

MEMORANDUM

To: ACRM

From: Peter Thomas and Steve Postal

Date: September 1, 2017

Re: Final Rule on Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018

On August 3, 2017, the Centers for Medicare & Medicaid Services (CMS) at the Department of Health and Human Services (HHS) published the [final rule](#) in the Federal Register updating the prospective payment rates for inpatient rehabilitation hospitals and units (IRFs) for federal fiscal year (FY) 2018, refining the ICD-10-CM list and the 60 Percent Rule presumptive methodology, and changing the IRF quality reporting program (QRP), among other things. CMS published a [fact sheet](#), as well as the display copy of the final rule, on July 31. The following are highlights of the final rule and how CMS responded to comments from rehabilitation stakeholders.

I. Update of the IRF Federal Prospective Payment Rates (FY 2018 IRF PPS)

- **Overall Impact.** In FY 2018, this final rule is estimated to increase payments to IRFs by \$75 million (0.9 percent) relative to FY 2017. This represents a slight decrease from the projections in the proposed rule (\$80 million and 1.0 percent, respectively).
 - CMS rejected MedPAC’s recommendation of a 5.0 percent decrease [but this, in part, is due to the statutory formula for annual updates to the IRF payment rates].
- **Facility-level adjustments.** These will be maintained at current levels for FY 2018.
- **Rural adjustments.** FY 2018 represents the third and final year of the phase-out of the 14.9 percent rural adjustment for 20 IRF providers that changed status from urban to rural. CMS therefore will no longer apply a rural adjustment to these IRFs.

II. Refinements to ICD-10-CM list and 60 Percent Rule Presumptive Methodology

In the proposed rule, CMS had agreed to review the list of ICD-10-CM conditions that are presumptively compliant with the ICD-9-CM medical code set. CMS wanted the refinements of this list to ensure compliance with the list of 60 Percent Rule qualifying conditions in 42 CFR 412.29(b)(2).

A. Finalized Proposals

In the final rule, CMS finalized its proposals to implement a series of changes involving presumptive compliance with the so-called 60% Rule. These changes are effective for IRF discharges occurring on and after October 1, 2017:

- Address certain ICD-10-CM diagnosis codes for patients with traumatic brain injury and hip fracture conditions, which include the following codes:
 - Brain Dysfunction—0002.21 Traumatic, Open Injury
 - Brain Dysfunction—0002.22 Traumatic, Closed Injury
 - Orthopedic Disorders—0008.11 Status Post Unilateral Hip Fracture
 - Orthopedic Disorders—0008.12 Status Post Bilateral Hip Fractures;
- **Major multiple trauma codes.** CMS finalized its proposal to address major multiple trauma codes that did not translate exactly between ICD-9-CM and ICD-10-CM. Specifically, CMS will deem presumptive compliance for cases that have two or more ICD-10-CM codes from three major multiple trauma lists (Lists A, B, and C, below).
 - In order for IRFs to appropriately count patients with multiple fractures as meeting the 60 Percent Rule requirement for IRFs, codes from the lists below could be used if combined if: 1) at least one lower extremity fracture is combined with an upper extremity fracture and/or rib/sternum fracture; or 2) fractures are present in both lower extremities:
 - List A: Major Multiple Trauma — Lower Extremity Fracture
 - List B: Major Multiple Trauma — Upper Extremity Fracture
 - List C: Major Multiple Trauma — Ribs and Sternum Fracture

B. Proposed Rule Provisions Not Finalized

Non-specific and arthritis diagnosis codes. CMS chose to not finalize its proposal to remove certain non-specific and arthritis diagnosis codes that were inadvertently re-introduced through the ICD-10-CM conversion process. Instead, CMS chose to “take a more cautious approach and give further consideration to the removal of the unspecified codes,” while encouraging IRFs “to adhere to ICD-10-CM guidelines and use the most specific information available to describe a medical disease, condition, or injury.”

