Small Entity Compliance Guide

Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010

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The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA, P.L. 104-121, March 29, 1996, as amended by P.L. 110-28, May 25, 2007) contains requirements for issuance of "small entity compliance guides." Guides are to explain what actions affected entities must take to comply with agency rules. Such guides must be prepared when agencies issue final rules for which agencies were required to prepare a Final Regulatory Flexibility Analysis under the Regulatory Flexibility Act (RFA). However, the guidance has been voluntarily prepared, as the overall impact of the IRF final regulation, as is detailed in the RFA of the regulation and discussed below, reflects an estimated positive increase in payments to the majority of IRFs with minimal associated burden requirements on small entities.

The complete text of this Final Rule can be found on the CMS Web site by clicking on the link to "CMS-1538-F" at: http://www.cms.hhs.gov/InpatientRehabFacPPS/LIRFF/list.asp#TopOfPage .

This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2010 (for discharges occurring on or after October 1, 2009 and on or before September 30, 2010) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Effective for IRF discharges occurring on or after January 1, 2010, this final rule also implements new IRF coverage requirements that will be used to determine whether individual IRF claims are for reasonable and necessary services under section 1862(a)(1) of the Act.

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRF revenue that is derived from Medicare payments. However, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are small entities and that Medicare payment constitutes the majority of their revenues.

Overall, we estimate that the net revenue impact of this final rule on all IRFs reflects an estimated increase in payments of approximately 2.5 percent, with an estimated increase in payments of 3 percent or higher for some categories of IRFs (such as urban IRFs in the East South Central, West North Central, West South Central, Mountain, and Pacific regions) and an estimated decrease in payments of 3.8 percent for the 17 teaching IRFs that have resident to average daily census ratios greater than 19 percent. Thus, we anticipate that this final rule would have a significant impact on a substantial number of small entities. However, the estimated impact of this final rule is generally positive because it provides an increase in payments across nearly all categories of IRFs, with the exception of teaching IRFs with resident to average daily census ratios of 10 percent or greater. These IRFs will experience an estimated negative impact on payments due to the decrease in the IRF teaching status adjustment factor for FY 2010.

Effective for IRF discharges occurring on or after January 1, 2010, this rule also implements new IRF coverage requirements for determining whether individual IRF claims are for reasonable and necessary services under section 1862(a)(1) of the Act. Briefly, the new coverage requirements:

- Outline the key decision points that should be considered and documented when making a decision to admit, retain, or discharge an IRF patient.
- Specify certain preadmission assessment requirements and eliminate the 3 to 10 day post-admission assessment period.
- Require a post-admission physician evaluation to verify that the beneficiary's preadmission assessment information remains unchanged, or to document any changes.
- Specify requirements for an individualized overall plan of care for each beneficiary.
- Emphasize the interdisciplinary approach to care provided in IRFs and increase the required frequency of interdisciplinary team meetings to reflect the compressed average length of stay in IRFs today compared with prior decades.
- Clarify the requirements for admission to an IRF, by specifying that a beneficiary must
  - be sufficiently medically stable to benefit from IRF services,
  - need the coordinated care of multiple therapy disciplines uniquely provided in IRFs,
  - benefit from the intensity of rehabilitation therapy services uniquely provided in IRFs, and
  - require close medical supervision for the management of medical conditions to support participation in an intensive rehabilitation therapy program.

CMS will conduct training and outreach on these new IRF coverage requirements prior to their effective date. Additional guidance on these requirements will also be available in Chapter 1, §110 ("Inpatient Rehabilitation Facility (IRF) Services") of the Medicare Benefit Policy Manual (MBPM, CMS Pub. 100-02) prior to January 1, 2010. This manual is available on the CMS Web site by clicking on the link to "100-02" at: http://www.cms.hhs.gov/Manuals/IOM.

In order to assist IRFs in understanding and adapting to Medicare billing and payment procedures, we have developed a Web page for IRFs that includes explanatory materials at http://www.cms.hhs.gov/InpatientRehabFacPPS/. The Spotlight section contains the most recent issuances.