



WISCONSIN HOSPITAL
ASSOCIATION

**SUMMARY OF THE FINAL
FFY 2010 MEDICARE
INPATIENT REHABILITATION
FACILITY RULE**

August 2009

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I. OVERVIEW

CMS published the final Medicare IRF PPS rule for federal fiscal year (FFY) 2010 in the August 7, 2009 *Federal Register*. Changes are effective October 1, 2009, unless otherwise noted.

Note: Text in italics is extracted from either the May 6, 2009 or August 7, 2009 *Federal Register*.

Major Provisions of the Final Rule:

- **Coverage Requirements:** CMS has adopted, as proposed with some modifications, specific IRF coverage requirements. Some of the changes include:

- require as an admission criterion that the patient can actively participate in an intensive rehabilitation program, with an expectation that measurable improvements will occur in a patient's functional capacity or adaptation to impairments;
- require that IRF services be ordered by a rehabilitation physician with specialized training and experience in rehabilitation services and be coordinated by an interdisciplinary team;
- require that an interdisciplinary team meet weekly to review a patient's progress and to make any modifications necessary to the patient's overall plan of care; and
- require a post-admission evaluation to document the status of the patient after admission to the IRF, and require the comparison of this to the pre-admission documentation. Based on this information, facilities can begin to develop a patient's overall plan of care by the end of the fourth day after a patient's admission. CMS did not adopt as proposed the requirement that a rehabilitation physician needs to consult with the interdisciplinary team when developing the post-admission evaluation.

CMS will delay implementation of the adopted coverage policies until January 1, 2010 to allow IRFs time to adjust internal processes and procedures to accommodate these new policies.

- **Marketbasket Update:** CMS will provide a full marketbasket update of 2.5% for FFY 2010. After applying the marketbasket update and several budget-neutrality adjustments, the final FFY 2010 standard payment conversion factor would increase from \$12,958 in FFY 2009 to \$13,661 in FFY 2010.

- **Facility-Level Adjustments:** CMS has finalized its proposal to update the facility-level adjustments for rural IRFs, low-income patients (LIPs), and teaching IRFs for FFY 2010 based on a three-year average using Medicare claims and cost report data for FFYs 2006, 2007, and 2008. The revised adjustments adopted by CMS would:

- decrease the rural adjustment from 21.3% in FFY 2009 to 18.4% in FFY 2010;
- decrease the LIP adjustment from 0.6229 in FFY 2009 to 0.4613 in FFY 2010; and
- decrease the teaching adjustment from 0.9012 in FFY 2009 to 0.6876 in FFY 2010. CMS states that the teaching adjustment is significantly lower than the originally proposed adjustment of 1.0494 due to the extreme volatility that occurs year-to-year based on more recent data.

- **Outlier Threshold:** The outlier threshold increases from \$10,250 in FFY 2009 to \$10,652 in FFY 2010.

- **Compliance Threshold:** CMS has adopted its proposal to require that IRFs submit IRF Patient Assessment Instrument (PAI) data on all Medicare Advantage patients beginning October 1, 2009. These data will be included in the calculation for determining whether facilities meet the required threshold under the presumptive methodology.

II. LEGISLATIVE MANDATES

The final FFY 2010 IRF PPS rule included a series of payment policy changes that addressed Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) mandates. Most important, MMSEA rolled back the phase-in of the “75% rule”, a requirement that at least 75% of admissions to an IRF meet one of 13 specified conditions. MMSEA lowered the threshold permanently to 60% and allows comorbid conditions to count toward that threshold.

III. STANDARD PAYMENT CONVERSION FACTOR

Marketbasket Update

Federal Register pages 39775 - 39778

Background: In FFY 2006, CMS adopted the rehabilitation, psychiatric, and long-term care (RPL) hospital marketbasket to reflect the operating and capital cost structures for IRFs, long-term care hospitals (LTCHs), and inpatient psychiatric facilities (IPFs). This methodology is now used to update all three of those payment systems.

CMS’ Final Rule: For FFY 2010, CMS will provide an “. . . IRF marketbasket increase factor . . . 2.5 percent.” This is based on “. . . IHS Global Insight, Inc. forecast for the second quarter of 2009 of the 2002-based RPL marketbasket.”

