

## FINAL MEDICARE INPATIENT REHABILITATION FACILITY PPS UPDATE FOR FY 2010

In the August 7, 2009 *Federal Register*, the Centers for Medicare and Medicaid Services (CMS) published a Final Rule updating the Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs). The changes in this rule are effective for fiscal year (FY) 2010, October 1, 2009 through September 30, 2010. Provisions of this rule are discussed below. All table references are to the August 7, 2009 *Federal Register*.

- PATIENT CLASSIFICATION PROVISIONS:** For payment purposes, IRF patients are classified into case-mix groups or CMGs based upon their clinical characteristics and resource needs. Patients receiving a full course of treatment are first classified into 21 rehabilitation impairment categories (RICs), based upon their primary reason for treatment. RICs are then subdivided into 87 CMGs using functional status (both motor and cognitive) and age. In addition, there are 4 CMGs for patients that expire, and 1 CMG for short stay cases (i.e., cases with a length of stay of 3 days or less). CMS is not making any changes to the CMG assignment rules for FY 2010.
- COMORBIDITIES:** CMS has determined that certain comorbidities (i.e., clinical conditions that are secondary to the patient's principal diagnosis or impairment) have a major effect on the costs of furnishing inpatient rehabilitation care. CMS divides all comorbidities considered relevant by the IRF PPS into three tiers (1 = high, 2 = medium, or 3 = low) depending on their impact on costs to account for these resource differences. For FY 2010 there are four new comorbidity additions. Each ICD-9-CM diagnosis code has been added to tier 3: 285.3, 416.2, 488.0, and 488.1. ICD-9-CM diagnosis codes 416.2, 488.0, and 488.a have all been excluded from rehabilitation impairment category (RIC) 15. There were no deletions or changes to the tier assignment or RIC exclusions. CMS posts updated tier comorbidity lists to the Medicare IRF PPS web site on an ongoing basis: [www.cms.hhs.gov/InpatientRehabFacPPS/](http://www.cms.hhs.gov/InpatientRehabFacPPS/).
- STANDARD PAYMENT CONVERSION FACTOR:** CMS calculates the market basket update for FY 2010 at 2.5 percent, using a market basket specifically developed for inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals (the RPL market basket). The FY 2010 conversion factor includes the market-basket increase, budget neutrality factors for the updates to the rural, LIP, and IRF teaching status adjustments of 1.0023, 1.0192, and 1.0037, respectively. For FY 2010, the standard payment conversion factor is \$13,661.
- CMG RELATIVE WEIGHTS AND AVERAGE LENGTHS OF STAY:** Payment weights are used to account for relative differences in resource use across CMGs. For each CMG, there are generally four payment weights, one for each comorbidity tier (high, medium, and low) and one weight to be applied when no comorbidities are present. For FY 2010, CMS is updating the IRF relative weights using updated FY 2008 IRF claims data, as well as updated 2007 IRF cost reports. Updated CMG weights and average lengths of stay for FY 2010 can be found in Table 1 of the Final Rule.
- CMG PAYMENT RATES:** Payment for the IRF PPS is discharge-based with separate payment rates established for each CMG and applicable comorbidity tier. In general, these payment rates are equal to the budget neutral conversion factor (\$13,661 for FY 2010) multiplied by CMG-specific weights. The CMG-specific payment rates for each comorbidity tier (updated for FY 2010) can be found in Table 4 of the Final Rule.

6. **WAGE ADJUSTMENT:** CMS uses a wage index based solely on core-based statistical areas (CBSAs). CMS is continuing to use the pre-reclassified and pre-floor hospital wage indexes by CBSA to determine the FY 2010 rates. The wage index values can be found in Table 1 of the addendum for urban facilities and in Table 2 for rural facilities. The labor-related share increases slightly to 75.779 percent for FY 2010. This is based on the HIS Global Insight Inc. forecast for the second quarter of 2009 with historical data through the first quarter of 2009. In FY 2009, the labor-related portion was 75.464 percent.
7. **FACILITY-LEVEL ADJUSTMENTS:** Facility level adjustments for rural, low income percentage (LIP), and teaching status adjustments have been updated for FY 2010 using the most current and complete Medicare claims and cost report data. PPS payments to IRFs in rural areas will be increased by 18.4 percent for FY 2010. An updated LIP adjustment formula has been used. The updated formula is:  $1 + \text{disproportionate share hospital (DSH) patient percentage raised to the power of } (0.4613)$ ; where the DSH patient percentage for each IRF is:

<b>Medicare SSI Days</b>	<b>+</b>	<b>Medicaid, Non-Medicare Days</b>
Total Medicare Days		Total Days

PPS payments to eligible IRFs that qualify for the teaching status adjustment will be adjusted by the following updated formula for FY 2010:

***(1 + full-time equivalent (FTE) residents/average daily census) raised to the power of (0.6876)***

8. **OUTLIER ADJUSTMENTS:** CMS is increasing the cost outlier threshold from \$10,250 to \$10,652 to maintain total estimated outlier payments at 3% of total estimated IRF payments. CMS is also changing the national cost-to-charge ratios (CCR) to 0.622 for rural IRFs and 0.494 for urban IRFs. National CCRs are used by new IRFs; IRFs that have an overall CCR in excess of three standard deviations above the corresponding national geometric mean, and other facilities for which an overall CCR could not be accurately calculated. The IRF national CCR ceiling is 1.61 for FY 2010.
9. **60% RULE AND ASSESSMENTS:** In order for a rehabilitation facility or unit to be exempt from the Acute Care Hospital Inpatient PPS (DRG-based), and to be classified as an IRF, a minimum percentage of the facility's total inpatient population must have one of 13 specified medical conditions. CMS set the compliance threshold at 60% for FY 2009 and FY 2010.

