DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #01-032

December 5, 2001

Dear State Medicaid Director:

Effective January 1, 2002, Medicare will implement a prospective payment system (PPS) for reimbursement to inpatient rehabilitation facilities (IRFs). Since some of our beneficiaries access both Medicare and Medicaid program benefits, you need to be aware of these upcoming Medicare changes. To that end, we enclose the Medicare Program Memorandum (PM) Transmittal A-01-110, providing instructions for the implementation of the IRF PPS, recently issued to Medicare Fiscal Intermediaries.

We strongly recommend that your staff continue to work closely with the Medicare Intermediaries in your State to ensure an effective implementation and coordination of benefits on behalf of Medicaid beneficiaries who also have Medicare coverage.

Information on the IRF PPS, including answers to the most frequently asked questions and IRF PPS hotlines are available on the Internet at: *http://www.hcfa.gov/medicare/irfpps.htm.*

Sincerely,

/s/

Dennis G. Smith
Director

Enclosure

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors' Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jennifer King
Health and Human Services Task Force Director
American Legislative Exchange Council

Trudy Matthews
Senior Health Analyst
Council of State Governments

Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal A-01-110 **Date: SEPTEMBER 14, 2001**

CHANGE REQUEST

SUBJECT: Instructions for Implementing the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

NOTE: The following instruction is a revision and modification of CR 1657 (Transmittal Number: A-01-92).

The purpose of this program memorandum (PM) is to provide general information and specific instructions related to the implementation of the Medicare prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs). This PM is divided into three sections. The first section reiterates the requirements for IRF classification, the second with payment provisions under IRF PPS, and the third with claims processing and billing by providers under IRF PPS.

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by §125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F) and §305 of the Benefits Improvement and Protection Act of 2000 (BIPA), authorizes the implementation of a per discharge prospective payment system (PPS), through new §1886(j) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units—referred to as inpatient rehabilitation facilities (IRFs).

The proposed rule published on November 3, 2000, established a 60 day comment period. On December 27, 2000, we published a notice in the ***Federal Register*** extending the comment period for an additional 30 days to February 1, 2001. After an extensive analysis of the changes required to CMS and provider information systems, we have determined that the earliest feasible date to implement the IRF PPS is for cost reporting periods beginning on or after January 1, 2002. The final rule was published in the ***Federal Register*** (66 FR 41316) on August 7, 2001. These payment rates will cover all costs of furnishing covered IRF services (that is, routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR §413.85 and §413.86, bad debts, and other costs not covered under the PPS.

MEDICARE IRF CLASSIFICATION REQUIREMENTS

In general, the criteria for a facility to be classified as an IRF remains unchanged from the requirements used to classify entities as exempt from the acute care hospital PPS. In order to be paid under the IRF PPS, a facility first must meet the conditions for payment under §412.604 of the regulations (established in the final rule). In addition, an entity must meet the requirements under §412.23(b) which in part states that a facility must:

> "show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease), and burns."

Hospitals that are not paid under the IRF PPS, but are paid under special payment provisions are: Veteran's Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1). Payment to foreign hospitals will be made in accordance with the provisions set forth in section 413.74 of the regulation.

PAYMENT PROVISIONS UNDER IRF PPS

Section 1886 of the BBA provides the basis for the establishment of the Federal payment rates applied under PPS to IRFs. The PPS will incorporate per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system.

Beneficiary liability will operate the same as under the current Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system. Even if Medicare payments are below cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

- Payment Adjustment Factors and Rates

The BBA sets forth the methodology for establishing the payment rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and other factors the Secretary deems necessary to ensure that payment most accurately reflects cost.

The BBA specifies that payments during fiscal years 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. As a result of the implementation of BIPA, a change has been made to eliminate the payment amount of 98 percent of the FY 2002 expenditures. Under §305 of the BIPA 2000, §1886(j)(3)(b) of the Act is amended to increase the amount of payment to 100 percent of FY 2002 expenditures.

For the initial period of PPS, beginning on or after January 1, 2002, all payment rates and associated rules were published in the ***Federal Register*** on August 7, 2001. For each succeeding fiscal year, the rates will be published in the ***Federal Register*** on or before August 1 of the year preceding the affected fiscal year.