Calculation of the FFY 2010 Standard Payment Conversion Factor

Federal Register pages 39779 - 39786

Final FFY 2009 Standard Payment Conversion Factor	\$12,958
Final FFY 2010 Adjustments:	
- RPL Marketbasket	1.0250
- Budget-Neutrality Factors:	
- Wage Index and Labor-related Share	1.0011
- Revisions to the CMG Relative Weights	1.0020
- Rural Adjustment Factor	1.0023
- LIP Adjustment Factor	1.0192
- Teaching Status Adjustment Factor	1.0037
Final FFY 2010 Standard Payment Conversion Factor:	\$13,661

IV. IRF PROGRAM REQUIREMENTS

IRF Coverage and Payment Requirements

Federal Register pages 39788 - 39798

Before introduction of the Inpatient PPS (IPPS), hospital care was reimbursed on a cost basis. When Medicare patients required rehabilitation services in addition to treatment of the acute care condition for which they were hospitalized, the program paid for those services as part of the same inpatient hospital stay. After the introduction of the IPPS and the creation of Diagnosis Related Groups (DRGs), CMS realized that DRGs did not address the variability of the rehabilitation portion of the hospital stay. Beginning in 1983, CMS developed post-acute hospital level rehabilitation services, which were excluded from IPPS payments and reimbursed at cost. The Balanced Budget Act of 1997 required CMS to implement a PPS for inpatient rehabilitation hospitals and units, effective for cost report periods beginning on or after January 1, 2002.

Rehabilitation services of varying intensity and duration are beneficial to patients with a broad range of conditions, and can be provided in a variety of other settings. By 2007, IRFs were treating more patients for orthopedic rather than neurological conditions. CMS has determined that the existing IRF payment requirements and instructions do not always distinguish between complex, high-intensity rehabilitation care and rehabilitation care in a less intensive setting. To address these concerns, CMS created an internal workgroup and received comments from providers that have been taken into consideration for FFY 2010.

MMSEA mandated that the Secretary of Health and Human Services (HHS) evaluate IRF access and utilization issues to address the increasingly high denial rates for Medicare IRFs arising from differing stakeholders' interpretations of IRF medical necessity. CMS does not include the findings from its review in the final rule; a formal report will be included in the agency's report to Congress.

IRF Service Requirements

CMS requires IRFs to provide rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services, ordered by a rehabilitation physician and delivered by qualified personnel.

Interdisciplinary Team

The "interdisciplinary team" approach in delivering care requires that treating clinicians interact with each other and the patient, and together define a set of coordinated goals for that IRF stay. Currently, IRFs use the "multidisciplinary team" approach, which requires only clinicians representing various rehabilitation disciplines to individually work with the patient to achieve an optimal level of care. However, the multidisciplinary team approach does not provide the patient the benefits of coordinated care offered in IRFs.

CMS' Proposal: For FFY 2010, CMS proposed ". . . *that the IRF shall ensure that each patient's treatment is managed using a coordinated interdisciplinary approach to treatment.*"

CMS' Final Rule: For FFY 2010, CMS has adopted the above proposal as final with the requirement that an interdisciplinary team meet weekly to review a patient's progress and to make any modifications necessary to the patient's overall plan of care.

IRF Admission Requirements

CMS believes that a comprehensive preadmission screening process is the key factor in identifying appropriate candidates for IRF care. Therefore, for FFY 2010 CMS proposed ". . . *to clarify our expectations regarding the scope of the preadmission assessment, and to require documentation of the clinical evaluation process that must form the basis of the admission decision.*"

CMS' Proposal: For FFY 2010, CMS proposed three requirements that a patient must meet to be admitted to an IRF. These requirements focused on the medical stability of an IRF patient, the types of rehabilitation therapy needs for that patient, when to begin, and the level of intensity of therapy services.

CMS' Final Rule: For FFY 2010, CMS has adopted the above requirements as final with some modifications and provided clarification in the final rule as outlined below.