In calculating an IRF's compliance rate to determine compliance with the 60% rule, CMS has used a method that extrapolated the compliance rate from Medicare fee-for-service data. This extrapolation method of determining compliance has become less reliable as more Medicare beneficiaries enroll in Medicare Part C or Medicare Advantage (MA) plans. Effective with admissions to or discharges from an IRF on or after October 1, 2009, IRFs must complete a patient assessment instrument (PAI) for each MA patient. If an IRF fails to submit all MA PAIs, CMS will not count the MA patients in the compliance percentage for that IRF. Additionally, CMS is removing the exemption that formerly allowed IRFs to not submit PAI's for Medicare patients for whom they were not seeking payment from Medicare. Effective with admissions to or discharges from an IRF on or after October 1, 2009, IRFs must complete a PAI for all Medicare patients (Part A or Part C).

10. **COVERAGE REQUIREMENTS REVISED:** Effective January 1, 2010, coverage criteria is being revised to ensure that Medicare beneficiaries who require the intensive rehabilitation services provided in an IRF, continue to have access to high quality care. Specific coverage requirements addressed in the Final Rule include:

- Each candidate for IRF care must undergo a comprehensive pre-admission screening conducted by a qualified clinician(s) designated by a rehabilitation physician (a licensed physician with special training and experience in rehabilitation medicine). If the comprehensive preadmission screening is performed more than 48 hours prior to admission, there must be a brief in-person or phone update to update the patient's medical and functional status prior to admission. Documentation of the screening and of the in-person or phone update (when required) must be retained in the patient's medical record.
- The rehabilitation physician must review the findings and results of the pre-admission screening and document his or her concurrence with them before ordering the IRF admission. The pre-admission screening should address (at a minimum) whether the patient's condition is sufficiently stable to allow the patient to actively participate in an intensive rehabilitation program, whether the patient at the time of admission has the appropriate therapy needs for placement in an IRF, whether the patient requires the intensive services of an inpatient rehabilitation setting (generally recognized as at least three hours of therapy per day for at least five days per week), and whether the patient can reasonably be expected to make measurable improvement that will be of practical value to the patient's functional capacity or adaptation to impairments.
- The patient must be able and willing to actively participate in an intensive rehabilitation program and is expected to make measurable improvement in his or her functional capacity or adaptation to impairments.
- IRF services be ordered by a rehabilitation physician with specialized training and experience in rehabilitation services and be coordinated by an interdisciplinary team; including at least a registered nurse with specialized training or experience in rehabilitation, a social worker or case manager (or both), and a licensed or certified therapist from each therapy discipline involved in treating the patient. The rehabilitation physician would be responsible for making the final decisions regarding the patient's treatment in the IRF.
- The IRF must use qualified personnel to provide required rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services.
- The interdisciplinary team must meet weekly to review the patient's progress and make any needed modifications to the individualized overall plan of care.
- A post-admission evaluation must be completed to document the status of the patient after admission to the IRF, and a comparison of this post-admission screen and the preadmission screening documentation must be completed. The rehabilitation physician is not required to consult with the interdisciplinary team members when developing the post-admission evaluation, but CMS encourages the physician to consider any available input from the interdisciplinary team members. Facilities will use this information to begin developing an overall plan of care that is designed to meet the individual patient's specific needs.
- The overall plan of care must be maintained in the patient's medical record and care must be completed by the end of the fourth day following the patient's admission.
- Therapy treatments must begin within 36 hours of midnight of the day of admission.

**11. IMPACT ANALYSIS OF FINAL POLICY CHANGES:** There are more than 200 freestanding IRFs and a little fewer than 1,000 IRF units in acute care hospitals in 2009. CMS estimates that total payments to IRFs will increase in fiscal 2010 by \$145 million. This is primarily due to the payment rate update of 2.5 percent, based on the Rehabilitation, Psychiatric, and Long-term

Care (RPL) market basket. The RPL market basket was developed to measure the rate of inflation for the resources used in treating the specific types of patients served by these facilities.

**FOR FURTHER INFORMATION**

If you have questions regarding the Inpatient Rehabilitation Facility Prospective Payment System changes described above, or if you need software to assign the appropriate casemix measures and calculate reimbursement, please contact our Client Services Department at 1-800-999-DRGS (3747). *Industry Insights*, as well as source documents and relevant statistics can be located on the Ingenix web site under News & Events: <http://www.ingenix.com/News/Industnews/>.