Medicare Inpatient Rehabilitation Facility Prospective Payment System

FY 2027 Final Rule Education

Tuesday, September 29

1 – 2 pm ET

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

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Objectives

1. Provide a high-level overview of the Inpatient Rehabilitation Facility (IRF) setting and FY 2027 IRF final rule updates
2. Summarize FY 2027 IRF Prospective Payment System (PPS) payment updates
3. Explain the finalized revision to the 36-hour requirement
4. Explain the finalized initial interdisciplinary team (IDT) meeting timing requirement
5. Summarize the IRF payment reform request for information (RFI)
6. Describe IRF Quality Reporting Program (QRP) updates

IRF Setting: Basis of Payment Requirements

IRFs provide **intensive rehabilitation therapy** in a resource-intensive hospital environment, as required under the IRF Basis of Payment requirements at 42 CFR § 412.622(a)(3)(ii).

Medicare patients must:

- require an inpatient stay
- require interdisciplinary care for complex nursing, medical management, and rehabilitation needs
- be able to actively participate in, and reasonably be expected to benefit from, intensive rehabilitation therapy

Why this matters:

IRF coverage requirements and documentation help support whether an IRF claim is reasonable and necessary under section 1862(a)(1) of the Social Security Act.

Why Documentation and Clinical Review Matter

Medicare payment depends on documentation that supports the care provided and the payment billed (42 CFR § 412.622 – Basis for Payment).

Recent OIG audit findings related to IRF documentation, coverage, and billing requirements highlight the importance of clear medical record documentation.

IRFs should ensure clinical, billing, and compliance teams have a shared process for reviewing key coverage and payment documentation.

OIG Report: Why This Education Matters

OIG identified differing interpretations between OIG, CMS, and IRF stakeholders related to documentation, coverage, and billing requirements.

Key areas reviewed: Plan of Care development, IDT meeting requirements, preadmission screening, physician supervision, therapy requirements, and IRF-PAI discharge assessments.

CMS concurred with OIG's recommendation to offer training and learning sessions to assist IRFs with compliance.

The topics covered in this presentation relate to several areas identified in the OIG audit, including IDT meeting requirements and therapy requirements.

Source: HHS-OIG May 2026 IRF audit report: https://oig.hhs.gov/documents/audit/11598/A-04-23-08096.pdf

FY 2027 IRF PPS Payment Overview

FY 2027 IRF PPS Payment Update

The annual payment update is **2.3 percent** after the required productivity adjustment.

Overall payments to IRFs are estimated to **increase by $340 million** in FY 2027.

The FY 2027 standard payment conversion factor is **$19,868.**

Other FY 2027 Payment Updates

These updates affect how FY 2027 IRF PPS payments are calculated. They don't create new provider documentation requirements.

- **Case-Mix Group (CMG) relative weights and average length of stay**: May affect payment amounts by CMG and short-stay transfer calculations
- **Labor-related share and wage index**: Affect the wage-adjusted portion of the IRF PPS payment
- **5-percent wage index cap**: Limits annual wage index decreases for applicable providers
- **Rural-to-urban transition**: Affected IRFs that were part of the 3-year rural transition will receive the standard payment without the rural adjustment

High-Cost Outlier and Cost-to-Charge Ratio Updates

These updates affect how Medicare calculates payment for unusually high-cost IRF cases. They don't create new provider documentation requirements.

- **High-cost outlier payments**: Continue to target approximately 3 percent of total estimated IRF payments
- **Outlier threshold**: Final FY 2027 threshold is **$8,857**, which is used to determine whether a high-cost case qualifies for an additional outlier payment
- **Cost-to-Charge Ratios (CCRs)**: Updated for FY 2027 and used in the outlier payment calculation to estimate case costs from charges

Coverage Requirement Updates

Coverage Requirement Updates: Provider Focus

The FY 2027 rule finalizes two existing policy requirements under 42 CFR § 412.622, Basis of Payment:

- 36-hour requirement revision
- Initial interdisciplinary team (IDT) meeting requirement

This section outlines the required actions, the applicable timelines, and the documentation that should be supported by the medical record.

