New PPS Proposed for Inpatient Rehabilitation Facilities

by Michelle Dougherty, RHIA

It's time to take a look at HCFA's published proposed rules for a new prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs).[1,2] This new payment system applies to both rehabilitation hospitals and hospital-based rehab units for cost report periods beginning on April 1, 2001. Reimbursement for IRFs will be based on the minimum data set for post acute care (MDS-PAC), a standardized assessment that has been tested but not used by the rehab industry. The MDS-PAC is a variation of the MDS 2.0 used by skilled nursing facilities.

There are three components to IRF PPS:

- a patient assessment instrument (MDS-PAC)
- a classification system (case mix groups which classifies discharges into functional related groups
- a unit of payment (discharge-based payment unit)

The proposed PPS will reimburse an inpatient rehab facility upon discharge, similar to the DRG system that also pays upon discharge. Under IRF PPS, there are 97 different case mix groups (CMGs) that are weighted based on the patient's condition and intensity of services required to treat the condition. Each of the CMGs will reimburse based on a predetermined amount that covers the patient's care including all routine, ancillary, and capital costs for providing rehab services.

Patient Assessment Instrument

The MDS-PAC, the basis for determining the CMG and reimbursement rate upon discharge, is considered a controversial choice because this assessment instrument has not been used industry-wide. A significant portion of the rehab industry uses the FIM (functional independence measure) and the patient assessment instrument administered by the Uniform Data Set for Medical Rehabilitation (UDSMR). However, the MDS-PAC was chosen because it was based on characteristics of the patient and would be a step toward developing a coordinated payment system for post-acute care across all settings that relies on one core tool.

The MDS-PAC assessments are required to be completed on a regular basis during a patient's stay until discharge or the end of Medicare coverage. There are four required assessments during a 60-day stay: a day four, day 11, day 30, and day 60 assessment. For each assessment, the proposed rule defines the observation period (usually three days) during which staff observe and assess the patient. The observation period ensures that the answers on the MDS-PAC are from the same period of time. In addition to the observation period, the rule defines the assessment reference date (ARD), the date the MDS is to be completed and signed off by facility staff, the date the MDS is to be encoded (entered into a computerized MDS-PAC software program), and the date the MDS-PAC is to be transmitted to HCFA's Medicare Data Collection Network (MDCN). (See MDS-PAC Assessment Schedule and Dates, page ##.)

In addition to the scheduled assessments, an assessment is also required upon discharge from the IRF or the end of Medicare coverage. The ARD for the discharge assessment is the day of discharge or the day that coverage ended. The completion date is day five after discharge, the encoding date is day seven after discharge, and the transmission date is seven days after encoding. In calculating the dates, the discharge day is considered day one and starts the schedule.

If a patient has an interruption in his or her stay, and is readmitted to an inpatient hospital in less than three days, the MDS-PAC schedule will continue with an adjustment in the ARD and completion dates to account for the break. When a patient has an interruption that lasts more than three days, the patient is considered a discharge and the entire MDS-PAC schedule restarts upon readmission. To calculate the three-day time period for an interrupted stay, day one ends at midnight on the first calendar day the patient left the facility. If the patient returns to the IRF by midnight of the third calendar day, the patient is considered to have an interruption in his or her stay.

Timely completion and submission of the MDS is critical in obtaining the full payment upon discharge. If an MDS is 10 days late, there is a 25 percent reduction in the discharge payment. If the MDS is more than 10 days late, the IRF will not receive any payment for the stay. The MDS must be transmitted and accepted into the MDCN before the facility can bill for the patient's stay.

Classification System

Based on the answers on the MDS-PAC, an impairment category is selected and a motor test and cognitive test score is determined. The information is used to determine the CMG, which classifies discharges into functional-related groups based on impairment, age, comorbidities, functional capability of the patient, and other factors that reflect resource use and care needs for the patient. (See Examples of CMGs and Relative Weights.)

Unit of Payment

The payment unit is based on the patient's discharge, meaning a claim is submitted upon discharge and the predetermined payment covers the services and care provided to the patients during their inpatient rehab stay. Because the system is discharge-based, there was concern that facilities could cheat the system by discharging a patient early, yet collecting the full discharge payment. As a result, policies were proposed for adjusting (reducing) payments for transfers, short stay outliers, cases that expire, and interrupted stays.

Notes

1. www.access.gpo.gov/su_docs/fedreg/a001103c.html
2. Information on the PPS system, a copy of the MDS-PAC form, and an item-by-item guide can be found on the HCFA Web site at www.hcfa.gov/medicare/irfpps.htm.

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MDS-PAC Assessment Schedule and Dates

MDS-PAC assessment type	Hospitalization time period and observation time period	MDS-PAC assessment reference date (ARD)	MDS-PAC completed by day	MDS-PAC encoded by day	MDS-PAC transmitted by day
Day 4	First 3 days	Day 3	4	10	16
Day 11	Days 8 to 10	Day 10	11	17	23
Day 30	Days 28-30	Day 30	31	37	43
Day 60	Days 58 to 60	Day 60	61	67	73

The day 4 MDS-PAC establishes the payment rate for the entire hospitalization time period.
For MDS scheduling, day one is the day of admission.

Examples of CMGs and Relative Weights

CMG	**Definition** **M = motor** **C = cognitive** **A = age**	**Split by comorbidity**	**Average Length of Stay**		**Relative Weight**	
			No comorbidity	**With comorbidity**	**No comorbidity**	**With comorbidity**
0101 (Stroke)	**M**=29-0	Yes	10.4	9.6	0.6058	0.6613
0201 (TBI)	**M**=33-0 and **C**=30-35	No	9.4	9.4	0.5504	0.5504

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