Other specified myopathies. CMS chose not to finalize its proposal to remove one ICD-10-CM code (G72.89 – Other specified myopathies). In the proposed rule, CMS stated that this code was being inappropriately applied clinically in a manner that does not represent a condition that presumptively requires intensive rehabilitation. In the final rule, CMS took “a more cautious approach to ensure that [it did] not restrict access to IRF care for patients with myopathies.”

[**Note:** On balance, this section of the final rule meaningfully addressed and corrected significant problems that arose with conversion from the ICD-9-CM to the ICD-10-CM code set with respect to the presumptive compliance methodology under the 60% Rule. Multiple rehabilitation stakeholders had submitted strongly worded comments on this section of the proposed rule. The final rule is welcome news for Medicare beneficiaries with brain injuries and hip fractures in particular, as well as the IRF providers who serve this patient population.]

C. Stakeholder Victories

Removal of combination code exclusions. CMS agreed with rehabilitation stakeholders, and removed the combination code exclusions on the IGC list that contain:

- S02.101B—Fracture of base of skull, right side, initial encounter for open fracture;

- S02.102B— Fracture of base of skull, left side, initial encounter for open fracture;
- S02.101A— Fracture of base of skull, right side, initial encounter for closed fracture; and
- S02.102A—Fracture of base of skull, left side, initial encounter for closed fracture from the IGC exclusion list (thereby allowing these codes to count toward the presumptive compliance criteria).

CMS agreed with the commenters that these codes indicate serious injuries and are representative of the conditions that are listed in 42 CFR 412.29(b)(2) as meeting the 60% Rule criteria. CMS also stated that these codes provide more specificity than the prior codes S02.10XA and S02.10XB because they indicate the anatomic location of the injury.

Publication of code changes. CMS agreed with stakeholder comments to publish tables of codes that CMS is adding and codes it is deleting. CMS also pledged to include this information in all future rulemaking. For this final rule, CMS organized the changes in Table 1—ICD–10–CM Exclusion Codes Removed From IGC List. This list is available for download on the CMS Web site at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/ICD-10-CM-DataFiles.zip>

D. Stakeholder Suggestions Not Adopted

CMS did not adopt the suggestion of rehabilitation stakeholders to not list S06.9X9A—Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter as an exclusion on the IGC list.

- CMS recognized that rehabilitation stakeholders expressed concerns that the information to code the specific cause of a patient’s injury and the duration of a patient’s loss of consciousness is often unavailable to the IRF because it is not in the records from the transferring facility (for example, an acute care hospital) and the IRF is unable administratively or clinically to retrieve this information. CMS also recognized that several commenters noted that the clinical treatment of patients is not necessarily affected by whether or not the IRF can determine the exact cause of the patient’s injury or the duration of the patient’s loss of consciousness. CMS remarked that commenters expressed concerns that the IRF would, in effect, be unfairly “penalized” in that it would have a more difficult time meeting the 60% Rule requirements under the presumptive methodology if it is unable to obtain the necessary information to code more specifically.
- However, CMS stated that as a required part of the IRF’s admission process (in accordance with the regulations at § 412.622(a)(4)(i)), the IRF must perform a comprehensive preadmission screening on each Medicare Part A fee-for-service patient. To meet the requirements of the comprehensive preadmission screening, the IRF clinical staff may, on rare occasions, need to consult diagnostic reports, radiological reports, and consultation notes, among other informational documentation. CMS argued that this information should provide the IRF clinicians enough of a clinical basis for determining a more specific diagnosis code for the patient. CMS argued that other more specific codes are available, such as those codes listed under subcategory S06.89-, Other specified intracranial injury. CMS stated that it believes that the IRF should make every effort to obtain the necessary information to code more specifically.

III. The 60 Percent Rule

In the proposed rule, CMS solicited comments on the 60 Percent Rule including, but not limited to, the list of currently qualifying conditions that are considered “presumptively compliant,” as well as ideas and information that would assist CMS in analyzing and updating the criteria for classifying facilities for payment under the IRF PPS. In the final rule, CMS did not respond to these comments, other than corrections to the ICD-10-CMS code outlined above.

IV. Removal of Payment Penalty for Late Transmissions of the IRF-PAI

CMS finalized its proposal to eliminate the 25 percent payment penalty to IRF patient assessment instrument (IRF-PAI) submissions by providers that are not timely transmitted to its data repository.