36-Hour Requirement Revision

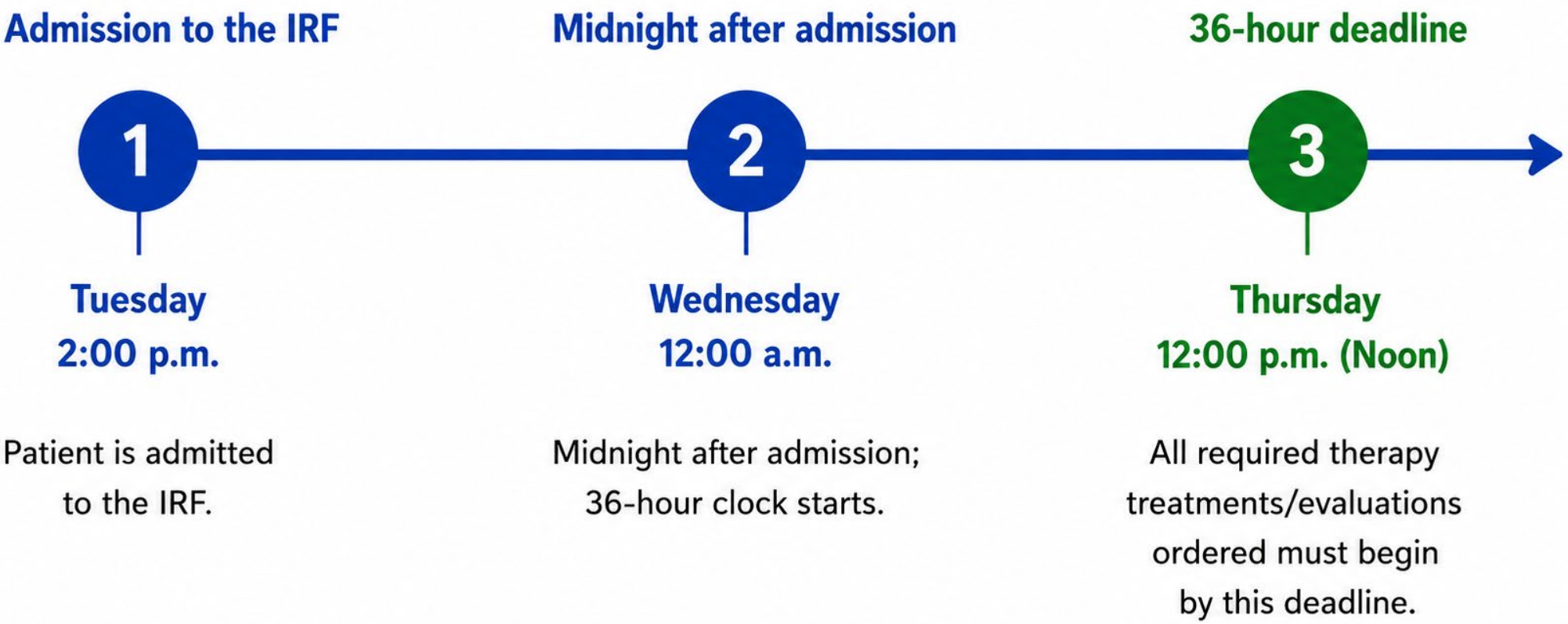
All required therapy treatments and/or therapy evaluations ordered at admission must begin no later than 36 hours from midnight on the day of admission to the IRF (42 CFR § 412.622(a)(3)(ii)).

Starting only one therapy doesn’t meet the requirement.

Therapy evaluations are generally considered to constitute the beginning of required therapy services and may count toward meeting the 36-hour requirement.

Compliance is determined through review of the IRF medical record documentation.

36-Hour Requirement Example



NOTE: Therapies/evaluations may include those identified through the preadmission screening when the rehabilitation physician concurs, or those ordered at admission.

36-Hour Requirement: What Is Included?

Included in the 36-hour requirement	Not part of the 36-hour requirement
Therapies and evaluations ordered at admission, including those identified through the PAS when the rehabilitation physician concurs and any additional therapies ordered at admission.	New therapies/evaluations ordered after the initial admission orders.

Reminder: Therapies/evaluations ordered after the initial admission orders should still begin as soon as possible to support high-quality care.

36-Hour Requirement: Documentation Focus

The medical record should clearly show:

- The patient's admission date and time
- Which therapy treatments and/or evaluations were ordered at admission
- The date and time each required therapy treatment and/or evaluation began

Documentation notes:

- The record should show whether all required therapies/evaluations subject to the 36-hour requirement began by the deadline
- Additional therapies/evaluations ordered after the initial admission orders are not subject to the 36-hour rule, but must still be documented

36-Hour Requirement: Quick Scenario

Scenario: A patient is admitted to the IRF on Tuesday at 2:00 pm. The preadmission screening (PAS) identifies physical therapy (PT) and occupational therapy (OT) as required therapies, and both are ordered at admission**.**

Compliant example	Non-compliant example
PT evaluation begins Wednesday at 9:00 am. OT evaluation begins **Thursday at 10:30 am**. Both begin before the Thursday noon deadline.	PT evaluation begins Wednesday at 9:00 am. OT evaluation begins **Thursday at 2:00 pm**. OT did not begin by the Thursday noon deadline.

Takeaway: The documentation must show that each required therapy treatment and/or evaluation ordered at admission began within the required timeframe.

