



INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENT SYSTEM

Target Audience: Medicare Fee-For-Service Providers

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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

Congress enacted Section 4421 of the Balanced Budget Act (BBA) of 1997 and amended [Section 1886\(j\)](#) of the Social Security Act (the Act) to authorize the implementation of a per-discharge prospective payment system for IRF services. Medicare makes IRF payments to inpatient rehabilitation hospitals and inpatient rehabilitation units, collectively known as IRFs.

Medicare bases the IRF PPS payments on information found in the IRF-Patient Assessment Instrument (IRF-PAI). The IRF-PAI contains patient clinical, demographic, and other information, which is used to 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 information about the facilities to apply facility-level adjustments.

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

IRF PPS ELEMENTS

The IRF PPS includes:

- Rates
- Classification criterion
- Reasonable and necessary criteria

Rates

Under the prospective payment system, IRFs receive a pre-determined payment amount as reimbursement for goods and services furnished for each Medicare patient's stay in the IRF. The Act requires Federal rates to reflect all costs of caring for a patient in the IRF, including routine, ancillary, and capital costs. The Federal rates exclude costs associated with operating approved educational activities defined in the Code of Federal Regulations (CFR) under [42 CFR 413.75 and 413.85](#), bad debts, and other costs not covered by PPS. Medicare adjusts Federal rates to reflect:

- Patient case mix (the relative resource intensity typically associated with each patient's clinical condition identified through 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.
 - 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 successively higher payment amount to the case.
 - 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 adjusts rates to reflect geographic differences in wage rates, using the hospital wage index.
- IRFs receive a rate increase based on the proportion of low-income patients they treat.
- IRFs with residency training programs receive a rate increase based on the number of interns and residents they train compared with their average daily census. This adjustment is subject to a cap.

The Federal government updates rates annually:

- To reflect inflation in the cost of goods and services to provide IRF services using a market basket index calculated for free-standing and hospital-based IRFs
- To reflect changes in local wage rates, using the hospital wage index

Classification Criterion

- To receive payment under the IRF PPS and be excluded from the Acute Care Hospital Inpatient PPS designation specified in [42 CFR 412.1\(a\)\(1\)](#), an entity must meet the IRF classification requirements stipulated in [Subpart B of 42 CFR Part 412](#).
- One requirement for the facility to be paid under the IRF PPS, specified at [42 CFR 412.29\(b\)](#), is that a minimum percentage of a facility's total inpatient population must require treatment in an IRF for one or more of 13 medical conditions listed in 42 CFR 412.29(b)(2). This minimum percentage is known as the compliance threshold.
- The compliance threshold was 75 percent before the Centers for Medicare & Medicaid Services (CMS) issued a final rule on May 7, 2004, which revised the classification criteria. The regulatory requirement was commonly referred to as the "75 percent rule."
- Beginning July 1, 2006, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) (Public Law 110-173) required setting the compliance threshold no higher than 60 percent.

The MMSEA also stipulated that CMS must continue to count comorbidities, if they meet certain criteria specified in 42 CFR 412.29(b)(1), in the calculation of the compliance threshold.

The 13 medical conditions that qualify under the current 60-percent MMSEA compliance threshold are as follows:

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 an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding 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 an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding 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 an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less-intensive rehabilitation settings immediately preceding 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 preceding the inpatient rehabilitation stay and meeting one or more of the following specific criteria:
 - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission
 - The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF
 - The patient is age 85 or older at the time of admission to the IRF

Compliance Percentage

- An IRF's compliance percentage is the percentage of the total inpatient population that requires treatment in an IRF for one or more of the 13 medical conditions previously listed.
- Medicare Administrative Contractors (MACs) use data from a specific period (the compliance-review period) to calculate the compliance percentage.
- Beginning on or after 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.

The MAC computes a percentage using:

- **The Presumptive Method:** The MAC uses 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 IRFs submit to CMS.

NOTE: MACs may:

- Beginning on or after October 1, 2015, perform mini-reviews of arthritis cases to ensure they meet regulatory requirements for inclusion in the IRF's presumptive methodology compliance percentage.
 - Beginning October 1, 2017, count certain ICD-10-CM diagnosis codes for patients with traumatic brain injury and hip fracture conditions, and cases that contain two or more ICD-10-CM codes from three major multiple trauma lists in the specified combinations.
- **A Review of Medical Records:** Analyzes a random sample of medical records representing IRF inpatients treated during the compliance-review period.

