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Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1448–P]

RIN 0938–AR66

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2014 (for discharges occurring on or after October 1, 2013 and on or before September 30, 2014) as required by the statute. We are also proposing to revise the list of diagnosis codes that are used to determine presumptive compliance under the ''60 percent rule,'' update the IRF facility-level adjustment factors, revise sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument, revise requirements for acute care hospitals that have IRF units, clarify the IRF regulation text regarding limitation of review, update references to previously changed sections in the regulations text, and revise and update quality measures and reporting requirements under the IRF quality reporting program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 1, 2013.

ADDRESSES: In commenting, please refer to file code CMS–1448–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1448–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1448–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Gwendolyn Johnson, (410)786–6954, for general information about the proposed rule. Caroline Gallaher, (410) 786–8705, for information about the quality reporting program. Susanne Seagrave, (410) 786–0044 or Kadie Thomas, (410) 786–0468, for information about the proposed payment policies and the proposed payment rates.

SUPPLEMENTARY INFORMATION: The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/.*

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Executive Summary

A. Purpose

This proposed rule updates the payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2014 (for discharges occurring on or after October 1, 2013 and on or before September 30, 2014) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2013 IRF PPS notice (77 FR 44618) to update the Federal prospective payment rates for FY 2014 using updated FY 2012 IRF claims and the most recent available IRF cost report data. We are also proposing to revise the list of diagnosis codes that are used to determine presumptive compliance under the ''60 percent rule,'' update the IRF facility-level adjustment factors using an enhanced estimation methodology, revise sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument, revise requirements for acute care hospitals that have IRF units, clarify the IRF regulation text regarding limitation of review, update references to previously changed sections in the regulations text, and revise and update quality measures

and reporting requirements under the IRF quality reporting program.

C. Summary of Costs, Benefits and Transfers

Provision description	Total transfers
FY 2014 IRF PPS payment rate update	The overall economic impact of this proposed rule is an estimated $150 million in increased payments from the Federal government to IRFs during FY 2014.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

Table of Contents

I. Background

A. Historical Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 1886(j) of the Act provides for the implementation of a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs).

Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880), we are providing below a general description of the IRF PPS for fiscal years (FYs) 2002 through 2013.

Under the IRF PPS from FY 2002 through FY 2005, as described in the FY 2002 IRF PPS final rule (66 FR 41316), the federal prospective payment rates were computed across 100 distinct case-mix groups (CMGs). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget neutral conversion factor). For a detailed discussion of the budget neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted federal prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made

adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRF's unadjusted Federal prospective payment rates.

For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRF would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the federal IRF PPS rate.

We established a CMS Web site as a primary information resource for the IRF PPS. The Web site is: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html?redirect=/InpatientRehabFacPPS/* and may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166) that we published on September 30, 2005, we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB) Core-Based Statistical Area (CBSA) market definitions, modifications to the CMGs, tier comorbidities, and CMG relative weights, implementation of a new teaching status adjustment for IRFs, revision and rebasing of the market basket index used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket index used to update IRF payments is a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs) (hereafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS case-mix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule (71 FR 48354).

In the FY 2008 IRF PPS final rule (72 FR 44284), we updated the federal prospective payment rates and the outlier threshold, revised the IRF wage index policy, and clarified how we determine high-cost outlier payments for transfer cases. For more information on the policy changes implemented for FY 2008, please refer to the FY 2008 IRF PPS final rule (72 FR 44284), in which we published the final FY 2008 IRF federal prospective payment rates.

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007) (MMSEA), amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF federal prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 federal prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF Federal prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007 and on or before March 31, 2008; and the revised FY 2008 IRF Federal prospective payment rates were effective for discharges occurring on or after April 1, 2008 and on or before September 30, 2008. The revised FY 2008 federal prospective payment rates are available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*.

In the FY 2009 IRF PPS final rule (73 FR 46370), we updated the CMG relative weights, the average length of stay values, and the outlier threshold; clarified IRF wage index policies regarding the treatment of ''New England deemed'' counties and multi-campus hospitals; and revised the regulation text in response to section 115 of the MMSEA to set the IRF compliance percentage at 60 percent (''the 60 percent rule'') and continue the practice of including comorbidities in the calculation of compliance percentages. We also applied a zero percent market basket increase factor for FY 2009 in accordance with section 115 of the MMSEA. For more information on the policy changes implemented for FY 2009, please refer to the FY 2009 IRF PPS final rule (73 FR 46370), in which we published the final FY 2009 IRF federal prospective payment rates.

In the FY 2010 IRF PPS final rule (74 FR 39762) and in correcting amendments to the FY 2010 IRF PPS final rule (74 FR 50712) that we published on October 1, 2009, we updated the federal prospective payment rates, the CMG relative weights, the average length of stay values, the rural, LIP, and teaching status adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (MA) (Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2010, please refer to the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712), in which we published the final FY 2010 IRF federal prospective payment rates.

After publication of the FY 2010 IRF PPS final rule (74 FR 39762), section 3401(d) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) as amended by section 10319 of the same Act and by section 1105 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) (collectively, hereafter referred to

as ''The Affordable Care Act''), amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 to 2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the Affordable Care Act, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to section 1886(j)(3) of the Act, we adjusted the FY 2010 Federal prospective payment rates as required, and applied these rates to IRF discharges occurring on or after April 1, 2010 and on or before September 30, 2010. Thus, the final FY 2010 IRF federal prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009 and on or before March 31, 2010; and the adjusted FY 2010 IRF federal prospective payment rates applied to discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The adjusted FY 2010 federal prospective payment rates are available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*.

In addition, sections 1886(j)(3)(C) and (D) of the Act also affected the FY 2010 IRF outlier threshold amount because they required an adjustment to the FY 2010 RPL market basket increase factor, which changed the standard payment conversion factor for FY 2010. Specifically, the original FY 2010 IRF outlier threshold amount was determined based on the original estimated FY 2010 RPL market basket increase factor of 2.5 percent and the standard payment conversion factor of $13,661. However, as adjusted, the IRF prospective payments are based on the adjusted RPL market basket increase factor of 2.25 percent and the revised standard payment conversion factor of $13,627. To maintain estimated outlier payments for FY 2010 equal to the established standard of 3 percent of total estimated IRF PPS payments for FY 2010, we revised the IRF outlier threshold amount for FY 2010 for discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The revised IRF outlier threshold amount for FY 2010 was $10,721.

Sections 1886(j)(3)(c)(ii)(II) and 1886(j)(3)(D)(i) also required the Secretary to reduce the market basket increase factor in FY 2011 by a 0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013, November 16, 2010) described the required adjustments to the FY 2011 and FY 2010 IRF PPS Federal prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010 and on or before September 30, 2011. It also updated the FY 2011 Federal prospective payment rates, the CMG relative weights, and the average length of stay values. Any reference to the FY 2011 IRF PPS notice in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice (75 FR 42836 and 75 FR 70013).

In the FY 2012 IRF PPS final rule (76 FR 47836), we updated the IRF federal prospective payment rates, rebased and revised the RPL market basket, and established a new quality reporting program for IRFs in accordance with section 1886(j)(7) of the Act. We also revised regulations text for the purpose of updating and providing greater clarity. For more information on the policy changes implemented for FY 2012, please refer to the FY 2012 IRF PPS final rule (76 FR 47836), in which we published the final FY 2012 IRF federal prospective payment rates.

The FY 2013 IRF PPS notice (77 FR 44618) described the required adjustments to the FY 2013 federal prospective payment rates and outlier threshold amount for IRF discharges occurring on or after October 1, 2012 and on or before September 30, 2013. It also updated the FY 2013 federal prospective payment rates, the CMG relative weights, and the average length of stay values. For more information on the updates for FY 2013, please refer to the FY 2013 IRF PPS notice (77 FR 44618).