- **Patient's Medical Stability**—CMS clarifies that in an IRF, the “. . . *patient's medical condition be such that it can be successfully managed in the IRF setting at the same time that the patient is participating in the intensive rehabilitation therapy program provided in an IRF.*”
- **Types and Intensity of Rehabilitation Therapies**—CMS specifies, “. . . *at the time of admission to the IRF, there must be a reasonable expectation that the patient is able to tolerate and benefit from the intensive rehabilitation services as generally prescribed in this rule*” CMS outlines that there are “. . . *primary types of therapy services provided in an IRF (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics therapy)*” and that “. . . *the intensity of these services is typically demonstrated in IRFs by the provision of intensive therapies at least three hours per day at least five days per week.*”

CMS also states that there are other therapies such as recreational, music, and respiratory therapies that may be appropriate for certain IRF patients but that these services are considered an adjunct to the primary types of therapies. CMS notes there is flexibility in measuring “intensive therapy” as being outside of the conventional (three hours per day for five days) measure, “. . . *as long as the reasons for the patient's periodic need for this program of intensive rehabilitation is well-documented in the patient's medical record and the overall amount of therapy is 'intensive' and can be reasonably expected to benefit the patient.*”

- **Initiation of Therapy**—CMS includes a requirement of IRFs to begin therapy “. . . *within 36 hours from midnight of the day of admission . . .*” to the IRF. CMS indicates that it is unreasonable to expect patients admitted on Friday, to wait over an entire weekend for their therapy to begin, given the typical short lengths of stay in an IRF.

CMS adds that the facility ensures there is a reasonable expectation that each admission meets the requirements by assuring “. . . *the detailed reasoning behind this reasonable expectation must be documented in the preadmission screening, and that it must be supported by the information in the post-admission physician evaluation and the overall individualized plan of care.*”

Pre-Admission Screening

CMS believes that it is important to capture the pre-admission screening information as close to the actual time of the IRF admission as possible to provide reliable information of the patient's condition at the time of admission.

CMS' Proposal: CMS proposed that the preadmission screening be conducted within 48 hours preceding the IRF admission.

CMS' Final Rule: CMS agreed with comments that such a requirement could preclude IRFs from performing preadmission screenings early in a patient's acute stay. Therefore, for FFY 2010, CMS is “. . . *changing the requirement to allow for a comprehensive preadmission screening that includes all of the required elements to be performed more than 48 hours immediately preceding the IRF admission, as long as*

an update is conducted in person or by telephone within 48 hours prior to the admission and documented in the patient's medical record to update the patient's medical and functional status."

Post-Admission Physician Evaluation

The purpose of the post-admission physician evaluation is to document a patient's status on admission to the IRF, compare it to the pre-admission screening documentation, and begin development of the patient's expected course of treatment.

CMS' Proposal: For FFY 2010, CMS proposed to require ". . . *post-admission evaluation by a rehabilitation physician within 24 hours of admission,*" that included ". . . *input from the interdisciplinary team.*"

CMS' Final Rule: For FFY 2010, CMS continues to require a post-admission physician evaluation be conducted ". . . *by a rehabilitation physician within 24 hours of the patient's admission . . .*", but is ". . . *removing the requirement that the rehabilitation physician obtain input from the interdisciplinary team in completing the post-admission physician evaluation.*"

Plan of Care and Interdisciplinary Team Conference

CMS' Proposal: For FFY 2010, CMS proposed ". . . *an individualized overall plan of care be developed for each IRF admission by a rehabilitation physician with input from the interdisciplinary team within 72 hours of the patient's admission to the IRF, and be retained in the patient's medical record.*"

CMS' Final Rule: CMS agreed with commenters that requiring completion of the plan of care before the IRF patient assessment instrument completion deadline of the fourth day following admission was not appropriate. Therefore, for FFY 2010 CMS is ". . . *requiring that the overall plan of care be completed by the end of the fourth day following the patient's admission to the IRF. . .*" CMS states that the plan of care can be developed in a variety of ways that do not require convening an interdisciplinary team conference at the same time, ". . . *as long as all of the required elements for the overall plan of care are present in the patient's medical record.*" CMS continues to require that the first team conference occur ". . . *within the first week of the patient's admission to the IRF.*"

CMS refers IRF providers ". . . *to section 110 of the Medicare Benefit Policy Manual, once the revisions that we anticipate issuing on January 1, 2010 have been published, for more specific guidance on what type of information to include when documenting an individualized overall plan of care.*"

HCFAR 85-2 Ruling

CMS' Proposal: For FFY 2010, CMS proposed to rescind the Health Care Financing Administration Ruling (HCFAR) since this document is inconsistent with the current payment system.

