

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



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Inpatient Rehabilitation Facility Prospective Payment System

PAYMENT SYSTEM SERIES





Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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

- ❖ Background
- ❖ Elements of the IRF PPS
- ❖ Payment updates
- ❖ IRF Quality Reporting Program (QRP)
- ❖ Resources

When “you” is used in this publication, we are referring to IRF providers.

Background

Section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33) modified how Medicare pays for IRF services by creating [Section 1886\(j\) of the Social Security Act](#) (the Act). Section 1886(j) of the Act authorized the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals (or Critical Access Hospitals [CAHs]), collectively known as IRFs. The IRF PPS payment for each patient is based on information found in the IRF-patient assessment instrument (PAI). The IRF-PAI contains patient clinical, demographic, and other information about

the patient, which classifies him or her into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility-level adjustments.

Elements of the IRF PPS

The IRF PPS includes these elements:

- ❖ Rates
- ❖ Classification criterion
- ❖ Reasonable and necessary criteria

Rates

As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related) other than costs associated with operating approved educational activities as defined in the Code of Federal Regulations (CFR) under [42 CFR 413.75](#) and [413.85](#), bad debts, and other costs not covered under the PPS. Federal rates are adjusted to reflect:

- ❖ Patient case mix, which is the relative resource intensity typically associated with each patient’s clinical condition as identified through the patient assessment process:
 - Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the IRF.
 - Cases are further grouped into case-mix groups (CMGs), which group similar cases according to their functional motor and cognitive scores and age.
 - Finally, cases are grouped into one of four tiers within each CMG, according to patients’ comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay). Each tier adds a successively higher payment amount to the case depending on whether the costs of the comorbidity are significantly higher than other cases in the same CMG (low, medium, or high).

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

❖ Facility characteristics:

- Rates are adjusted to reflect geographic differences in wage rates, using the hospital wage index. To transition to the wage index associated with the new Office of Management and Budget (OMB) delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, described in [OMB Bulletin No. 13-01](#):
 - For fiscal year (FY) 2017, IRFs classified as rural in FY 2015 and classified as urban under the new OMB delineations in FY 2016 receive one-third of the FY 2015 rural adjustment.
 - For FY 2018, IRFs classified as rural in FY 2015 and classified as urban under the new OMB delineations in FY 2016 will not receive any rural adjustment.
- IRFs in rural areas receive an increase to their rates.
- IRFs receive an increase to their rates depending on the proportion of low-income patients they treat.
- IRFs with residency training programs receive an increase to their rates based on the number of interns and residents they train compared with their average daily census. This adjustment is subject to a cap.

Federal rates are updated annually:

- ❖ To reflect inflation in the cost of goods and services used to produce 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
- ❖ Through rulemaking that, by law (Section 1886(j) of the Act), must be provided for publication in the Federal Register on or before the August 1 that precedes the October 1 start of each new Federal FY

Classification Criterion

To be excluded from the Acute Care Hospital Inpatient PPS specified in [42 CFR 412.1\(a\)\(1\)](#) and instead be paid under the IRF PPS, an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital (or CAH) must meet the requirements for classification as an IRF stipulated in Subpart B of 42 CFR Part 412. One criterion specified at [42 CFR 412.29\(b\)](#) Medicare uses for classifying a hospital or unit of a hospital as an IRF 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 prior to the Centers for Medicare & Medicaid Services (CMS) issuing 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 (Public Law 110-173) stipulated that the compliance threshold should be set no higher than 60 percent. Thus, we now refer to this regulatory requirement as the 60 percent rule.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 also stipulated that IRFs must continue to use comorbidities that meet certain criteria as specified in 42 CFR 412.29(b)(1) to determine the compliance threshold as they have been since the May 7, 2004, final rule.

The 13 medical conditions that qualify for the 60 percent rule, as specified in the May 7, 2004, final rule, 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

We established additional clinical criteria to require evidence that other less intensive treatments were attempted and failed to improve the patient's condition before admission to the IRF for these three qualifying conditions because the severity/complexity can vary significantly:

- 10) Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living
- 11) Systemic vasculitides with joint inflammation resulting in significant functional impairment of ambulation and other activities of daily living
- 12) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more 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, and significant functional impairment of ambulation and other activities of daily living

We identified these patient characteristics, which add complexity likely to require an IRF level of care, for this qualifying condition:

- 13) Knee or hip joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
 - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care 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

Your compliance percentage is the percentage of the total inpatient population that requires treatment in an IRF for one or more of the medical conditions listed at 42 CFR 412.29(b)(2). The Medicare Administrative Contractor (MAC) uses data from a specific time period known as the compliance review

period to calculate a compliance percentage. 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.

The MAC computes a percentage by either:

- ❖ **The Presumptive Method** – Using a CMS software program that analyzes the IRF PPS impairment group codes and etiologic diagnosis and comorbidity codes. These are International Classification of Diseases, Tenth Revision, Clinical Modification codes on the IRF-PAIs you submitted to CMS during a specific compliance review time period. Note that for compliance review periods beginning on or after October 1, 2015, MACs may perform an additional mini-review of arthritis cases to ensure that such cases meet all regulatory requirements for inclusion in the IRF's presumptive methodology compliance percentage.
- ❖ **A Review of Medical Records** – Analyzing a random sample of medical records that represent inpatients the IRF treated during the compliance review time period.