B. Provisions of the Affordable Care Act Affecting the IRF PPS in FY 2012 and Beyond

The Affordable Care Act included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was discussed above, section 3401(d) of the Affordable Care Act also added section 1886(j)(3)(C)(ii)(I) (providing for a ''productivity'' adjustment'' for fiscal year 2012 and each subsequent fiscal year). The proposed productivity adjustment for FY 2014 is discussed in section V.A. of this proposed rule. Section 3401(d) of the Affordable Care Act requires an additional 0.3 percentage point adjustment to the IRF increase factor for FY 2014, as discussed in section V.A. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act notes that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Section 3004(b) of the Affordable Care Act also addressed the IRF PPS program. It reassigned the previously-designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs. Under that program, data must be submitted in a form and manner, and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) will require application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

Under section 1886(j)(7)(D)(i) and (ii) of the Act, the Secretary is generally required to select quality measures for the IRF quality reporting program from those that have been endorsed by the consensus-based entity which holds a performance measurement contract under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). So long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization, section 1886(j)(7)(D)(ii) of the Act authorizes the Secretary to select non-endorsed measures for specified areas or medical topics when there are no feasible or practical endorsed measure(s). Under section 1886(j)(7)(D)(iii) of the Act, the

Secretary is required to publish the measures that will be used in FY 2014 no later than October 1, 2012.

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF PPS quality reporting data available to the public. In so doing, the Secretary must ensure that IRFs have the opportunity to review any such data prior to its release to the public. Future rulemaking will address these public reporting obligations.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument (PAI), designated as the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Part C (Medicare Advantage) patient, as described in the FY 2010 IRF PPS final rule. All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the GROUPER software. The GROUPER software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.*

Once a Medicare fee-for-service Part A patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA), compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105, enacted on December 27, 2002) (ASCA) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI) or Medicare Administrative Contractor (MAC). In addition, once a Medicare Advantage patient is discharged, in accordance with the Medicare Claims Processing Manual chapter 3 section 20.3 (Pub. 100–04), hospitals (including IRFs) must submit an informational only bill (TOB 111) which includes Condition Code 04 to their Medicare contractor. This will ensure that the Medicare Advantage days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF low-income percentage adjustment) for Fiscal Year 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amends section 1862(a) of the Act by adding paragraph (22) which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial ''in such unusual cases as the Secretary finds appropriate.'' For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final rule (70 FR 71008, November 25, 2005). CMS instructions for the limited number of Medicare claims submitted on paper are available at *http://www.cms.gov/manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR, parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *http://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The Medicare FI or MAC processes the claim through its software system. This software system includes pricing programming called the ''PRICER'' software. 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, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

II. Summary of Provisions of the Proposed Rule

In this proposed rule, we are proposing to update the IRF Federal prospective payment rates, to revise the list of eligible International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) diagnosis codes that are eligible under the ''60 percent rule,'' to update the IRF facility-level adjustment factors, to revise the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI), to revise requirements for acute care hospitals that have IRF units, clarify the IRF regulation text regarding limitation of review, and to revise and update quality measures and reporting requirements under the quality reporting program for IRFs. We are also proposing to revise existing regulations text for the purpose of updating and providing greater clarity. These proposals are as follows:

A. Proposed Updates to the IRF Federal Prospective Payment Rates for Federal Fiscal Year (FY) 2014

The proposed updates to the IRF federal prospective payment rates for FY 2014 are as follows:

- Update the FY 2014 IRF PPS relative weights and average length of stay values using the most current and complete Medicare claims and cost report data in a budget neutral manner, as discussed in section III. of this proposed rule.
- Update the FY 2014 IRF PPS facility-level adjustment factors, using the most current and complete Medicare claims and cost report data with an enhanced estimation methodology, in a budget neutral manner, as discussed in section IV. of this proposed rule.
- Update the FY 2014 IRF PPS payment rates by the proposed market basket increase factor, based upon the most current data available, with a 0.3 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iii) of the Act and a

proposed productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this proposed rule.

- Discuss the Secretary's Proposed Recommendation for updating IRF PPS payments for FY 2014, in accordance with the statutory requirements, as described in section V. of this proposed rule.
- Update the FY 2014 IRF PPS payment rates by the FY 2014 wage index and the labor-related share in a budget neutral manner, as discussed in section V. of this proposed rule.
- Describe the calculation of the IRF Standard Payment Conversion Factor for FY 2014, as discussed in section V. of this proposed rule.
- Update the outlier threshold amount for FY 2014, as discussed in section VI. of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2014, as discussed in section VI. of this proposed rule.
- Describe proposed revisions to the list of eligible ICD–9–CM diagnosis codes that meet the presumptive compliance criteria in section VII. of this proposed rule.
- Describe proposed non-quality-related revisions to IRF–PAI sections in section VIII. of this proposed rule.
- Describe proposed revisions and updates to quality measures and reporting requirements under the quality reporting program for IRFs in accordance with section 1886(j)(7) of the Act, as discussed in section XIII. of this proposed rule.

B. Proposed Revisions to Existing Regulation Text

In this proposed rule, we are also proposing the following revisions to the existing regulations:

- Revisions to § 412.25(a)(1)(iii) to specify a minimum required number of beds that are not excluded from the inpatient prospective payment system (IPPS) for a hospital that has an IRF unit, as described in section X. of this proposed rule.
- Technical corrections to § 412.130, to reflect prior changes to the regulations at § 412.29 and § 412.30 that we made in the FY 2012 IRF PPS final rule (76 FR 47836), as described in section IX. of this proposed rule.
- Clarifications to § 412.630, to reflect the scope of section 1886(j)(8) of the Act, as described in section XI. of this proposed rule.
- Revision to § 412.29(d), to clarify that Medicare requires the rehabilitation physician's review and concurrence on the preadmission screening for Medicare Part A fee-for-service patients only, as described in section XII. of this proposed rule.

III. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2014

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2014. As required by statute, we always use the most recent available data to update the CMG relative weights and average lengths of stay. For FY 2014, we are proposing to use the FY 2012 IRF claims and FY 2011 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2012 IRF cost report data are available for analysis, but the majority of the FY 2012 IRF claims data are available for analysis.

In this proposed rule, we propose to apply these data using the same methodologies that we have used to update the CMG relative weights and average length of stay values in the FY 2011 notice (75 FR 42836), the FY 2012 final rule (76 FR 47836), and the FY 2013 notice (77 FR 44618). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step.

Step 3. We use the adjusted costs from the second step to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2014 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2013 IRF PPS notice (77 FR 44618).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are proposing to update the CMG relative weights for FY 2014 in such a way that total estimated aggregate payments to IRFs for FY 2014 are the same with or without the changes (that is, in a budget neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate proposed budget neutrality factor for use in updating the FY 2014 CMG relative weights, we propose to use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2014 (with no proposed changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2014 by applying the proposed changes to the CMG relative weights (as discussed above).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (1.0000) that would maintain the same total estimated aggregate payments in FY 2014 with and without the proposed changes to the CMG relative weights.

Step 4. Apply the proposed budget neutrality factor (1.0000) to the FY 2013 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.E. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the standard payment conversion factor for FY 2014.

Table 1, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' presents the CMGs, the comorbidity tiers, the proposed corresponding relative weights, and the proposed average length of stay values for each CMG and tier for FY 2014. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment. The proposed relative weights and average length of stay values shown in Table 1 are subject to change for the final rule if more recent data become available for use in these analyses.