CMS' Final Rule: For FFY 2010, CMS has adopted the above proposal as final; however, CMS realized that the recession needs to be done through issuance of a notice in the *Federal Register*. Therefore, CMS plans to do so at a future date, notifying the public of this change effective for discharges on or after January 1, 2010.

V. PATIENT CLASSIFICATION SYSTEM

IRF Patient Classification System

Federal Register pages 39765 - 39773

Background: Before FFY 2006, IRF PPS payments were based on 100 distinct case-mix groups (CMGs). Patients were first categorized into one of 21 rehabilitation impairment categories (RICs) based on the primary reason for rehabilitative care. From there, patients were further categorized into CMGs within the RICs based upon their ability to perform activities of daily living or based on age and cognitive ability. There were 95 CMGs derived using this categorization and another five CMGs to account for very short stays and patients who expire in the IRF. Within each of the 95 CMGs, there were four tiers, each with a different relative weight, which was determined based on comorbidities.

In the FFY 2006 final rule, CMS adopted major revisions to the IRF PPS based on analyses by RAND Corporation, using data provided by IRFs after the implementation of the IRF PPS. Although CMS kept the same basic structure to the payment system as described above, substantial modifications were made to the CMGs, tier comorbidities, and relative weights, causing a significant redistributive affect among IRFs.

Currently, there are 87 CMGs with four tiers and another five CMGs to account for very short stays and patients who expire in the IRF. CMS calculates CMG weights and average length of stay (ALOS) using IRF PPS claims data. In FFY 2009, CMS began using cost-to-charge ratios (CCRs) specific to IRF sub-providers in calculating CMG weights. However, for freestanding IRFs, CMS continues to use the CCR data from the freestanding IRF's cost reports.

CMS' Final Rule: For FFY 2010, CMS is “. . . updating the CMG relative weights and average length of stay values for FY 2010 . . . using FY 2008 IRF claims and FY 2007 IRF cost report data.”

VI. COMPLIANCE THRESHOLD REQUIREMENTS

Federal Register pages 39798 - 39800

Background: Prior to the enactment of MMSEA, CMS required hospitals to meet the “75% rule,” which determined whether a hospital or unit of a hospital qualified as an IRF. According to the rule, at least 75% of a facility's total inpatient population must be diagnosed with one of 13 pre-established medical conditions for that facility to be classified as an IRF. This minimum percentage is known as the “compliance threshold.”

When MMSEA was enacted, it revised the 75% rule requirements and established that the compliance threshold could be no greater than 60%, with the continued use of comorbidities as qualifying conditions.

CMS provided two methodologies that could be used to calculate an IRF's compliance percentage. The first method is referred to as the “presumptive methodology.” If a facility's Medicare Part A fee-for-service inpatient population is at least 50% or more of the facility's total inpatient population, then the compliance percentage can be calculated by taking the total number of IRF-PAIs for patients diagnosed with at least one of the 13 medical conditions, divided by the total number of IRF-PAIs submitted by the facility.

If a facility does not meet the criteria under the “presumptive methodology,” then the second methodology known as the “medical review methodology” is applied. This method uses a sample of medical records from the facility's total inpatient population to estimate the facility's compliance percentage. The “medical review methodology” is time-consuming and labor-intensive.

Since 2004, there has been an increased enrollment of Medicare beneficiaries into Medicare Advantage (MA) plans, which has led to decreases in the Medicare Part A fee-for-service program. As a result, many IRFs are unable to benefit from the “presumptive methodology” requirements. Currently, IRFs are not required to submit IRF-PAI data on MA patients.

CMS’ Proposal: For FFY 2010, CMS proposed “. . . to require that IRFs submit IRF-PAI data on all of their MA patients to facilitate better calculations under the 60 percent rule.”

For IRFs that fail to submit all MA IRF PAIs data, CMS proposed “. . . forfeiture of the facility’s ability to have any of its Medicare Part C data used in the calculations”

In addition, CMS proposed to “. . . preserve the long-standing five-year record retention requirement for the IRF-PAIs completed on Medicare Part A fee-for-service patients . . . but we are proposing a 10-year record retention requirement for IRF-PAIs completed on Medicare Part C (Medicare Advantage) patients to maintain consistency with the record retention requirements for Medicare Part C data”

CMS’ Final Rule: For FFY 2010, CMS has adopted the above proposal as final without modification.

