehabilitation therapy program
  - Need an intensive, coordinated interdisciplinary care approach

**PAYMENT UPDATES**

Refer to the [FY 2020 IRF PPS Final Rule](#) for more information about payment updates.
IRF QRP

Since fiscal year (FY) 2014, Medicare subjects IRFs that do not report quality data to a 2.0 percentage point reduction to the annual market basket update.

Quality Reporting Measures Required for FY 2020 Annual Update

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Short Stay)
- NQF #0431—Influenza Vaccination Coverage Among Healthcare Personnel
- NQF #1717—NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure
- NQF #0674—Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- NQF #2631—Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
- NQF #2633—IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients
- NQF #2634—IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
- NQF #2635—IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
- NQF #2636—IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
- Medicare Spending Per Beneficiary (MSPB)-Post Acute Care (PAC) IRF QRP
- Discharge to Community-Post Acute Care (PAC) IRF QRP*
- Potentially Preventable 30-Day Post-Discharge Re-Admission Measure for IRF QRP
- Potentially Preventable Within Stay Re-Admission Measure for IRF QRP
- Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care (PAC) IRF QRP
- Transfer of Health Information to the Provider Post-Acute Care**
- Transfer of Health Information to the Patient Post-Acute Care**

*CMS is updating the specifications for the Discharge to Community PAC IRF QRP measure to exclude baseline nursing home residents.

**CMS will adopt the Transfer of Health Information to the Provider PAC and Transfer to the Patient PAC beginning with FY 2022. IRFs report the data using the IRF-PAI and must collect data on both measures for Medicare Part A and Medicare Advantage patients beginning with patients discharged on or after October 1, 2020.
Beginning with FY 2019, IRFs no longer need to submit data on All Cause Unplanned 30-day post IRF Discharge Re-admission Measure.

CMS is finalizing its policy to no longer publish a list of compliant IRFs on the IRF QRP website.

For more information about quality data submission and reporting, refer to the IRF QRP webpage.

**RESOURCES**

Table 1. IRF PPS Resources

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