TABLE 1—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0101	Stroke M>51.05	0.8001	0.7122	0.6556	0.6248	9	9	9	8
0102	Stroke M>44.45 and M<51.05 and C>18.5.	0.9921	0.8831	0.8129	0.7748	11	12	10	10
0103	Stroke M>44.45 and M<51.05 and C<18.5.	1.1613	1.0337	0.9516	0.9069	13	13	12	11
0104	Stroke M>38.85 and M<44.45	1.2210	1.0869	1.0006	0.9536	14	12	12	12
0105	Stroke M>34.25 and M<38.85	1.4283	1.2715	1.1704	1.1154	15	14	14	14
0106	Stroke M>30.05 and M<34.25	1.6327	1.4534	1.3379	1.2751	16	17	16	15
0107	Stroke M>26.15 and M<30.05	1.8413	1.6391	1.5088	1.4380	19	20	17	17
0108	Stroke M<26.15 and A>84.5	2.3160	2.0616	1.8978	1.8087	23	24	22	21
0109	Stroke M>22.35 and M<26.15 and A<84.5.	2.1034	1.8724	1.7236	1.6426	21	21	19	20
0110	Stroke M<22.35 and A<84.5	2.7387	2.4380	2.2443	2.1388	28	28	25	25
0201	Traumatic brain injury M>53.35 and C>23.5.	0.8068	0.6835	0.6059	0.5641	10	10	8	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5.	1.0536	0.8926	0.7912	0.7366	12	10	10	10
0203	Traumatic brain injury M>44.25 and C<23.5.	1.2422	1.0524	0.9329	0.8685	14	13	12	11
0204	Traumatic brain injury M>40.65 and M<44.25.	1.3000	1.1013	0.9762	0.9089	12	13	12	12
0205	Traumatic brain injury M>28.75 and M<40.65.	1.5755	1.3347	1.1831	1.1015	17	16	14	14
0206	Traumatic brain injury M>22.05 and M<28.75.	1.9459	1.6485	1.4613	1.3605	18	19	17	16
0207	Traumatic brain injury M<22.05 ...	2.5684	2.1759	1.9287	1.7957	33	26	21	20
0301	Non-traumatic brain injury M>41.05.	1.0992	0.9462	0.8502	0.7859	10	11	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05.	1.3735	1.1824	1.0625	0.9820	13	14	12	12
0303	Non-traumatic brain injury M>26.15 and M<35.05.	1.6221	1.3964	1.2548	1.1597	16	16	14	14
0304	Non-traumatic brain injury M<26.15.	2.1731	1.8708	1.6810	1.5537	24	21	19	18
0401	Traumatic spinal cord injury M>48.45.	1.1451	0.9494	0.8847	0.7923	13	13	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45.	1.4139	1.1724	1.0924	0.9784	17	14	14	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35.	2.3069	1.9128	1.7823	1.5963	26	23	20	20
0404	Traumatic spinal cord injury M<16.05 and A>63.5.	4.2117	3.4921	3.2539	2.9142	46	41	35	34
0405	Traumatic spinal cord injury M<16.05 and A<63.5.	3.4483	2.8592	2.6642	2.3861	37	32	31	27
0501	Non-traumatic spinal cord injury M>51.35.	0.8500	0.6729	0.6328	0.5761	9	9	8	8
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35.	1.1064	0.8759	0.8237	0.7500	12	11	10	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15.	1.4276	1.1302	1.0628	0.9677	15	13	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25.	1.6534	1.3089	1.2309	1.1207	14	16	14	14
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25.	1.9495	1.5433	1.4514	1.3214	21	18	17	16
0506	Non-traumatic spinal cord injury M<23.75.	2.7308	2.1619	2.0330	1.8510	30	25	23	21
0601	Neurological M>47.75	0.9661	0.7875	0.7272	0.6589	10	10	9	9
0602	Neurological M>37.35 and M<47.75.	1.2904	1.0518	0.9713	0.8801	12	12	11	11
0603	Neurological M>25.85 and M<37.35.	1.6184	1.3191	1.2182	1.1038	15	15	14	13
0604	Neurological M<25.85	2.1563	1.7575	1.6231	1.4706	22	19	18	17
0701	Fracture of lower extremity M>42.15.	0.9445	0.8052	0.7712	0.6996	10	10	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15.	1.2149	1.0357	0.9920	0.8999	12	12	12	11
0703	Fracture of lower extremity M>28.15 and M<34.15.	1.4770	1.2591	1.2060	1.0940	15	15	14	13
0704	Fracture of lower extremity M<28.15.	1.8753	1.5987	1.5312	1.3891	18	18	18	17

TABLE 1—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0801	Replacement of lower extremity joint M>49.55.	0.7009	0.6238	0.5675	0.5200	7	8	7	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55.	0.9206	0.8193	0.7453	0.6830	10	10	9	9
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5.	1.2478	1.1105	1.0103	0.9257	12	13	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5.	1.1083	0.9863	0.8973	0.8222	11	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65.	1.3678	1.2173	1.1075	1.0148	15	15	13	12
0806	Replacement of lower extremity joint M<22.05.	1.6590	1.4765	1.3433	1.2308	17	17	15	15
0901	Other orthopedic M>44.75	0.9026	0.7480	0.6895	0.6254	11	9	9	8
0902	Other orthopedic M>34.35 and M<44.75.	1.2051	0.9987	0.9206	0.8350	12	12	11	11
0903	Other orthopedic M>24.15 and M<34.35.	1.5094	1.2509	1.1530	1.0459	15	15	14	13
0904	Other orthopedic M<24.15	1.9660	1.6293	1.5019	1.3623	19	18	17	16
1001	Amputation, lower extremity M>47.65.	1.0372	0.9443	0.8131	0.7478	12	11	10	10
1002	Amputation, lower extremity M>36.25 and M<47.65.	1.3081	1.1909	1.0255	0.9431	13	13	12	12
1003	Amputation, lower extremity M<36.25.	1.9330	1.7599	1.5154	1.3936	19	20	17	16
1101	Amputation, non-lower extremity M>36.35.	1.2388	1.1334	1.0487	1.0147	13	13	12	12
1102	Amputation, non-lower extremity M<36.35.	1.7069	1.5618	1.4450	1.3981	16	17	16	16
1201	Osteoarthritis M>37.65	0.9482	0.9350	0.8467	0.7752	9	11	10	10
1202	Osteoarthritis M>30.75 and M<37.65.	1.1813	1.1649	1.0549	0.9659	14	14	13	12
1203	Osteoarthritis M<30.75	1.4671	1.4468	1.3101	1.1995	13	17	15	14
1301	Rheumatoid, other arthritis M>36.35.	1.1815	0.9991	0.9005	0.8171	12	10	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35.	1.5305	1.2942	1.1666	1.0585	16	15	14	13
1303	Rheumatoid, other arthritis M<26.15.	1.9677	1.6639	1.4998	1.3608	18	19	17	16
1401	Cardiac M>48.85	0.8864	0.7216	0.6539	0.5919	9	9	9	8
1402	Cardiac M>38.55 and M<48.85 ...	1.1973	0.9747	0.8832	0.7995	12	11	11	10
1403	Cardiac M>31.15 and M<38.55 ...	1.4604	1.1889	1.0773	0.9752	14	14	12	12
1404	Cardiac M<31.15	1.8618	1.5157	1.3734	1.2433	19	17	15	14
1501	Pulmonary M>49.25	1.0003	0.8590	0.7747	0.7436	10	9	9	9
1502	Pulmonary M>39.05 and M<49.25.	1.2590	1.0812	0.9751	0.9359	12	12	11	11
1503	Pulmonary M>29.15 and M<39.05.	1.5224	1.3074	1.1791	1.1318	15	14	13	13
1504	Pulmonary M<29.15	1.8896	1.6227	1.4634	1.4047	21	17	16	15
1601	Pain syndrome M>37.15	1.0309	0.8817	0.8282	0.7568	9	10	10	9
1602	Pain syndrome M>26.75 and M<37.15.	1.3536	1.1577	1.0874	0.9937	12	14	13	12
1603	Pain syndrome M<26.75	1.7052	1.4584	1.3699	1.2518	18	17	15	15
1701	Major multiple trauma without brain or spinal cord injury M>39.25.	1.0875	0.9493	0.8541	0.7718	11	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25.	1.3611	1.1881	1.0689	0.9659	13	14	13	12
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05.	1.6427	1.4339	1.2901	1.1658	17	16	14	14
1704	Major multiple trauma without brain or spinal cord injury M<25.55.	2.0841	1.8193	1.6368	1.4790	24	20	18	18
1801	Major multiple trauma with brain or spinal cord injury M>40.85.	1.1476	1.0623	0.9340	0.7874	14	13	12	10