Initial Interdisciplinary Team (IDT) Meeting Requirement

Initial IDT Meeting Requirement

The first interdisciplinary team meeting must occur on or before the fourth day from the date the patient is admitted to the IRF (42 CFR § 412.622(a)(5)).

- Day 1 is the day of admission
- The initial IDT meeting should support coordinated care early in the patient's stay
- The initial IDT meeting and individualized overall plan of care are separate requirements that both support coordinated care and must be completed by Day 4.

Initial IDT Meeting: Day-Count Examples

Key rule: Day 1 is the date of admission. The initial IDT meeting must occur on or before Day 4.

	Day 1	Day 2	Day 3	Day 4
Example 1	Monday **Admission day**	Tuesday	Wednesday	Thursday **Initial IDT due by end of this day**
Example 2	Thursday **Admission day**	Friday	Saturday	Sunday **Initial IDT due by end of this day**

Reminder: If Day 4 falls on a weekend or holiday, IRFs should plan workflows so the initial IDT meeting still occurs by Day 4.

Subsequent IDT Meetings

After the initial IDT meeting, the date of that meeting determines the timing for the patient's remaining IDT meetings.

- The rehabilitation physician's concurrence must be documented and retained in the medical record with the IDT meeting findings
- Remaining IDT meetings must occur at least once per week after the date of the prior team meeting (42 CFR § 412.622(a)(5)(iii))
- For purposes of 42 CFR § 412.622, a "week" means a period of 7 consecutive calendar days.

Initial IDT Meeting: Documentation and Participation

The initial IDT meeting documentation should be separate from the plan of care documentation in the medical record (42 CFR § 412.622(a)(5)).

The initial IDT meeting documentation should show that the meeting discussed:

- implementation of appropriate therapy services identified in the PAS and ordered at admission
- establishment or review of the patient's stated rehabilitation goals
- any problems that could impede those goals

Only the rehabilitation physician may lead and participate remotely; other required team members must attend in person.

The current requirement does not allow Physician Assistants to lead IDT meetings.

Operational Considerations for IRFs

Review admission-day workflows for patients admitted later in the day or later in the week.

Confirm how therapy orders move from the PAS and admission orders into scheduling and documentation workflows.

Plan for weekend and holiday coverage for therapy initiation and IDT meeting requirements.

Coordinate documentation review across clinical, billing, and compliance teams before claim submission.

Use FAQs, quick-reference handouts, and scenario-based examples to support staff training.

IRF Payment Reform

Future IRF Payment Reform RFI

The FY 2027 IRF proposed rule included an RFI on potential future refinements to the IRF PPS.

The RFI requested feedback on updates to how primary diagnoses and comorbidities are used to classify patients by case-mix.

These potential updates would support efforts to modernize the IRF PPS.

CMS will continue to explore potential IRF PPS refinements through research, analysis, public engagement, and future rulemaking. A Technical Expert Panel occurred on September 22, 2026, and a report will be posted on the CMS IRF PPS webpage.

IRF QRP

IRF QRP Updates

- The FY 2027 rule revises IRF QRP data submission deadlines beginning with the FY 2029 IRF QRP.
- The revised deadlines apply to IRF-PAI and CDC NHSN data.
- A summary of comments received on future IRF QRP measure concepts is provided in the rule.
- These updates do not create FY 2027 payment or coverage workflow changes.

Wrap-up

Key Takeaways

FY 2027 payment updates affect reimbursement, but do not create new provider documentation requirements.

All required therapy treatments and/or evaluations ordered at admission must begin no later than 36 hours from midnight on the day of admission to the IRF.

The initial IDT meeting must occur on or before Day 4, with Day 1 as the day of admission.

Medical record documentation should clearly support therapy initiation, IDT timing, and ongoing IDT meeting cadence.

RFI topics are informational and are not finalized FY 2027 payment reform changes.

Resources & Questions

- Inpatient Rehabilitation Facility PPS webpage
- IRF QRP Resource
- IRF QRP technical questions: IRF.Questions@cms.hhs.gov
- Further questions: IRFCoverage@cms.hhs.gov

Acronyms

ALOS: Average Length of Stay

CCR: Cost-to-Charge Ratio

CDC: Center for Disease Control and Prevention

CMG: Case-Mix Group

IDT: Interdisciplinary Team

IRF: Inpatient Rehabilitation Facility

IRF-PAI: IRF Patient Assessment Instrument

IRF PPS: IRF Prospective Payment System

MAC: Medicare Administrative Contractor

NHSN: National Healthcare Safety Network

OT: Occupational Therapy

PAS: Preadmission Screening

POC: Plan of Care

PPS: Prospective Payment System

PT: Physical Therapy

QRP: Quality Reporting Program

RFI: Request for Information