

Chapter 17

Section 1

Inpatient Rehabilitation Facilities (IRFs)

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Authority: [32 CFR 199.14\(a\)\(10\)](#)

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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. DHA 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 a CMS approved IRF-PAI software product. This may include jIRVEN, which is provided to IRFs for free on the CMS web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html>. jIRVEN provides an option for IRFs to collect and maintain IRF-PAI information on any IRF patients. The jIRVEN software product allows the IRF to enter data for each patient into the program and create an electronic IRF-PAI for each patient. The IRF would import the IRF-PAI data for the TRICARE patient into the jIRVEN system to produce a report that includes a distinct five-character CMG number for the patient which accounts for the existence of any relevant comorbidities. The first character of the CMG number is an alphabetic character that indicates the comorbidity tier. The last four characters of the CMG number are numeric characters that represent the distinct CMG number. The IRFs shall indicate this CMG reported for the TRICARE patient IRF-PAI report on the TRICARE claim.

4.4.3.7.2 For TRICARE Medicare-eligible patients, electronically transmit complete, accurate, and encoded data from the PAI for each TRICARE patient to the national data repository. An IRF may also attempt to electronically submit the PAI to CMS data repository for non-Medicare-eligible TRICARE patients, however, this data may or may not be accepted. Transmittal of the TRICARE patient's IRF-PAI does not affect TRICARE payment.

4.4.3.8 Once a TRICARE IRF patient is discharged, the IRF submits a Healthcare Insurance Portability and Accountability Act (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 shall 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 shall 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 shall 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), DHA 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 DHA 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 DHA 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. DHA is not establishing a separate reporting requirement for IRFs, but will utilize Medicare's payment adjustments resulting from their IRFQRP that are included in the IRF-PPS Pricer.

4.5.6 IRF PPS Pricer Software. CMS has developed an IRF Pricer Program that calculates the IRF payment rate for each case. 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 following web page: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/IRF.html>. The contractors shall use the IRF PPS Pricer to calculate the appropriate IRF payment for the TRICARE patient.

4.6 QRP

DHA 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

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

4.8.1.1 The IRF serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs), i.e., 10% or more of an IRF's total inpatient admissions are for ADSMs and ADDs.

4.8.1.2 The IRF is a TRICARE network hospital.

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

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

4.8.2 Following is the GTMCPA Payment Process for TRICARE IRFs.

4.8.2.1 The IRF shall submit a request for a discretionary GTMCPA payment to their regional Managed Care Support Contractor (MCSC). The request shall be made to the contractor within 12 months of the end of the IRF year (October 1 through September 30) for which the IRF is requesting a GTMCPA payment. For example, an IRF shall submit a request for a GTMCPA payment for the IRF year ending September 30, 2019, by September 30, 2020. Late submissions or requests for extensions shall not be considered.

4.8.2.2 The IRF shall submit the following information to the contractor for review and consideration:

- Their IRF-specific Medicare provider number.
- The total number of IRF admissions (from all payers) during the 12-month period in the previous TRICARE IRF year and the total number of TRICARE ADSM and ADD admissions in this same period. An IRF shall not include TRICARE Non-Active Duty Service Member (NADSM) or Non-Active Duty Family Member (NADFM) admissions (i.e., TRICARE retiree or TRICARE retiree dependents), TRICARE for Life (TFL) beneficiary admissions, overseas beneficiary admissions, or TRICARE beneficiary admissions with Other Health Insurance (OHI). TRICARE Uniformed Services Family Health Plan (USFHP) ADSM and ADD IRF admissions may be included in the IRF's submission if the stays were paid utilizing the IRF-PPS Reimbursement System, however, these admissions shall be separately identified as TRICARE USFHP admissions by the IRF.
- The total billed and paid amounts for all TRICARE IRF admissions paid by the IRF PPS at the IRF during the 12-month period, excluding TRICARE OHI and TRICARE USFHP admissions. This includes non-OHI claims for ADSMs, ADDs, and retirees and their dependents.

4.8.2.3 The contractor shall perform a thorough evaluation of the IRF's request in [paragraph 4.8.2.2](#). The evaluation shall consist of the following:

4.8.2.3.1 The contractor shall evaluate the IRF's package for completeness. The contractor shall verify the IRF has provided all components in [paragraph 4.8.2.2](#).

4.8.2.3.2 The contractor shall perform a validation that the IRF meets the disproportionate share criteria (as stated in [paragraph 4.8.1](#)). The contractor shall independently calculate the number of TRICARE ADD/ADSM IRF admissions, utilizing the contractor's data systems, and divide it by the total number of IRF admissions (from all payers) reported by the IRF in [paragraph 4.8.2.2](#). The contractor shall compare this result to the IRF's submission in [paragraph 4.8.2.2](#) to ensure the hospital met the disproportionate share criteria in [paragraph 4.8.1](#). The contractor shall work with the IRF to resolve discrepancies in the reported data prior to submission of the request to DHA if the IRF's data show that they qualify, but the contractor's data show that they do not.

4.8.2.3.3 The contractor shall perform an evaluation to determine if the IRF is essential for continued network adequacy and is necessary to support military contingency mission requirements. The contractor shall report the following data elements for the prior IRF year, i.e., the year prior to the requested GTMCPA, as well as provide a brief narrative with supporting rationale, describing why the IRF is essential for continued network adequacy and why a GTMCPA payment is necessary to maintain this continued network adequacy.

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- 4.8.2.3.3.1** Number of IRFs and IRF beds in the network locality;
 - 4.8.2.3.3.2** Efforts that have been made to create an adequate network;
 - 4.8.2.3.3.3** Availability of IRF services in the locations or nearby; and
 - 4.8.2.3.3.4** Other cost effective alternatives and other relevant factors.

