

## Chapter 17

## Section 1

# Inpatient Rehabilitation Facilities (IRFs)

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

### 2.0 DESCRIPTION

An IRF is a facility that is classified by the Centers for Medicare and Medicaid Services (CMS) as an IRF and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xx\)](#). Inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals or Critical Access Hospitals (CAHs) are collectively known as IRFs.

### 3.0 ISSUE

How are IRFs to be reimbursed?

### 4.0 POLICY

#### 4.1 Statutory Background

Under Title 10, United States Code (USC), Section 1079(i)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under the TRICARE program, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare." Based on this statutory provision, DHA has adopted Medicare's Prospective Payment System (PPS) for reimbursement of IRFs currently in effect for the Medicare program as required under Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law (PL) 105-33) 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 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 the patient into distinct groups based on clinical characteristic and expected resource needs. Separate payments are calculated for each group, including the application of case and facility-level adjustments.

## **4.2 Applicability And Scope Of Coverage**

All IRFs that meet the classification criteria for payment under the IRF PPS under Title 42 CFR Part 412, subpart B, are considered authorized IRFs under the TRICARE program.

## **4.3 Payment On A Per Discharge Basis.**

Under the PPS, IRFs receive a pre-determined amount per discharge for inpatient services furnished to TRICARE beneficiaries.

**4.3.1** Payment in full. The payment made under the IRF PPS represents payment in full (subject to applicable deductibles, cost-shares, and copayments) for inpatient operating and capital-related costs associated with furnishing TRICARE covered services in an IRF, but not for the cost of direct graduate medical education.

**4.3.2** In addition to payments based on prospective payment rates, IRFs receive payments for the following:

**4.3.2.1** Bad debt expenses, as provided in 42 CFR 412.622(b)(2)(i).

**4.3.2.2** A payment amount per unit for blood clotting factor provided to TRICARE inpatients who have hemophilia.

## **4.4 Elements of the TRICARE IRF PPS**

### **4.4.1 Rates**

**4.4.1.1** As required by the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related) other than costs associated with operating approved education activities as defined in 42 CFR Parts 413.75 and 413.85, bad debts, and other costs not covered under the PPS. Federal rates are adjusted to reflect:

**4.4.1.1.1** Patient case-mix, which is the relative resource intensity typically associated with each patient's clinical condition as identified through the patient assessment process:

**4.4.1.1.1.1** Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the IRF.

**4.4.1.1.1.2** Cases are further grouped into case-mix groups (CMGs), which group similar cases according to their functional motor and cognitive scores and age.

**4.4.1.1.1.3** 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).

**4.4.1.1.1.4** Additional adjustments are made for interrupted stays, short stays of less than three days, short stay transfers, and high-cost outlier cases.

**4.4.1.1.2 Facility Level Adjustment Factors:**

**4.4.1.1.2.1** Rates are adjusted to reflect geographic differences in wage rates, using the hospital wage index.

**4.4.1.1.2.2** Rates are further adjusted to account for a facility's proportion of low-income patients, teaching status, and rural area location.

**4.4.1.2** Federal rates are updated annually:

**4.4.1.2.1** To reflect inflation in the cost of goods and services used to produce IRF services using a market basket index calculated for freestanding and hospital-based IRFs.

**4.4.1.2.2** To reflect changes in local wage rates, using the hospital wage index.

**4.4.2 Classification Criterion**

**4.4.2.1** To be excluded from the TRICARE Diagnosis Related Group (DRG)-based payment system 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.

**4.4.2.2** One criterion specified at 42 CFR 412.29(b) that 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 412.20(b)(2). This minimum percentage is known as the compliance threshold, or the 60% rule. TRICARE is adopting Medicare's 60% requirement for IRFs.

**4.4.3 Patient Assessments**

**4.4.3.1 Admission Orders**

At the time that each patient is admitted, the IRF shall have physician orders for the patient's care during the time the patient is hospitalized.

**4.4.3.2 PAI**

Payment for services is contingent on the requirement that IRFs complete a PAI upon admission and discharge. IRFs shall use the CMS IRF-PAI as specified in 42 CFR 412.606 that covers a time period that is in accordance with the assessment schedule in 42 CFR 412.610.

**4.4.3.3 Comprehensive Assessments**

A clinician of the IRF shall perform a comprehensive, accurate, standardized, and reproducible assessment of each TRICARE inpatient as specified in 42 CFR 412.606(c).

**4.4.3.4 Coordination of the Collection of Patient Assessment Data**

A clinician of an IRF who has participated in performing the patient assessment shall accept

responsibility for the data as specified in 42 CFR 412.612.

#### **4.4.3.5 Transmission of Patient Assessment Data**

The IRF shall encode, i.e., enter data items into the fields of the computerized patient assessment software program, and transmit the patient assessment data for each inpatient based on the data requirements in 42 CFR 412.614. The IRF shall transmit the patient assessment data:

**4.4.3.5.1** Using the computerized version of the PAI available from CMS; or

**4.4.3.5.2** Using a computer program(s) that conforms to CMS' standard electronic record layout, data specifications, and data dictionary, includes the required PAI data set, and meets CMS' other specifications.

#### **4.4.3.6 Data Collection Software**

The Inpatient Rehabilitation Validation and Entry System (jIRVEN) was developed by CMS. jIRVEN is a free Java-based software application which provides an option for IRFs to collect and maintain PAI information. Facilities are able to enter and subsequently export their data from the application for submission to the appropriate national data repository.

**4.4.3.7** The IRF shall:

**4.4.3.7.1** Electronically encode all required data into the IRF-PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF-PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities. The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last 4 characters are numeric characters that represent the distinct CMG number. Free downloads of the jIRVEN software product, including the Grouper software, are available on the CMS web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html>.