V. Changes to the IRF Quality Reporting Program (QRP)

CMS finalized its proposals to:

- Replace the current pressure ulcer measure (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)(NQF #0678)) with an updated version of that measure (Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury);
- Remove the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities measure. In the proposed rule, CMS had argued that other measurement tools already address readmissions; and
- Begin publically reporting six new measures for display on the IRF Compare Website by fall 2018. The six new measures are:
 - Assessment-based measures
 - Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631);
 - Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674);
 - Claims-based measures
 - Medicare Spending Per Beneficiary-PAC IRF QRP;
 - Discharge to Community-PAC IRF QRP;
 - Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP; and
 - Potentially Preventable Within Stay Readmission Measure for IRFs.

Quality measures for future years. As it stated in the proposed rule, CMS will consider implementing proposed IRF QRP quality measures “for future years,” including:

- Patient Experience of Care;
- Application of Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay) (NQF #0676); and

- Modification of the Discharge to Community-Post Acute Care Inpatient Rehabilitation Facility Quality Reporting Program measure.

Standardized patient assessment data. Beginning with FY 2019 IRF QRP, standardized patient assessment data must be reported by IRFs. CMS finalized its proposal to satisfy this requirement using the data submitted on the existing pressure ulcer measure. For the FY 2020 program year, CMS finalized its proposal that IRFs begin reporting standardized patient assessment data with respect to five specified patient assessment categories required by law that include:

- Functional status;
- Cognitive function;
- Special services, treatments and interventions;
- Medical conditions and co-morbidities; and
- Impairments.

VI. Request for Information on CMS Flexibilities and Efficiencies

In response to the proposed rule, CMS invited public comment regarding ideas for regulatory or sub-regulatory, policy, practice, and procedural changes to better accomplish flexibility and efficiency in Medicare, including reducing unnecessary burdens for clinicians, other providers, and patients and their families. CMS is hoping that these suggestions will increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible. Multiple rehabilitation stakeholders submitted extensive comments on this Request for Information. In the final rule, CMS did not respond to these comments but it is assumed that they will be examining these responses in the context of the Administration's longer-term regulatory relief agenda.

VII. IRF Experience of Care Survey

In response to the proposed rule, rehabilitation stakeholders proposed that the IRF experience of care survey should include questions that better address therapy services, in addition to making the draft survey and survey implementation process publicly available and allowing an opportunity for stakeholder input well in advance of implementing it in the IRF Quality Reporting Program (QRP). In the final rule, CMS stated that it will take these comments into consideration as it finishes developing the survey and related survey-based measures.

VIII. IRF Compare Website

In response to the proposed rule, rehabilitation stakeholders expressed concern that the measures on the IRF Compare website are not discernable and relevant to the general public, and questioned whether differences in quality that are displayed are clinically meaningful and distinguishable between high- and low-quality providers. In the final rule, CMS responded that it disagrees that there is not enough variability to distinguish between high-and low-quality providers, stating that most of the measures are endorsed by the National Quality Forum (NQF) and go through a rigorous vetting process including analysis of data regarding variability, validity, and reliability.

Conclusion

The IRF final rule provides some victories for rehabilitation stakeholders. It is encouraging to note that the final rule increases payments to inpatient rehabilitation hospitals and units by 0.9 percent, rejecting MedPAC's suggestion to decrease payments by 5.0 percent. It is a positive and welcome development that the proposed rule addresses certain ICD-10-CM diagnosis codes for patients with traumatic brain injury and hip fracture conditions. Responding to comments by rehabilitation stakeholders, CMS chose to not finalize its proposals 1) to remove certain non-specific and arthritis diagnosis codes that were inadvertently re-introduced through the ICD-10-CM conversion process, and 2) to remove one ICD-10-CM code (G72.89 – Other specified myopathies). In the final rule, CMS did not respond to comments it solicited on the burdensome 60 Percent Rule that often results in diversion of some patients away from IRF care and into less intensive settings even though they qualify for IRF care.