TABLE 1—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85.	1.7108	1.5837	1.3924	1.1739	18	19	17	14
1803	Major multiple trauma with brain or spinal cord injury M<23.05.	2.7350	2.5317	2.2259	1.8766	32	28	23	22
1901	Guillain Barre M>35.95	1.0958	0.9305	0.9064	0.8886	13	10	11	11
1902	Guillain Barre M>18.05 and M<35.95.	2.1340	1.8120	1.7652	1.7305	23	21	18	20
1903	Guillain Barre M<18.05	3.5000	2.9719	2.8951	2.8382	41	32	31	30
2001	Miscellaneous M>49.15	0.8897	0.7304	0.6716	0.6138	9	9	8	8
2002	Miscellaneous M>38.75 and M<49.15.	1.1865	0.9741	0.8956	0.8186	12	11	11	10
2003	Miscellaneous M>27.85 and M<38.75.	1.4910	1.2241	1.1254	1.0286	14	14	13	12
2004	Miscellaneous M<27.85	1.9537	1.6039	1.4746	1.3478	20	18	17	15
2101	Burns M>0	2.1782	1.5737	1.4885	1.4056	24	21	17	16
5001	Short-stay cases, length of stay is 3 days or fewer.	.....	.....	.....	0.1541	.....	.....	.....	3
5101	Expired, orthopedic, length of stay is 13 days or fewer.	.....	.....	.....	0.6604	.....	.....	.....	8
5102	Expired, orthopedic, length of stay is 14 days or more.	.....	.....	.....	1.4552	.....	.....	.....	17
5103	Expired, not orthopedic, length of stay is 15 days or fewer.	.....	.....	.....	0.7653	.....	.....	.....	9
5104	Expired, not orthopedic, length of stay is 16 days or more.	.....	.....	.....	1.9930	.....	.....	.....	22

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how the application of the proposed revisions for FY 2014 would affect particular CMG relative weight values, which affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget neutral manner (as described above), total estimated aggregate payments to IRFs for FY 2014 would not be affected as a result of the CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 2—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMG RELATIVE WEIGHTS

[FY 2013 Values Compared With FY 2014 Values]

Percentage change	Number of cases affected	Percentage of cases affected
Increased by 15% or more	0	0.0
Increased by between 5% and 15%	2,325	0.7
Changed by less than 5%	340,496	98.7
Decreased by between 5% and 15%	1,939	0.6
Decreased by 15% or more	92	0.0

As Table 2 shows, almost 99 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the proposed revisions for FY 2014. The largest increase in the proposed CMG relative weight values that affects a particularly large number of IRF discharges is a 0.9 percent increase in the CMG relative weight value for CMG 0704—Fracture of Lower Extremity, with a motor score less than 28.15—in the ''no comorbidity'' tier. In the FY 2012 data, 18,770 IRF discharges (5.4 percent of all IRF discharges) were classified into this CMG and tier.

The largest decrease in a CMG relative weight value affecting the most cases is a 2.0 percent decrease in the CMG relative weight for CMG 0903—Other Orthopedic with a motor score between 24.15 and 34.35—in the no comorbidity tier. In the FY 2012 IRF claims data, this change affects 6,605 cases (1.9 percent of all IRF cases).

The changes in the average length of stay values for FY 2014, compared with the FY 2013 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

IV. Proposed Updates to the Facility-Level Adjustment Factors for FY 2014

A. Background on Facility-Level Adjustments

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate ''by such . . . factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.'' For example, we adjust the federal prospective payment amount associated with a CMG to account for facility-level characteristics such as an IRF's LIP, teaching status, and location

in a rural area, if applicable, as described in § 412.624(e).

In the FY 2010 IRF PPS final rule (74 FR 39762), we updated the adjustment factors for calculating the rural, LIP, and teaching status adjustments based on the most recent three consecutive years' worth of IRF claims data (at that time, FY 2006, FY 2007, and FY 2008) and the most recent available corresponding IRF cost report data. As discussed in the FY 2010 IRF PPS proposed rule (74 FR 21060 through 21061), we observed relatively large year-to-year fluctuations in the underlying data used to compute the adjustment factors, especially the teaching status adjustment factor. Therefore, we implemented a 3-year moving average approach to updating the facility-level adjustment factors in the FY 2010 IRF PPS final rule (74 FR 39762) to provide greater stability and predictability of Medicare payments for IRFs.

Each year, we review the major components of the IRF PPS to maintain and enhance the accuracy of the payment system. For FY 2010, we implemented a change to our methodology that was designed to decrease the IRF PPS volatility by using a 3-year moving average to calculate the facility-level adjustment factors. For FY 2011, we issued a notice to update the payment rates, which did not include any policy changes or changes to the IRF facility-level adjustments. As we found that the implementation of the 3-year moving average did not fully address year-to-year fluctuations, in the FY 2012 IRF PPS proposed rule (76 FR 24214 at 24225 through 24226) we analyzed the effects of having used a weighting methodology. The methodology assigned greater weight to some facilities than to others in the regression analysis used to estimate the facility-level adjustment factors. As we found that this weighting methodology inappropriately exaggerated the cost differences among different types of IRF facilities, we proposed to remove the weighting factor from our analysis and update the IRF facility-level adjustment factors for FY 2012 using an un-weighted regression analysis. However, after carefully considering all of the comments that we received on the proposed FY 2012 updates to the facility-level adjustment factors, we decided to hold the facility-level adjustment factors at FY 2011 levels for FY 2012 to conduct further research on the underlying data and the best methodology for calculating the facility-level adjustment factors. We based this decision, in part, on comments we received about the financial hardships that the proposed updates would create for facilities with teaching programs and a higher disproportionate share of low-income patients.

B. Proposed Updates to the IRF Facility-Level Adjustment Factors

Since the FY 2012 final rule (76 FR 47836), we have conducted further research into the best methodology to use to estimate the IRF facility-level adjustment factors, to ensure that the adjustment factors reflect as accurately as possible the costs of providing IRF care across the full spectrum of IRF providers. Our recent research efforts have shown that significant differences exist between the cost structures of freestanding IRFs and the cost structures of IRF units of acute care hospitals (and critical access hospitals, otherwise known as ''CAHs''). We have found that these cost structure differences substantially influence the estimates of the adjustment factors. Therefore, we believe that it is important to control for these cost structure differences between hospital-based and freestanding IRFs in our regression analysis, so that these differences do not inappropriately influence the adjustment factor estimates. In Medicare's payment system for the treatment of end-stage renal disease (ESRD), we already control for the cost structure differences between hospital-based and freestanding facilities in the regression analyses that are used to set payment rates. Also, we received comments from an IRF industry association on the FY 2012 IRF PPS proposed rule suggesting that the addition of this particular control variable to the model could improve the methodology for estimating the IRF facility-level adjustment factors.

Thus, we propose to add an indicator variable to our 3-year moving average methodology for updating the IRF facility-level adjustments that would have an assigned value of ''1'' if the facility is a freestanding IRF hospital and have an assigned value of ''0'' if the facility is an IRF unit of an acute care hospital (or CAH). Adding this variable to the regression analysis enables us to control for the differences in costs that are primarily due to the differences in cost structures between freestanding and hospital-based IRFs, so that those differences do not become inappropriately intertwined with our estimates of the differences in costs between rural and urban facilities, high LIP percentage and low LIP percentage facilities, and teaching and non-teaching facilities. Further, by including this variable in the regression analysis, we greatly improve our ability to predict an IRF's average cost per case (that is, the R-squared of the regression model increases from about 11 percent to 41 percent). In this way, it enhances the precision with which we can estimate the IRF facility-level adjustments.

Therefore, in this proposed rule, we propose to use the same methodology used in the FY 2010 IRF PPS final rule (74 FR 39762), including the 3-year moving average approach, with the addition of this new control variable, which equals ''1'' if the facility is a freestanding IRF hospital and ''0'' if it is an IRF unit of an acute care hospital (or a CAH). We propose to update the adjustment factors using the most recent three years' worth of IRF claims data (FY 2010, FY 2011, and FY 2012) and the most recent available corresponding IRF cost report data. As we did in the FY 2010 IRF PPS final rule (74 FR 39762), we propose to use the cost report data that corresponds with each IRF claim, when available. In the rare instances in which the corresponding year's cost report data are not available, we propose to use the most recent available cost report data, as we also did in the FY 2010 IRF PPS final rule (74 FR 39762).