4.8.2.3.4 If the contractor's independent analysis shows that: (1) the IRF met the disproportionate share criteria; and (2) the IRF is essential for continued network adequacy, the contractor shall submit all documentation in [paragraphs 4.8.2.2](#) and [4.8.2.3.3](#) to the Chief, MCSC Program. If the IRF fails to meet the disproportionate share criteria or is not essential for continued network adequacy, the contractor shall notify the Chief, MCSC Program of their findings, but shall not submit the full request for a GTMCPA payment to the Chief, MCSC Program unless requested by the Chief, MCSC Program.

4.8.3 The Chief, MCSC Program will perform a thorough review and analysis of the IRF's submission and the contractor's review, utilizing any DHA data the Chief, MCSC Program deems necessary, to determine if the IRF meets the four criteria listed in [paragraph 4.8.1](#) and qualifies for a GTMCPA payment. If the IRF qualifies, the GTMCPA payment shall be set by the contractor utilizing DHA and CMS data so that the IRF's Payment-to-Cost Ratio (PCR) for TRICARE IRF services does not exceed a ratio of 1.15. The TRICARE IRF PCR shall be calculated using the IRF's Medicare Cost-To-Charge Ratio (CCR) in the most recent version of the CMS IRF Provider Specific File (PSF). If a freestanding TRICARE IRF does not have a Medicare IRF-specific CCR in the PSF, the contractor shall calculate an average CCR based on the Medicare IRF CCRs in the most recent PSF file, weighted by total number of TRICARE cases in each IRF in the contractor's region during the relevant period. If a specialty IRF unit in an acute care hospital does not have a Medicare IRF unit-specific CCR, then the contractor shall use the Medicare CCR for the co-located acute care hospital to determine the IRF's TRICARE costs. An IRF shall not be approved for a GTMCPA if the payment would result in the IRF's PCR exceeding 1.15. The Chief, MCSC Program will forward their recommendation for approval of the GTMCPA payment and the recommended percentage adjustment to the Director, DHA. Disapprovals by the DTRO will not be forwarded to the Director, DHA, for review and approval. The PCR shall be calculated as follows:

- Step 1:** Determine the IRF's total TRICARE payments in the 12-month period, excluding TRICARE OHI and USFHP claims. The IRF GTMCPA payment is specific to the IRF PPS reimbursement system and there is no authority to include non-IRF PPS paid amounts in the PCR calculation.
- Step 2:** Determine the IRF's estimated TRICARE costs by identifying the TRICARE billed charges for all non-OHI, non-USFHP TRICARE IRF admissions. The contractor shall then multiply the IRF's total TRICARE billed charges for these beneficiaries during the 12-month period by the Medicare IRF-specific CCR (as determined in [paragraph 4.8.3](#)).
- Step 3:** Divide Step 1 (total TRICARE non-OHI, non-USFHP IRF payments in the 12-month period) by Step 2 (total TRICARE non-OHI, non-USFHP IRF estimated costs in the 12-month period).
- Step 4:** If the amount in Step 3 is lower than 1.15 the IRF may receive a GTMCPA payment so that the IRF's total TRICARE payments in the 12-month period are equal to or less than

115% of their TRICARE costs in the same period. The percentage used is at the discretion of the Director, DHA, or designee.

4.8.4 TRICARE IRF payments (non-OHI, non-USFHP) for the qualifying IRF will be increased by the Director, DHA, or designee, at his/her discretion by way of an additional GTMCPA payment after the end of the TRICARE IRF year (October 1 through September 30). Subsequent adjustments to the GTMCPA payment will be issued to the qualifying IRF for the prior IRF year, when requested by the IRF, to ensure claims that were paid-to-completion the previous year are adjusted. These adjustments are separate from the applicable GTMCPA payment approved for the current IRF year.

4.8.5 Upon approval of the GTMCPA payment request by the Director, DHA, or designee, the Chief, MCSC Program will notify the Contracting Officer (CO) who will send a letter to the contractor notifying them of the GTMCPA payment approval.

4.8.6 The contractor shall process the GTMCPA payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TRICARE Encounter Data (TEDs), Demonstrations. No GTMCPA payments shall be sent out without approval from DHA-Aurora (DHA-A), Contract Resource Management (CRM), budget.

4.8.7 DHA will send an approval to the contractors to issue GTMCPA payments out of the non-financially underwritten bank account based on fund availability.

4.8.8 GTMCPA payments will be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the Chief, MCSC Program in order to determine if the IRF continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

4.8.9 The Director, DHA, or designee is the final approval authority for GTMCPA payments. A decision by the Director, DHA, or designee to approve, reject, adopt, modify, or extend GTMCPA payments is not subject to the appeal and hearing procedures in [32 CFR 199.10](#).

4.8.10 DHA, upon request, will provide the detailed IRF claims data and Medicare CCR used to calculate the IRF's PCR and maximum GTMCPA payment, if any, to the requesting IRF through the contractor.

4.8.11 GTMCPAs may be extended to IRF facilities that have changed their network status during the IRF GTMCPA year. If an IRF network facility changes their status during the IRF year, and the facility was and remained a network facility that is essential for military readiness, contingency operations, and network adequacy and the facility served a disproportionate share of ADSMs and ADDs during the period of the year it was subject to IRF reimbursement, then a prorated IRF GTMCPA may be authorized. Any IRF adjustment will only apply to IRF payments.

4.9 Billing and Coding Requirements

4.9.1 Once an IRF patient is discharged, the IRF shall submit a 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 shall 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 DHA 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 (DVA)/Veterans Health Administration (VHA) 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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