VII. FACILITY-LEVEL ADJUSTMENTS

Wage Index

Federal Register pages 39778 - 39779

Background: The labor-related portion of the standard payment conversion factor is adjusted for differences in area wage levels using a wage index. The wage index for IRFs is calculated using acute inpatient PPS wage data, without geographic reclassifications, and without applying the rural floor. This is the same wage index that is used for skilled nursing facilities, inpatient psychiatric facilities, and home health agencies.

CMS’ Final Rule: For FFY 2010, CMS “. . . continues to use the Core-Based Statistical Area (CBSA) labor market area definitions and the pre-reclassification and pre-floor hospital wage index data based on 2005 cost report data.”

Based on the relative weights from the RPL marketbasket, CMS increased the labor-related share from 75.464% in FFY 2009 to 75.779% in FFY 2010.

Low-Income Patient Adjustment

Federal Register pages 39773 - 39775

Background: Currently, IRFs receive an adjustment to their standard payment conversion factor to account for the cost differences associated with the treatment of low-income patients. The formula used to calculate the low-income patient (LIP) adjustment is:

(1 + DSH patient percentage) raised to the power of 0.6229 where the DSH patient percentage is defined as:

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

The current LIP multiplier of 0.6229 was calculated using cost report data from FFY 2003.

CMS' Proposal: For FFY 2010, CMS proposed to use the average of the most recent three years of IRF data (FFY 2005, FFY 2006, and FFY 2007) to calculate a proposed LIP multiplier of 0.4372. The LIP multiplier will be used in the LIP adjustment formula, using each facility's data for the most recent cost report year.

CMS' Final Rule: For FFY 2010, CMS will apply a LIP multiplier of 0.4613, based on the most recent three years of IRF data (FFY 2006, FFY 2007, and FFY 2008).

Rural Location Adjustment

Federal Register pages 39773 - 39775

Background: Currently, rural IRFs receive an adjustment to their standard payment conversion factor to account for the cost differences associated with the treatment of patients in rural areas. Based on an analysis performed by Rand Corporation in FFY 2006, CMS determined that rural IRFs continue to have higher costs associated with caring for Medicare patients than their urban counterparts, and CMS increased the rural adjustment from 19.14% to 21.3%. The current adjustment factor of 21.3% was calculated using Cost Report data from FFY 2003.

CMS' Proposal: For FFY 2010, CMS proposed to use the average of the most recent three years of IRF data (FFY 2005, FFY 2006, and FFY 2007) to calculate a proposed rural adjustment of 18.27%.

CMS' Final Rule: For FFY 2010, CMS will apply a rural adjustment of 18.4%, based on the most recent three years of IRF data (FFY 2006, FFY 2007, and FFY 2008).

Teaching Status Adjustment

Federal Register pages 39773 - 39775

Background: In FFY 2006, CMS adopted an adjustment to account for the higher *indirect* operating costs experienced by IRFs that participate in Graduate Medical Education (GME) programs. Before FFY 2006, only payments for Direct GME were provided to IRFs. The adjustment is calculated using the ratio of interns and residents assigned to the IRF to the average daily census (ADC) for the IRF. The IRF PPS teaching payment adjustment is:

$$(1 + [(Interns + Residents)/ADC]) \text{ raised to the power of } 0.9012.$$

The current teaching status adjustment multiplier of 0.9012 was calculated using cost report data from FFY 2003.

An example of the calculation of the teaching adjustment is shown below. In this case, the IRF would receive a 16.31% increase in its per-discharge payments:

IRF ADC:	$4,000 \text{ (total IRF patient days)} / 365 = 10.96$
IRF Interns and Residents per ADC:	$2.0 \text{ (residents)} / 10.96 = 0.1825$
IRF Teaching Adjustment:	$(1 + 0.1825)^{0.9012} = 1.1631$

CMS will continue to cap the number of IRF residents, similar to the cap that limits increases in residents under the inpatient and inpatient psychiatric facility (IPF) PPSs. An IRF's full-time equivalent resident cap is determined based on the final settlement of the IRF's most recent cost report period ending on or before November 15, 2004—this policy is consistent with the IPF PPS. Residents with less than full-time status and residents rotating through the IRF for less than a full year will be counted in proportion to the time they spend in their assignment with the IRF. CMS will not allow IRFs to aggregate the full-time equivalent resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. For purposes of determining the teaching adjustment under the IRF PPS, the number of residents cannot exceed the number of residents in the facility's base year.