To calculate the proposed updates to the rural, LIP, and teaching status adjustment factors for FY 2014, we propose to use the following steps:

[Steps 1 and 2 are performed independently for each of three years of IRF claims data: FY 2010, FY 2011, and FY 2012.]

Step 1. Calculate the average cost per case for each IRF in the IRF claims data.

Step 2. Use logarithmic regression analysis on average cost per case to compute the coefficients for the rural, LIP, and teaching status adjustments. We are also proposing to incorporate an additional indicator variable to account for whether a facility is a freestanding IRF hospital or a unit of an acute care hospital (or a CAH).

Step 3. Calculate a simple mean for each of the coefficients across the three years of data (using logarithms for the LIP and teaching status adjustment coefficients (because they are continuous variables), but not for the rural adjustment coefficient (because the rural variable is either zero (if not rural) or 1 (if rural)). To compute the LIP and teaching status adjustment factors, we convert these factors back out of the logarithmic form.

Based on this methodology, we propose to update the rural adjustment factor for FY 2014 from 18.4 percent to 14.28 percent. We propose to update the LIP adjustment factor for FY 2014 from 0.4613 to 0.3158 and the teaching status adjustment factor for FY 2014 from 0.6876 to 0.9859. The proposed adjustment factors are subject to change

for the final rule if more data become available for use in these analyses.

Further, although we believe that updating the facility-level adjustment factors with the proposed methodology will enhance the accuracy and fairness of the IRF PPS payment rates, we recognize that this would result in significant financial impacts for IRF providers. Thus, we welcome comments from the industry on whether updating the adjustment factors at this time or freezing them at the current levels for an additional year would be a better approach.

C. Budget Neutrality Methodology for the Updates to the IRF Facility-Level Adjustment Factors

Consistent with the way that we implemented changes to the IRF facility-level adjustment factors (the rural, LIP, and teaching status adjustments factors) in the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166), which was the only year in which we updated these adjustment factors, we propose to make changes to the rural, LIP, and teaching status adjustment factors for FY 2014 in such a way that total estimated aggregate payments to IRFs for FY 2014 would be the same with or without the proposed changes (that is, in a budget neutral manner) by applying budget neutrality factors for each of these three changes to the standard payment amount. To calculate the proposed budget neutrality factors used to update the rural, LIP, and teaching status adjustment factors, we propose to use the following steps:

Step 1. Using the most recent available data (currently FY 2011), calculate the estimated total amount of IRF PPS payments that would be made in FY 2014 (without applying the proposed changes to the rural, LIP, or teaching status adjustment factors).

Step 2. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2014 if the proposed update to the rural adjustment factor were applied.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (1.0030) that would maintain the same total estimated aggregate payments in FY 2014 with and without the proposed change to the rural adjustment factor.

Step 4. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2014 if the proposed update to the LIP adjustment factor were applied.

Step 5. Divide the amount calculated in step 1 by the amount calculated in step 4 to determine the proposed budget neutrality factor (1.0174) that would maintain the same total estimated aggregate payments in FY 2014 with and without the proposed change to the LIP adjustment factor.

Step 6. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2014 if the proposed update to the teaching status adjustment factor were applied.

Step 7. Divide the amount calculated in step 1 by the amount calculated in step 6 to determine the proposed budget neutrality factor (0.9966) that would maintain the same total estimated aggregate payments in FY 2014 with and without the proposed change to the teaching status adjustment factor.

Step 8. Apply the proposed budget neutrality factors for the updates to the rural, LIP, and teaching status adjustment factors to the FY 2013 IRF PPS standard payment amount after the application of the proposed budget neutrality factors for the wage adjustment and the CMG relative weights.

The proposed budget neutrality factors for the proposed changes to the rural, LIP, and teaching status adjustment factors are subject to change in the final rule if more recent data become available for use in these analyses or if the proposed payment policies associated with the proposed budget neutrality factors change. In section V.E of this proposed rule, we discuss the proposed methodology for calculating the standard payment conversion factor for FY 2014.

V. Proposed FY 2014 IRF PPS Federal Prospective Payment Rates

A. Proposed Market Basket Increase Factor, Productivity Adjustment, Other Adjustment, and Secretary's Recommendation for FY 2014

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services, which is referred to as a market basket index. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF federal prospective payment rates for each FY. Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iii) of the Act required the application of a 0.3 percentage point reduction to the market basket increase factor for FY 2014. In addition, section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment, as described below. Thus, in this proposed rule, we are proposing to update the IRF PPS payments for FY 2014 by a market basket increase factor based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act as described below and a 0.3 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iii) of the Act.

For this proposed rule, we propose to use the same methodology described in the FY 2012 IRF PPS final rule (76 FR 47836 at 47848 through 47863) to compute the FY 2014 market basket increase factor and labor-related share. In that final rule, we rebased the RPL market basket from a 2002 base year to a 2008 base year. Based on IHS Global Insight's first quarter 2013 forecast, the most recent estimate of the 2008-based RPL market basket increase factor for FY 2014 is 2.5 percent. IHS Global Insight (IGI) is an economic and financial forecasting firm that contracts with CMS to forecast the components of providers' market baskets.

In accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47858 through 47859), we propose to apply a productivity adjustment to the FY 2014 RPL market basket increase factor. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY cost reporting period, or other annual period) (the ''MFP adjustment''). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS Web site at *http://www.bls.gov/mfp* to obtain the historical BLS-published MFP data. The projection of MFP is currently produced by IGI, using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47859). The most recent estimate of the MFP adjustment for FY 2014 (the 10-year moving average of MFP for the period ending FY 2014) is 0.4 percent, which was calculated using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47858 through 47859) and is based on IGI's first quarter 2013 forecast.

Thus, in accordance with section 1886(j)(3)(C) of the Act, we propose to base the FY 2014 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the most recent estimate of the FY 2008-based RPL market basket (currently estimated to be

2.5 percent based on IGI's first quarter 2013 forecast). We propose to then reduce this percentage increase by the current estimate of the MFP adjustment for FY 2014 of 0.4 percentage point (the 10-year moving average of MFP for the period ending FY 2014 based on IGI's first quarter 2013 forecast), which was calculated as described in the FY 2012 IRF PPS final rule (76 FR 47836, 47859). Following application of the productivity adjustment, we propose to further reduce the applicable percentage increase by 0.3 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iii) of the Act. Therefore, the current estimate of the proposed FY 2014 IRF update is 1.8 percent (2.5 percent market basket update less 0.4 percentage point MFP adjustment less 0.3 percentage point legislative adjustment). Furthermore, we also are proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket and MFP adjustment), we would use such data, if appropriate, to determine the FY 2014 market basket update and MFP adjustment in the final rule.

B. Secretary's Proposed Recommendation

For FY 2014, the Medicare Payment Advisory Commission (MedPAC) recommends that a 0 percent update be applied to IRF PPS payment rates for FY 2013. As discussed above, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is proposing to update IRF PPS payment rates for FY 2014 by an adjusted market basket increase factor of 1.8 percent because section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2014.

C. Proposed Labor-Related Share for FY 2014

The proposed labor-related share for FY 2014 is updated using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47860 through 47863). Using this method and IGI's first quarter 2013 forecast of the 2008-based RPL market basket, the proposed IRF labor-related share for FY 2014 is the sum of the FY 2014 relative importance of each labor-related cost category. This figure reflects the different rates of price change for these cost categories between the base year (FY 2008) and FY 2014. As shown in Table 3, the proposed FY 2014 labor-related share is 69.658 percent. We propose that if a more recent estimate of the FY 2014 labor-related share is subsequently available, we would use such data, if appropriate, to determine the FY 2014 labor-related share in the final rule.

TABLE 3—PROPOSED FY 2014 IRF RPL LABOR-RELATED SHARE RELATIVE IMPORTANCE

	Proposed FY 2014 Relative Importance Labor-Related Share
Wages and Salaries	48.491
Employee Benefits	13.019
Professional Fees: Labor-Related	2.069
Administrative and Business Support Services	0.417
All Other: Labor-Related Services	2.086
Subtotal	66.082
Labor-Related Portion of Capital Costs (.46)	3.576
Total Labor-Related Share	69.658

Source: IHS Global Insight, Inc. 1st quarter 2013 forecast; Historical Data through 4th quarter, 2012.