Although the MAC may determine that you met an applicable compliance threshold by using the presumptive method, it still has the discretion to also use a random sample of medical records to calculate a compliance percentage. A compliance percentage calculated by the MAC analyzing a random sample of medical records will always supersede a compliance percentage calculated by using the presumptive method. Also, the MAC must use the random sample medical record method to calculate the compliance percentage when:

- ❖ The compliance percentage using the presumptive method fails to meet the applicable compliance threshold
- ❖ The facility's Medicare population is less than half of its total patient population

The MAC must notify the appropriate CMS Regional Office (RO) of the results. Based on this information, the RO determines your classification status prior to the start of your next cost reporting period. Your classification status as an IRF must be

determined at the beginning of your cost reporting period and is effective for the entire cost reporting period. When a provider is not classified as an IRF, it is not eligible for payment under the IRF PPS. It may instead be paid under the Acute Care Hospital Inpatient PPS or, if applicable, the payment system Medicare uses to pay CAHs, provided it meets all of the requirements to be paid under one of these other payment systems.

Reasonable and Necessary Criteria

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

- ❖ Specify a preadmission assessment that a rehabilitation physician reviewed and approved prior to IRF admission
- ❖ Require a post-admission physician evaluation to verify that the patient's preadmission assessment information remains unchanged or to document any changes
- ❖ Specify requirements for an individualized overall plan of care for each patient
- ❖ Emphasize the interdisciplinary approach to care provided in IRFs and require interdisciplinary team meetings at least once per week throughout the IRF stay
- ❖ Clarify the requirements for admission to an IRF by specifying that a patient must:
 - Require the active and ongoing therapeutic intervention of multiple therapy disciplines
 - Generally require an intensive rehabilitation therapy program uniquely provided in IRFs
 - Be sufficiently medically stable to benefit from IRF services
 - Require close medical supervision by a physician for managing medical conditions to support participation in an intensive rehabilitation therapy program
 - Require an intensive and coordinated interdisciplinary approach to care

Payment Updates

For more information about IRF PPS payment updates, refer to [Final Fiscal Year 2017 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities \(CMS-1647-F\)](#) and [Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017 Final Rule](#).

IRF QRP

Per [Section 1886\(j\)\(7\)\(A\)\(i\) of the Act](#), you must report quality data for these events that occur in the IRF setting:

- ❖ Urinary catheter-associated urinary tract infections (CAUTI) events on all patients
- ❖ Percent of Medicare patients with new or worsened pressure ulcers since admission

The initial reporting period included measures related to CAUTI and new or worsened pressure ulcer events that occurred from October 1, 2012, through December 31, 2012. IRF quality reporting cycles were based on a full calendar year (CY), from January 1 through December 31 of the applicable year through September 30, 2013. Quality measure data related to health care-acquired infections reported to the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) will remain on a CY reporting cycle. Quality measure data reported on the IRF-PAI changed to FY reporting cycle (October 1 through September 30) on October 1, 2014.

For FY 2015, you must report quality data on these measures for admissions and discharges occurring on or after January 1, 2015:

- ❖ NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus Bacteremia Outcome Measure (National Quality Forum [NQF] #1716)
- ❖ NHSN Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection Outcome Measure (NQF #1717)

For FY 2016 and each influenza vaccination season, you must report quality data on this measure no later than May 15 of each year:

- ❖ Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) for the period October 1 (or when the vaccine becomes available) through March 31

For FY 2017, you must report quality data on these measures:

- ❖ All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities
- ❖ Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)
- ❖ Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)

For FY 2018, you must report quality data on these measures:

- ❖ Medicare Spending Per Beneficiary–Post-Acute Care (PAC) Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- ❖ Discharge to Community–PAC IRF QRP
- ❖ Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP

IRFs that do not report quality data will be subject to a 2 percentage point reduction to the applicable market basket increase factor.

For more information about data submission and reporting requirements for quality measures, visit the [Inpatient Rehabilitation Facilities \(IRF\) Quality Reporting Program \(QRP\)](#) webpage.



Resources

The chart below provides IRF PPS resource information.

IRF PPS Resources

For More Information About...	Resource
IRF PPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS Chapter 1, Section 110, of the Medicare Benefit Policy Manual (Publication 100-02)
Compilation of Social Security Laws	SSA.gov/OP_Home/ssact/title18/1800.htm
Code of Federal Regulations	GPO.gov/fdsys/search/home.action
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Section 1886(j) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
42 CFR 413.75 and 413.85	http://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fbd15d72ac8af7b1c&mc=true&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl
OMB Bulletin No. 13-01	https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf
42 CFR 412.1(a)(1)	http://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fbd15d72ac8af7b1c&mc=true&node=se42.2.412_11&rqn=div8
42 CFR 412.29(b)	http://www.ecfr.gov/cgi-bin/text-idx?SID=50966cd9b383e15fbd15d72ac8af7b1c&mc=true&node=se42.2.412_129&rqn=div8
Section 1862(a)(1) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
Final Fiscal Year 2017 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1647-F)	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-29-3.html
Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2017 Final Rule	https://www.gpo.gov/fdsys/pkg/FR-2016-08-05/pdf/2016-18196.pdf
Section 1886(j)(7)(A)(i) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting

Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Chapter 1, Section 110, of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_booklet.pdf



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