Although MACs may use the presumptive method to determine if you meet an applicable compliance threshold, they can still review a random sample of medical records if they believe this would be a more accurate way of calculating your compliance percentage. A compliance percentage calculated by a MAC reviewing a random sample of medical records **always** supersedes 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 notify the appropriate CMS Regional Office (RO) of the results. The RO then determines an IRF's classification status prior to 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 all of the other payment systems' requirements.

Reasonable and Necessary Criteria

The following coverage requirements determine whether individual IRF claims are for reasonable and necessary services under [Section 1862\(a\)\(1\)](#) of the Act for discharges that occur on or after January 1, 2010:

- 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 remains 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 any additional documentation requirements

- Clarifies the 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 uniquely provided 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 2019 IRF PPS Final Rule](#) for more information about IRF PPS payment updates.

IRF QRP

[Section 1886\(j\)\(7\)\(A\)\(i\)](#) of the Act requires IRFs to submit data to the Secretary of the U.S. Department of Health & Human Services on specified quality measures. Beginning with FY 2014, the Secretary reduces the market basket update by 2 percentage points for any IRF that fails to comply with quality data submission requirements for the applicable FY.

Measures for Annual Payment Update

These tables provide the current measures for the FY 2019 annual payment update and one measure for the FY 2020 annual payment update.

Measures Required for FY 2019 Annual Payment Update

Number	Required Measure	Data Source
1	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	IRF-PAI
2	National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (National Quality Forum [NQF] #0138)	NHSN/Centers for Disease Control and Prevention (CDC)
3	Influenza Vaccination among Healthcare Personnel (NQF #0431)	NHSN/CDC
4	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (NQF #0680)***	IRF-PAI
5	All Cause Unplanned 30-day post IRF Discharge Readmission Measure**	Claims-Based
6	NHSN Facility-wide Inpatient Hospital-onset Methicillin resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)***	NHSN/CDC
7	NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)	NHSN/CDC
8	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	IRF-PAI
9	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	IRF-PAI
10	IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (NQF #2633)	IRF-PAI
11	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)	IRF-PAI
12	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)	IRF-PAI
13	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)	IRF-PAI
14	Medicare Spending per Beneficiary (MSPB)–Post Acute Care IRF QRP	Claims-Based
15	Discharge to Community–Post Acute Care IRF QRP	Claims-Based
16	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP	Claims-Based

Measures Required for FY 2019 Annual Payment Update (cont.)

Number	Required Measure	Data Source
17	Potentially Preventable Within Stay Readmission Measure for IRF QRP	Claims-Based

**Beginning with FY 2019, IRFs no longer need to submit data on measure number 5, All Cause Unplanned 30-day post IRF Discharge Readmission Measure.

***Data collection for the MRSA and Patient Flu measures ends on October 1, 2018. The use of a dash, or any valid code, for O0250A, O0250B, and O0250C is acceptable effective October 1, 2018. Refer to the [FY 2019 IRF PPS Final Rule](#) (83 FR 38576) for more information on measure removals.

Measure Required for FY 2020 Annual Payment Update

Number	Required Measure	Data Source
18	Drug Regimen Review Conducted with Follow-Up for Identified Issues–Post Acute Care IRF QRP	IRF-PAI

Visit the [IRF QRP](#) webpage for more information about data submission and reporting requirements for quality measures.

RESOURCES

IRF PPS Resources

For More Information About...	Resource
Chapter 1, Section 110, of the Medicare Benefit Policy Manual	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
IRF PPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (Section 110)
Medicare Learning Network® (MLN) Catalog	Go.CMS.gov/mln-catalog
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019	FederalRegister.gov/d/2018-16517

Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR 412.1(a)(1)	https://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fd15d72ac8af7b1c&mc=true&node=se42.2.412_11&rgn=div8
42 CFR 412.29(b)	https://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fd15d72ac8af7b1c&mc=true&node=se42.2.412_129&rgn=div8
42 CFR 413.75 and 413.85	https://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fd15d72ac8af7b1c&mc=true&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl
FY 2019 IRF PPS Final Rule	https://www.federalregister.gov/d/2018-16517
IRF QRP	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting
Section 1862(a)(1)	https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
Section 1886(j)	https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
Section 1886(j)(7)(A)(i)	https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
Subpart B of 42 CFR Part 412	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=dc94a6371351c1bfafbb49f1a32a1700&mc=true&n=pt42.2.412&r=PART&ty=HTML#sp42.2.412.b

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