D. Proposed Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget neutral manner.

In the FY 2009 IRF PPS final rule (73 FR 46378), we maintained the methodology described in the FY 2006 IRF PPS final rule to determine the wage index, labor market area definitions and hold harmless policy consistent with the rationale outlined in the FY 2006 IRF PPS final rule (70 FR 47880, 47917 through 47926).

For FY 2014, we are maintaining the policies and methodologies described in the FY 2012 IRF PPS final rule (76 FR 47836, at 47863 through 47865) relating to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we are using the CBSA labor market area definitions and the FY 2013 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2013 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2008, and before October 1, 2009 (that is, FY 2009 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data in which to base the calculation for the FY 2014 IRF PPS wage index.

In accordance with our established methodology, we have historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the hospital wage data used to determine the IRF PPS wage index. The OMB bulletins are available at *http://www.whitehouse.gov/omb/bulletins/index.html.*

In keeping with the established IRF PPS wage index policy, we propose to use the prior year's (FY 2013) pre-floor, pre-reclassified hospital wage index data to derive the FY 2014 applicable IRF PPS wage index. We anticipate using the FY 2014 pre-floor, pre-reclassified hospital wage index data to

derive the applicable IRF PPS wage index for FY 2015. We note, however, that the proposed FY 2014 pre-floor, pre-reclassified hospital wage index does not use OMB's new 2010 Census-based area delineations, which were outlined in the February 28, 2013 OMB Bulletin 13–01. This bulletin contains a number of significant changes. For example, there are new CBSAs, counties that change from urban to rural, counties that change from rural to urban, and existing CBSAs that are being split apart. The OMB Bulletin with these changes was not published in time for us to incorporate these changes into the FY 2014 pre-floor, pre-reclassified hospital wage index, since the proposed rule was already in the advanced stages of development at that time and the changes and their ramifications would need to be extensively reviewed and verified prior to their inclusion in the rule. We therefore intend to propose the incorporation of these CBSA changes in our FY 2015 hospital wage index. Assuming that we would continue to follow our established methodology for the IRF PPS wage index, this means that the 2010 Census-based CBSA changes would not be reflected in the IRF PPS wage index until FY 2016.

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted Federal payment rate for IRFs by the proposed FY 2014 labor-related share based on the FY 2008-based RPL market basket (69.658 percent) to determine the labor-related portion of the standard payment amount. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this proposed rule. These tables are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/.* Table A is for urban areas and Table B is for rural areas.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner. We calculate a proposed budget neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the proposed FY 2014 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2009 hospital cost report data) and the proposed labor-related share in a budget neutral manner:

Step 1. Determine the total amount of the estimated FY 2013 IRF PPS rates, using the FY 2013 standard payment conversion factor and the labor-related share and the wage indexes from FY 2013 (as published in the FY 2013 IRF PPS notice (77 FR 44618)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2013 standard payment conversion factor and the proposed FY 2014 labor-related share and CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2014 budget neutral wage adjustment factor of 1.0011.

Step 4. Apply the proposed FY 2014 budget neutral wage adjustment factor from step 3 to the FY 2013 IRF PPS standard payment conversion factor after the application of the adjusted market basket update to determine the proposed FY 2014 standard payment conversion factor.

We discuss the calculation of the proposed standard payment conversion factor for FY 2014 in section V.E. of this proposed rule.

E. Description of the Proposed IRF Standard Conversion Factor and Payment Rates for FY 2014

To calculate the proposed standard payment conversion factor for FY 2014, as illustrated in Table 4, we begin by applying the proposed adjusted market basket increase factor for FY 2014 that was adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act, to the standard payment conversion factor for FY 2013 ($14,343). Applying the proposed 1.8 percent adjusted market basket increase factor for FY 2014 to the revised standard payment conversion factor for FY 2013 of $14,343 yields a standard payment amount of $14,601. Then, we apply the proposed budget neutrality factor for the FY 2014 wage index and labor-related share of 1.0011, which results in a standard payment amount of $14,617. We next apply the proposed budget neutrality factors for the revised CMG relative weights of 1.0000, which results in a standard payment conversion factor of $14,617 for FY 2014.

We then apply the proposed budget neutrality factors for the facility adjustments. Applying the budget neutrality factor for the revised rural adjustment of 1.0030 results in a standard payment conversion factor of $14,661. We then apply the budget neutrality factor for the revised LIP adjustment of 1.0174 resulting in a standard payment conversion factor of $14,916. Lastly, we apply the budget neutrality factor for the revised teaching adjustment of 0.9966 which results in a final standard payment conversion factor of $14,865.

TABLE 4—CALCULATIONS TO DETERMINE THE PROPOSED FY 2014 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
Standard Payment Conversion Factor for FY 2013	$14,343
Market Basket Increase Factor for FY 2014 (2.5 percent), reduced by 0.3 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and a 0.4 percentage point reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	× 1.018
Budget Neutrality Factor for the Wage Index and Labor-Related Share	× 1.0011
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	× 1.0000
Budget Neutrality Factor for the Update to the Rural Adjustment Factor	× 1.0030
Budget Neutrality Factor for the Update to the LIP Adjustment Factor	× 1.0174
Budget Neutrality Factor for the Update to the Teaching Status Adjustment Factor	× 0.9966
Proposed FY 2014 Standard Payment Conversion Factor	= 14,865

After the application of the CMG relative weights described in Section III of this proposed rule, to the proposed FY 2014 standard payment conversion factor ($14,865), the resulting proposed unadjusted IRF prospective payment rates for FY 2014 are shown in Table 5.