**4.4.3.7.2** Electronically transmit complete, accurate, and encoded data from the PAI for each TRICARE patient to the national data repository.

**4.4.3.8** Once an IRF patient is discharged, the IRF submits a HIPAA compliant electronic claim, or a paper claim (UB-04) using the five-character CMG number assigned by the jIRVEN Grouper software when submitting claims for processing.

#### **4.4.3.9 Assessment Process for Interrupted Stays**

The IRF shall follow the assessment process for interrupted stays as specified in 42 CFR 412.614.

#### **4.4.4 Reasonable and Necessary Criteria**

In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements in 42 CFR 412.622(3)(i) through

(iv) at the time of the patient's admission to the IRF.

#### **4.4.4.1 Documentation.**

To document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in [paragraph 4.5.3](#) at the time of admission, the patient's medical record at the IRF must contain the documentation outlined in 42 CFR 412.622(4)(i) through (iii).

#### **4.4.4.2 Interdisciplinary Team Approach To Care**

In order for an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet the requirements in 42 CFR 412.622 (A) through (C).

### **4.5 Basis of Payment**

**4.5.1** For admissions prior to October 1, 2018, IRFs shall be reimbursed based on billed charges or negotiated rates.

**4.5.2** For admissions on or after October 1, 2018, inpatient services provided in IRFs shall be reimbursed in accordance with Medicare's IRF PPS as found in Title 42 CFR, Part 412, Subpart P. IRF PPS payments will be made on the basis of prospectively determined rates and applied on a per discharge basis.

**4.5.3** To the extent practicable, in accordance with 10 USC 1079(i)(2), TRICARE will adopt Medicare's IRF PPS methodology, to include Medicare's relative weights, payment rates, adjustments for the 60% compliance threshold, and high cost-outlier payments.

**4.5.4** TRICARE is adopting Medicare's IRF adjustments for interrupted stays, short stays of less than three days, short-stay transfers, teaching adjustments, rural adjustments, and the Low Income Payment (LIP) adjustment.

**4.5.5** TRICARE is also adopting Medicare's IRF Quality Reporting Program (IRFQRP) payment adjustments for TRICARE-authorized IRFs that reflect Medicare's annual payment update for that facility. TRICARE is not establishing a separate reporting requirement for hospitals, but will utilize Medicare's payment adjustments resulting from their IRFQRP.

**4.5.6** IRF PPS Pricer Software. CMS has developed an IRF Pricer Program that calculates the IRF payment rate. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, outlier payments, and the teaching status adjustment.

**4.5.7** CMS' IRF PPS Pricer software is available for download at the bottom of the following web page: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/software.html>.

#### **4.6 QRP**

TRICARE will apply the same QRP reductions as Medicare.

#### **4.7 Transition Period**

In the Final Rule (FR) published in the **Federal Register** on December 29, 2017, DHA created a multi-year transition period to buffer the impact from any potential decrease in revenue that rehabilitation facilities may experience during the implementation of a revised IRF inpatient payment system. This transition period provides IRFs with sufficient time to adjust and budget for potential revenue reductions. The transition is as follows:

**4.7.1** For the first 12 months following implementation, the TRICARE IRF PPS allowable cost will be 135% of Medicare IRF PPS amounts.

**4.7.2** For the second 12 months following implementation, the TRICARE IRF PPS allowable cost will be 115% of the Medicare IRF PPS amounts.

**4.7.3** For the third 12 months following implementation, and subsequent years, the TRICARE IRF PPS allowable cost will be 100% of the Medicare IRF PPS amounts.

#### **4.8 General Temporary Military Contingency Payment Adjustment (GTMCPA) Payments**

The Director, DHA, or designee, may approve a GTMCPA payment based on all of the following criteria:

**4.8.1** The IRF serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM), i.e., 10% or more of an IRF's total admissions are for ADSMs and ADFMs.

**4.8.2** The IRF is a TRICARE network hospital.

**4.8.3** The IRF's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and

**4.8.4** Without the GTMCPA, the Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

#### **4.9 Billing and Coding Requirements**

**4.9.1** Once an IRF patient is discharged, the IRF shall submit a Healthcare Insurance Portability and Accountability Act (HIPAA) compliant electronic claim, or a paper claim (UB-04) using the five-character CMG number when submitting claims for processing. In addition to all entries previously required on a claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF PPS.

**4.9.2** The IRF shall bill using Bill Type **11X** along with Revenue Code **0024**.

**4.9.3** Contractors shall process the claim using Type Of Institution **46** for IRFs.

**4.9.4** The contractors shall use Pricing Rate Code (PRC) **CI** for CAH IRF reimbursement and **RF** for all other IRF reimbursement.

#### **4.10 Direct Medical Education**

DHA will reimburse IRFs who file a request for their direct medical education costs in a timely manner, as outlined in Chapter 6, Section 8. Although the procedures listed in Chapter 6, Section 8 pertain to DRGs, those same procedures are to be used to reimburse IRFs for direct medical education costs.

#### **5.0 EXCLUSIONS**

**5.1** The TRICARE IRF PPS methodology does not apply to hospitals in States that are reimbursed by Medicare and TRICARE under a waiver that exempts them from Medicare's Inpatient Prospective Payment System (IPPS) or the TRICARE DRG-based payment system.

**5.2** Children's hospitals are excluded from the TRICARE IRF PPS methodology.

**5.3** Department of Veterans Affairs (VA) hospitals are excluded from the TRICARE IRF PPS methodology.

**5.4** The IRF PPS reimbursement method does not apply to any costs of physician services or other professional services provided to IRF patients.

#### **6.0 EFFECTIVE DATE**

Implementation of the IRF PPS reimbursement method for inpatient services is effective for admissions on or after October 1, 2018.

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