CMS' Proposal: For FFY 2010, CMS proposed to use the average of the most recent three years of IRF data (FFY 2005, FFY 2006, and FFY 2007) to calculate a proposed teaching status adjustment multiplier of 1.0494.

CMS' Final Rule: For FFY 2010, CMS will apply a teaching adjustment of 0.6876, based on the most recent three years of IRF data (FFY 2006, FFY 2007, and FFY 2008). CMS states that this adjustment is “. . . significantly lower than the teaching status adjustment factor that we calculated in the proposed rule (1.0494). This is due to the relatively large year-to-year fluctuations in the teaching status adjustment factor”

VIII. CASE-LEVEL ADJUSTMENTS

Cost Outliers

Federal Register pages 39786 - 39788

Background: Facilities qualify for IRF PPS outlier payments if the estimated cost of the case (measured by applying a facility's CCR to the charges for the discharge) exceeds a fixed-loss threshold (which equals the CMG payment for the case plus an outlier threshold).

CMS establishes the outlier threshold amount each year such that estimated outlier payments equal 3% of total estimated IRF PPS payments.

CMS' Proposal: For FFY 2010, CMS proposed to “. . . update the outlier threshold amount to \$9,976 to maintain estimated outlier payments at 3% of total estimated aggregate IRF payments. . . .”

CMS' Final Rule: For FFY 2010, “. . . we are finalizing our decision to update the outlier threshold amount . . . to \$10,652.” “. . . we are adjusting the outlier threshold amount in this final rule solely to account for the 2.5 percent market basket adjustment . . . and the FY 2010 updates to the facility-level adjustment . . . so that we will continue to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF

payments for FY 2010.” CMS used “. . . the most recent available data to estimate the IRF outlier threshold amount for FY 2010, and have therefore used the FY 2008 IRF claims data”

IRF Cost-to-Charge Ratio Ceilings

Federal Register pages 39786 - 39788

Background: CMS established national CCR ceilings for urban and rural IRFs to ensure that outlier payments are equitably distributed.

CMS applies the national urban and rural CCRs in the following situations:

- new IRFs that have not yet submitted their first Medicare cost report;
- IRFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean; and
- other IRFs for whom accurate data with which to calculate an overall CCR are not available.

For FFY 2009, the national CCR average was 0.619 for rural IRFs and 0.490 for urban IRFs.

CMS’ Final Rule:

For FFY 2010, CMS will apply a “. . . national average CCR of 0.622 for rural IRFs” and a “. . . national CCR of 0.494 for urban IRFs. . . .”

Transfers

No *Federal Register* pages were identified for this topic area.

Background: A patient discharged from an IRF is considered an early transfer when two conditions are met:

- the LOS is less than the ALOS for non-transfer cases in the specific CMG; and
- the patient is discharged to another institutional care setting such as another IRF, an inpatient hospital, long-term care hospital, or a nursing home that accepts Medicare and/or Medicaid payments.

Discharges to home health care, outpatient rehabilitation, or day treatment services are not counted as a transfer for payment purposes, but are treated as part of the normal progression of care and paid a full discharge payment.

Transfer cases are paid a per diem rate that is calculated by dividing the normal case payment for the CMG by the ALOS for the CMG. The transfer payment amount includes an additional half-day payment for the first day.

CMS’ Final Rule: For FFY 2010, CMS has adopted no changes to the transfer methodology.

Interrupted Stays

No *Federal Register* pages were identified for this topic area.

Background: An interrupted stay is defined as one in which the beneficiary is discharged, and then returns to the facility by midnight of the third day following the discharge. These cases receive only one discharge payment based on the admission assessment from the initial stay.

CMS’ Final Rule: For FFY 2010, CMS has adopted no changes to the interrupted stay methodology