TABLE 5—PROPOSED FY 2014 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$ 11,893.49	$ 10,586.85	$ 9,745.49	$ 9,287.65
0102	14,747.57	13,127.28	12,083.76	11,517.40
0103	17,262.72	15,365.95	14,145.53	13,481.07
0104	18,150.17	16,156.77	14,873.92	14,175.26
0105	21,231.68	18,900.85	17,398.00	16,580.42
0106	24,270.09	21,604.79	19,887.88	18,954.36
0107	27,370.92	24,365.22	22,428.31	21,375.87
0108	34,427.34	30,645.68	28,210.80	26,886.33
0109	31,267.04	27,833.23	25,621.31	24,417.25
0110	40,710.78	36,240.87	33,361.52	31,793.26
0201	11,993.08	10,160.23	9,006.70	8,385.35
0202	15,661.76	13,268.50	11,761.19	10,949.56
0203	18,465.30	15,643.93	13,867.56	12,910.25
0204	19,324.50	16,370.82	14,511.21	13,510.80
0205	23,419.81	19,840.32	17,586.78	16,373.80
0206	28,925.80	24,504.95	21,722.22	20,223.83
0207	38,179.27	32,344.75	28,670.13	26,693.08
0301	16,339.61	14,065.26	12,638.22	11,682.40
0302	20,417.08	17,576.38	15,794.06	14,597.43
0303	24,112.52	20,757.49	18,652.60	17,238.94
0304	32,303.13	27,809.44	24,988.07	23,095.75
0401	17,021.91	14,112.83	13,151.07	11,777.54
0402	21,017.62	17,427.73	16,238.53	14,543.92
0403	34,292.07	28,433.77	26,493.89	23,729.00
0404	62,606.92	51,910.07	48,369.22	43,319.58
0405	51,258.98	42,502.01	39,603.33	35,469.38
0501	12,635.25	10,002.66	9,406.57	8,563.73
0502	16,446.64	13,020.25	12,244.30	11,148.75
0503	21,221.27	16,800.42	15,798.52	14,384.86
0504	24,577.79	19,456.80	18,297.33	16,659.21
0505	28,979.32	22,941.15	21,575.06	19,642.61
0506	40,593.34	32,136.64	30,220.55	27,515.12
0601	14,361.08	11,706.19	10,809.83	9,794.55
0602	19,181.80	15,635.01	14,438.37	13,082.69
0603	24,057.52	19,608.42	18,108.54	16,407.99
0604	32,053.40	26,125.24	24,127.38	21,860.47
0701	14,039.99	11,969.30	11,463.89	10,399.55
0702	18,059.49	15,395.68	14,746.08	13,377.01
0703	21,955.61	18,716.52	17,927.19	16,262.31
0704	27,876.33	23,764.68	22,761.29	20,648.97
0801	10,418.88	9,272.79	8,435.89	7,729.80
0802	13,684.72	12,178.89	11,078.88	10,152.80
0803	18,548.55	16,507.58	15,018.11	13,760.53
0804	16,474.88	14,661.35	13,338.36	12,222.00
0805	20,332.35	18,095.16	16,462.99	15,085.00
0806	24,661.04	21,948.17	19,968.15	18,295.84
0901	13,417.15	11,119.02	10,249.42	9,296.57
0902	17,913.81	14,845.68	13,684.72	12,412.28
0903	22,437.23	18,594.63	17,139.35	15,547.30
0904	29,224.59	24,219.54	22,325.74	20,250.59
1001	15,417.98	14,037.02	12,086.73	11,116.05
1002	19,444.91	17,702.73	15,244.06	14,019.18
1003	28,734.05	26,160.91	22,526.42	20,715.86
1101	18,414.76	16,847.99	15,588.93	15,083.52
1102	25,373.07	23,216.16	21,479.93	20,782.76
1201	14,094.99	13,898.78	12,586.20	11,523.35
1202	17,560.02	17,316.24	15,681.09	14,358.10
1203	21,808.44	21,506.68	19,474.64	17,830.57
1301	17,563.00	14,851.62	13,385.93	12,146.19
1302	22,750.88	19,238.28	17,341.51	15,734.60
1303	29,249.86	24,733.87	22,294.53	20,228.29
1401	13,176.34	10,726.58	9,720.22	8,798.59
1402	17,797.86	14,488.92	13,128.77	11,884.57
1403	21,708.85	17,673.00	16,014.06	14,496.35
1404	27,675.66	22,530.88	20,415.59	18,481.65
1501	14,869.46	12,769.04	11,515.92	11,053.61
1502	18,715.04	16,072.04	14,494.86	13,912.15
1503	22,630.48	19,434.50	17,527.32	16,824.21
1504	28,088.90	24,121.44	21,753.44	20,880.87
1601	15,324.33	13,106.47	12,311.19	11,249.83
1602	20,121.26	17,209.21	16,164.20	14,771.35

TABLE 5—PROPOSED FY 2014 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
1603	25,347.80	21,679.12	20,363.56	18,608.01
1701	16,165.69	14,111.34	12,696.20	11,472.81
1702	20,232.75	17,661.11	15,889.20	14,358.10
1703	24,418.74	21,314.92	19,177.34	17,329.62
1704	30,980.15	27,043.89	24,331.03	21,985.34
1801	17,059.07	15,791.09	13,883.91	11,704.70
1802	25,431.04	23,541.70	20,698.03	17,450.02
1803	40,655.78	37,633.72	33,088.00	27,895.66
1901	16,289.07	13,831.88	13,473.64	13,209.04
1902	31,721.91	26,935.38	26,239.70	25,723.88
1903	52,027.50	44,177.29	43,035.66	42,189.84
2001	13,225.39	10,857.40	9,983.33	9,124.14
2002	17,637.32	14,480.00	13,313.09	12,168.49
2003	22,163.72	18,196.25	16,729.07	15,290.14
2004	29,041.75	23,841.97	21,919.93	20,035.05
2101	32,378.94	23,393.05	22,126.55	20,894.24
5001				2,290.70
5101				9,816.85
5102				21,631.55
5103				11,376.18
5104				29,625.95

F. Example of the Methodology for Adjusting the Proposed Federal Prospective Payment Rates

Table 6 illustrates the methodology for adjusting the proposed federal prospective payments (as described in sections V.A. through V.C. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted federal prospective payment rate for CMG 0110 (without comorbidities) appears in Table 5.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0155), a wage index of 0.8472, and a rural adjustment of 14.28 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0451 percent), a wage index of 0.8862, and a teaching status adjustment of 0.0610.

To calculate each IRF's labor and non-labor portion of the proposed Federal prospective payment, we begin by taking the proposed unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 5. Then, we multiply the proposed labor-related share for FY 2014 (69.658 percent) described in section V.C. of this proposed rule by the proposed unadjusted federal prospective payment rate. To determine the non-labor portion of the proposed federal prospective payment rate, we subtract the labor portion of the proposed federal payment from the proposed unadjusted Federal prospective payment.

To compute the proposed wage-adjusted federal prospective payment, we multiply the labor portion of the proposed federal payment by the appropriate wage index found in tables A and B. These tables are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/*. The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the proposed wage-adjusted federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0610, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted federal prospective payment rates. Table 6 illustrates the components of the adjusted payment calculation.

TABLE 6—EXAMPLE OF COMPUTING THE IRF FY 2014 FEDERAL PROSPECTIVE PAYMENT

Steps		Rural facility A (Spencer Co., IN)		Urban facility B (Harrison Co., IN)	
1	Unadjusted Federal Prospective Payment		$ 31,793.26		$ 31,793.26
2	Labor Share	×	0.69658	×	0.69658
3	Labor Portion of Federal Payment	=	22,146.55	=	22,146.55
4	CBSA Based Wage Index (shown in the Addendum , Tables 1 and 2)	×	0.8472	×	0.8862
5	Wage-Adjusted Amount	=	18,762.56	=	19,626.27
6	Nonlabor Amount	+	9,646.71	+	9,646.71
7	Wage-Adjusted Federal Payment	=	28,409.27	=	29,272.98
8	Rural Adjustment	×	1.1428	×	1.000
9	Wage- and Rural- Adjusted Federal Payment	=	32,466.11	=	29,272.98
10	LIP Adjustment	×	1.0155	×	1.0451
11	FY 2014 Wage-, Rural- and LIP- Adjusted Federal Prospective Payment Rate	=	32,969.33	=	30,593.19
12	FY 2014 Wage- and Rural-Adjusted Federal Prospective Payment		32,466.11		29,272.98
13	Teaching Status Adjustment	×	0	×	0.0610
14	Teaching Status Adjustment Amount	=	0.00	=	1,785.65
15	FY 2014 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+	32,969.33	+	30,593.19

TABLE 6—EXAMPLE OF COMPUTING THE IRF FY 2014 FEDERAL PROSPECTIVE PAYMENT—Continued

16	Total FY 2014 Adjusted Federal Prospective Payment	=	32,969.33	=	32,378.84

Thus, the proposed adjusted payment for Facility A would be $32,969.33 and the proposed adjusted payment for Facility B would be $32,378.84.

VI. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS

A. Proposed Update to the Outlier Threshold Amount for FY 2014

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2012 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, and 77 FR 44618, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2014, we propose to use FY 2012 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316 and 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2013. Based on an analysis of this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.8 percent in FY 2014. Therefore, we propose to update the outlier threshold amount to $10,111 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2014.

B. Proposed Update to the IRF Cost-to-Charge Ratio Urban and Rural Ceilings

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2014, based on analysis of the most recent data that is available. We apply 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 the national CCR ceiling for FY 2014, as discussed below.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2014, we estimate a proposed national average CCR of 0.638 for rural IRFs, which we calculate by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we estimate a national average CCR of 0.511 for urban IRFs, which we calculate by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher costs factor more heavily into the averages than the CCRs of IRFs with lower costs. For this proposed rule, we have used the most recent available cost report data (FY 2011). This includes all IRFs whose cost reporting periods begin on or after October 1, 2010, and before October 1, 2011. If, for any IRF, the FY 2011 cost report was missing or had an ''as submitted'' status, we used data from a previous fiscal year's (that is, FY 2004 through FY 2010) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, the national CCR ceiling is set at 1.43 for FY 2014. This means that, if an individual IRF's CCR exceeds this ceiling of 1.43 for FY 2014, we would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF). We estimate the national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as discussed above) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

We note that the proposed national average rural and urban CCRs and our estimate of the national CCR ceiling in this section are subject to change in the final rule if more recent data become available for use in these analyses.