Case-Mix Groups

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. We used Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are formed using codes from the International Classification of Diseases 9th Revision (ICD-9s). In addition to the RICs, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age also allows us to improve the explanatory power of the CMGs if we split some of the groups based on this variable. Lastly, comorbidites were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

Case-Level Adjustments

Payment will be based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. Below, we first describe the case-level adjustments of the IRF PPS. More than one case level adjustment may apply to the same case. Thus, for ease of understanding we present the discussion of the case-level adjustments in the same order that will be used to assess whether or not they apply. For instance, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for interrupted stay cases and the payment will be based on the initial assessment. For example, if a Medicare beneficiary is discharged on February 1, 2001, and is readmitted on February 3, the case would be considered an interrupted stay and only one CMG payment will be made based on the initial assessment. However, if the Medicare beneficiary was readmitted on February 4, then it would not be considered an interrupted stay. A separate DRG payment will not be made to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, a DRG payment can be made if the beneficiary does not return to the same IRF on the same day as they were discharged. If a case is determined to be an interrupted stay, other adjustments may apply to this payment amount. For example, the case still may meet the definition of a transfer case described below.

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. We will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Further cases that expire with a length of stay of 3 days or less, will also be classified to CMG 5001.

Separate CMGs will also be made for cases that expire with a length of stay greater than 3 days. To improve the explanatory power of the groups, we created four additional CMGs to account for cases that expire. CMG 5101 will be used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09 and the length of the stay is greater than 3 days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

Facility-level Adjustments

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facility's located in rural areas, and an adjustment for treating low income patients. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can only be determined to qualify for these additional payments after all other facility-level adjustments are computed. Thus, for ease of understanding we present the discussion of these facility-level and outlier adjustments in the same order that will be used to assess their applicability.

To adjust payments for area wage differences, we first identify the labor-related portion of the prospective payment rates. The labor-related portion is 72.395 percent and the non-labor related portion is 27.605 percent. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. We are using the inpatient acute care hospital wage data to compute the wage indices. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare part B,

because these services are not covered under the IRF PPS. The wage index that will apply to the IRF PPS payment rates excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists. IRFs will be divided into labor market areas. As with other CMS payment systems, we define urban areas as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to geographic reclassification under §1886(d)(8) or (d)(10) of the Act.

Payments will be adjusted for facilities located in rural areas. We will consider a facility to be a rural IRF if they are located in a non-MSA area.

Additional payments will be made for treating low income patients (LIP). There are two parts in computing this adjustment. The first, is the calculation of the disproportionate share variable (DSH). This is computed by:

$$DSH = \frac{\text{SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

Once the DSH is calculated, we use this percentage to determine the LIP adjustment as specified in the IRF PPS final rule.

Additional payments will be made for those cases that are high cost outliers. A case will be considered to be an outlier if the estimated cost of the case exceeds an adjusted threshold amount. The estimated cost of the case will be calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled cost report. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments will be added to the adjusted payment amount. The outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above).

- Phase-In Implementation

Under the BBA, the Federal fiscal year in which a facility's cost reporting period begins, determines which transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during Federal fiscal year 2001. The second transition period percentages are applicable to cost reporting periods beginning during Federal fiscal year 2002, that is, periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning during Federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted Federal prospective payment.

Since we are implementing the IRF PPS for discharges that occur during the IRF's cost reporting period that begins on or after January 1, 2002, IRFs will be phased directly into the second transition period, where payment will be based on 66 2/3% of the PPS payment and 33 1/3% of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its **entire** cost reporting period beginning prior to January 1, 2002.

In addition, §305 of the BIPA 2000 states facilities may elect to be paid 100% PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their intermediary no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made
in writing to the Medicare fiscal intermediary for the facility. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before

the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before
the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

- Medicare Patient Assessment Instrument

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The final rule contains detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, we will provide an item-by-item guide, which will include detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

CLAIMS PROCESSING AND BILLING

BILLING REQUIREMENTS UNDER IRF PPS

Billing IRF PPS Services

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on Form HCFA-1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill 11X) to their intermediaries. The Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, along with the UB-92 version 6.0 are at
http://www.hcfa.gov/medicare/edi/edi3.htm. These formats are effective through October 16, 2002. The X12N 837 version 4010 (HIPAA) to UB-92 version 6.0 mapping is at
http://www.hcfa.gov/medicare/edi/hipaadoc.htm. The 837 version 4010 can be downloaded at

http://www.wpc-edi.com. The new revenue code, 0024, will be used in conjunction with the HIPPS Rate Code to identify the CMG group the beneficiary was classified into. In addition to all entries previously required on a UB-92, the following additional instructions must be followed so you can accurately price and reimburse a claim under PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation units the third digit will be a T.

