

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2026	Date: August 13, 2010
	Change Request 7076

SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2011

I. SUMMARY OF CHANGES: On August 7, 2001, we published in the Federal Register, a final rule that established the PPS for IRFs, as authorized under 1886(j) of the Social Security Act (the Act). In that final rule, we set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by 1886(j)(3)(C) of the Act.

EFFECTIVE DATE: October 1, 2010

IMPLEMENTATION DATE: October 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/140.2/Payment Provisions Under IRF PPS
R	3/140.3/Billing Requirements Under IRF PPS

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2026	Date: August 13, 2010	Change Request: 7076
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SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2011

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: On August 7, 2001, we published in the **Federal Register**, a final rule that established the PPS for IRFs, as authorized under §1886(j) of the Social Security Act (the Act). In that final rule, we set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by §1886(j)(3)(C) of the Act.

B. Policy: The FY 2011 IRF PPS Update Notice published on July 22, 2010, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF PRICER software package will be released prior to October 1, 2010, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2010, through September 30, 2011. The new revised Pricer program must be installed timely to ensure accurate payments for the IRF PPS claims with discharges occurring on or after October 1, 2010, through September 30, 2011.

Under the new IRF coverage requirements that became effective January 1, 2010, an IRF is eligible to receive the IRF short stay payment for 3 days or less (Health Insurance Prospective Payment system (HIPPS)/Case Mix Group (CMG) A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS/CMG A5001).

In addition to updating the rates for FY 2011, this CR also seeks to clarify contractor action for transfer edits based on the Office of Inspector General report entitled, "Review of Inpatient Rehabilitation Facilities' Compliance with Medicare's Transfer Regulation During Fiscal Years 2004 Through 2007," (A-04-09-00059). Based on findings in this report, CMS is reminding Contractors to process claims for correct program payment as they receive responses from the Common Working File (CWF) identifying transfer cases meeting the transfer regulation requirements.

PRICER Updates: For IRF PPS FY 2011 (October 1, 2010 – September 30, 2011)

- The standard Federal rate is: **\$13,860**
- The fixed loss amount is: **\$ 11,410**
- The labor-related share is: **0.75271**
- The non-labor related share is: **0.24729**
- Urban national average CCR is: **0.489**
- Rural national average CCR is: **0.620**
- The Low Income Patient (LIP) Adjustment is: **0.4613 (no change from FY 2010)**

- The Teaching Adjustment is: **0.6876 (no change from FY 2010)**
- The Rural Adjustment is: **1.1840 (no change from FY 2010)**

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
7076.1	FISS shall install and pay IRF claims with the FY 2011 IRF PPS Pricer for discharges on or after October 1, 2010.						X				
7076.2	Contractors shall take the appropriate action to adjust or cancel claims based on the CWF unsolicited response for IRF transfer claims.	X		X							
7076.3	For discharges January 1, 2010, and after, contractors shall revise any edits that prohibit IRFs from submitting HIPPS/CMG "A5001" on claims if the day count is greater than 3.						X				
7076.4	Contractors shall not allow HIPPS/CMG "A5001" to be entered by IRFs upon claim submission if the day count is 3 or less.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
7076.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Policy: Susanne Seagrave at susanne.seagrave@cms.hhs.gov or 410-786-0044

Claims Processing: Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986

Fred Rooke at fred.rooke@cms.hhs.gov or 410-786-6987

Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 410-786-0187

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

140.2 - Payment Provisions Under IRF PPS

(Rev.2026, Issued: 08-13-10, Effective: 10-01-10, Implementation: 10-04-10)

A-03-008

Section 1886 of the BBA provides the basis for establishing the Federal payment rates applied under PPS to IRFs. The PPS incorporates per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system. IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre-admission services, but are subject to the 1-day payment window (24-hour rule) for pre-admission services.

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.

Below are the annual rate update Change Requests (CRs) for the applicable Fiscal Years (FYs):

FY 2011 – CR 7076

FY 2010 – CR 7029

FY 2010 – CR 6607

FY 2009 – CR 6166

FY 2008 – CR 5694

FY 2007 – CR 5273

FY 2006 – CR 4037

FY 2005 – CR 3378

FY 2004 – CR 2894

FY 2003 – CR 2250

Change Requests can be accessed through the following CMS Transmittals Web site:

http://www.cms.hhs.gov/Transmittals/01_Overview.asp

140.3 - Billing Requirements Under IRF PPS

(Rev. 2026, Issued: 08-13-10, Effective: 10-01-10, Implementation: 10-04-10)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

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 1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill 11X) to their FIs. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF 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 distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.
- The following Patient Discharge Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

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 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.

- *For atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).*

Covered Charges 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 through 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. Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

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

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

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. 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. Report any services that can be billed under the Part B benefit using 12X TOB.

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. 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.