- The Revenue Code, Form Locator (FL) 42, (Record Type (RT) 60, field 5), (SV201), must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can only appear on a claim once.

- The following Patient Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, and 63.

  NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates, FL44, (RT60, field 6), (SV202-2), must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A,B,C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

- Covered Charges, FL47, (RT60, field 10), (SV203), should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF PRICER will calculate and return the payment

  amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit thru discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period

that begins on or after January 1, 2002.

Standard Systems/CWF Edits

- To insure that revenue code 0024 is not reported more than once on bill type 11X;
- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.
- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;
- Note: units entered on the 0024 must be accepted, but are not required.
- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;
- To insure that Occurrence Span Code 74 FL36, (RT 40, fields 22, 24, 26), (2300 loop HI code BI), is present on the claim if there is an interrupted stay $\leq$ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and
- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired).
- The accommodation revenue code 018x, (RT 50, field 5), (SV201), (leave of absence) will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74 (RT 40, field 22-27) and date range.

Billing Ancillary Services Under IRF PPS

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- IRFs are required to report the number of units in FL 46 based on the procedure or service.
- IRFs are required to report the actual charge for each line item, in Total Charges, FL 47.

Benefits Exhausted--If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3 (RT 40, field 8-21), 2300 loop HI code BH). If benefits are exhausted prior to the stay, submit a no pay claim which will be coded by the FI with no pay code B.

NOTE: For more information on outlier payments when benefits are exhausted, please visit http://www.hcfa.gov/pubforms/transmit/A991760.htm. Although this

references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

IRF PRICER SOFTWARE

CMS has developed an IRF PRICER Program that calculates the Medicare payment rate. PRICER will use a variety of inputs listed below to calculate the payment rate.

Inputs to PRICER

- Provider Specific File (Instructions for updating the provider specific data for IRF PPS will appear in Sections 3656.3 and 3850 of the MIM.)

- Bill Data
  - -Provider #
  - -Patient Status
  - -Payment Modification Flag (If condition code is 66, set flag "Y" otherwise use "N".)
  - -Covered Charges
  - -Discharge date
  - -HIPPS/CMG Rate Code
  - -Length of Stay (LOS)
  - -Covered Days
  - -Lifetime Reserve Days (LTR)

PRICER returns the following information:

- PPS Return Code
- MSA
- Wage Index
- Average LOS
- Relative Weight

- Total Payment Amount
- PPS Federal payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low Income Payment (LIP) Amount
- LOS
- Regular Days Used
- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend

- Facility costs
- Outlier threshhold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

The PRICER will be available electronically to the Standard Systems.

Remittance Advices

A new remittance advice remark code has been developed to notify an IRF when the CMG code has been changed: N100 PPS code corrected during adjudication.

As with any new code, notify potential recipients of the code of its existence and meaning prior to initial use. Continue to use existing reason and remark codes in your remittance advice transactions to explain other adjustments made to the claim during adjudication.

Providers that receive version 3051.4A.01 of the Electronic Remittance Advice (ERA) will receive the CMG code under which payment is made in the service level procedure code field, identified with qualifier HC. If the CMG is modified during adjudication, the paid under CMG, rather than the submitted CMG, will be reported at the service level. Providers who begin to receive version 4010 of the ERA will have the CMG reported in the same location, but with qualifier ZZ. Providers that receive earlier versions of the ERA, or who receive only paper RAs, will not receive service level details.

Medicare Summary Notices and Notice of Utilization

Continue to use existing notices for IRF for PPS coverage.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

This PM may be discarded after January 1, 2003.

These instructions should be implemented within your current operating budget.

If you have any questions, contact Todd Smith (410) 786-1420.