VII. Proposed Refinements to the Presumptive Compliance Criteria Methodology

A. Background on the Compliance Percentage

The compliance percentage has been part of the criteria for defining IRFs

since implementation of the IPPS in 1983. In the September 1, 1983 interim final rule with comment period (48 FR 39752) which allowed IRFs to be paid separately from the IPPS, the initial compliance percentage was set at 75 percent. The 1983 interim rule stipulated that in accordance with sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act, a rehabilitation hospital and a rehabilitation unit were excluded from the IPPS. Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act also give the Secretary the discretion to define a rehabilitation hospital and unit.

A hospital or unit deemed excluded from the IPPS and paid under the IRF PPS must meet the general requirements in subpart B and subpart P of part 412. Subject to the special payment provisions of § 412.22(c), a hospital or unit must meet the general criteria set forth in § 412.22 and in the regulations at § 412.23(b), § 412.25, and § 412.29 that specify the criteria for a provider to be classified as a rehabilitation hospital or unit. Hospitals and units meeting these criteria are eligible to be paid on a prospective payment basis as an IRF under the IRF PPS.

The 1983 interim final rule stipulated that one of the criteria for being classified as an IRF was that, during the facility's most recently completed 12-month cost reporting period, the hospital must be primarily engaged in furnishing intensive rehabilitation services, as demonstrated by patient medical records, indicating that at least 75 percent of the IRF's patient population were treated for one or more of the 10 medical conditions specified in the regulation that typically required the intensive inpatient rehabilitation treatment provided in an IRF. These criteria, along with other related criteria, distinguished an inpatient rehabilitation hospital or unit from a hospital that furnished general medical or surgical services, as well as rehabilitation services. We believed then, as we do now, that by examining the types of conditions for which a hospital's inpatients are treated, and the proportion of patients treated for conditions that typically require intensive inpatient rehabilitation, we would be able to distinguish those hospitals in which the provision of rehabilitation services was primary rather than secondary. Thus, Medicare pays for rehabilitation services at IRFs at a higher rate than other hospitals because IRFs are designed to offer specialized inpatient rehabilitation care to patients with intensive needs.

The original medical conditions specified under the compliance percentage, or ''75 percent rule,'' were stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, and polyarthritis (including rheumatoid arthritis). In the January 3, 1984 final rule (49 FR 234), we expanded the list of eligible medical conditions to include neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease) and burns. In the May 7, 2004 final rule (69 FR 25752), we modified and expanded the list of eligible medical conditions by removing polyarthritis and substituting three more clearly defined arthritis-related conditions. The three conditions that replaced polyarthritis included the following:

- Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which results from a systemic disease activation immediately before admission, but has the potential to improve with more intensive rehabilitation.
- Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which results from a systemic disease activation immediately before admission, but has the potential to improve with more intensive rehabilitation.
- Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving three or more major joints (elbow, shoulders, hips, or knees) with joint deformity and substantial loss of range of motion, atrophy, significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but has the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis is no longer considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

In the May 7, 2004 final rule (69 FR 25752), a 13th condition was also added to include patients who undergo knee and/or hip joint replacement during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet at least one of the following specific criteria:

- Underwent bilateral knee or hip joint replacement surgery during the acute hospitalization immediately preceding the IRF admission.
- Are extremely obese patients as measured by the patient's Body Mass Index (BMI) of at least 50, at the time of admission to the IRF.
- Are patients considered to be''frail elderly,'' as determined by a patient's age of 85 or older, at the time of admission to the IRF (the provision currently states only that the patients be age 85 or older at the time of admission to the IRF.)

In 2002, we surveyed Medicare fiscal intermediaries to determine how they were enforcing the 75 percent rule. Although the 75 percent rule was one of the criteria that was used to distinguish an IRF from an acute care hospital from 1983 to 2004, we found evidence that different fiscal intermediaries were enforcing the rule differently. We found fiscal intermediaries were using inconsistent methods to determine whether IRFs were in compliance with the regulation, and that some IRFs were not being reviewed for compliance at all. This led to concerns that some IRFs might have been out of compliance with the regulation and inappropriately classified as IRFs, while other IRFs may have been held to overly high standards. Because of these concerns we sought to establish a more uniform enforcement of the 75 percent rule.

In the May 16, 2003 IRF PPS proposed rule (68 FR 26786), we solicited comments on the regulatory requirements of the 75 percent rule. Though we did not, at that time, propose amending the regulatory requirements for the 75 percent rule located in then § 412.23(b)(2), we did propose to amend these requirements in the September 9, 2003 proposed rule titled, ''Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility'' (68 FR 53266). In that rule, we proposed some revisions to the 75 percent rule, including lowering the compliance percentage to 65 percent during a 3-year transition period for cost reporting periods between January 1, 2004 and January 1, 2007. Also, in response to

comments on the September 9, 2003 proposed rule and as stated above, the May 7, 2004 final rule (69 FR 25752) expanded the number of medical conditions that would meet the compliance percentage from 10 to 13 and provided that patient comorbidities may also be included in determining an IRF's compliance with the requirements during the transition period.

In the September 9, 2003 proposed rule, we defined a ''comorbidity'' as a specific patient condition that is secondary to the patient's principal diagnosis or impairment that is the primary reason for the inpatient rehabilitation stay. In the May 7, 2004 rule, we adopted the provision to use a patient with a comorbidity counting towards the compliance threshold during the transition period. In the determination of the compliance percentage, a patient comorbidity counts toward the percentage if the comorbidity falls in one of the conditions specified at § 412.29(b)(2) *and* has caused significant decline in functional ability in the individual that even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to IRFs.

Anticipating that IRFs needed some time to adjust and adapt their processes to the changes in the enforcement of the 75 percent rule, in the May 7, 2004 final rule, we provided IRFs with a 3-year phase-in period (cost reporting periods beginning on or after July 1, 2004 through July 1, 2007) to establish the compliance threshold of 75 percent of the IRF's total patient population. The 3-year phase-in period was intended to begin with cost reporting periods on or after July 1, 2004 with the threshold at 50 percent of the IRF's population and gradually increase to 60 percent, then to 65 percent, and then to expire with cost reporting periods beginning on or after July 1, 2007, when the compliance percentage would once again be at 75 percent.

Section 5005 of the Deficit Reduction Act of 2005 (DRA, Pub. L. 109–171, enacted February 8, 2006) and section 1886(d)(1)(B) of the Act modified the provisions of the 75 percent rule originally specified in the May 7, 2004 final rule. To reflect these statutory changes, in the August 7, 2007 final rule (72 FR 44284), we revised the regulations to prolong the overall duration of the phased transition to the full 75 percent threshold by stipulating that an IRF must meet the full 75 percent compliance threshold as of its first cost reporting period that starts on or after July 1, 2008. We also extended the policy of using a patient's comorbidities to the extent they met the conditions as outlined in the regulations to determine compliance with the classification criteria at then § 412.23(b)(2)(1) to the first cost reporting period that starts on or after July 1, 2008.

Subsequently, section 115 of the MMSEA amended section 5005 of the DRA to revise elements of the 75 percent rule that are used to classify IRFs. In accordance with the statute, in the August 8, 2008 final rule (73 FR 46370), we revised the compliance rate that IRFs must meet to be excluded from the IPPS and be paid under the IRF PPS to 60 percent for cost reporting periods beginning in or after July 1, 2006. Also, in accordance with the statute, we required that patient comorbidities that satisfy the criteria as specified at then § 412.23(b)(2)(i) [now located at § 412.29(b)(1) and § 412.29(b)(2)] be included in calculations used to determine whether an IRF meets the 60 percent compliance percentage for cost reporting periods beginning on or after July 1, 2007. As a result of these changes, the requirements started being referred to as the ''60 percent rule,'' instead of the ''75 percent rule.'' The regulations finalized in the FY 2009 IRF PPS Final Rule (73 FR 46370) continue to be in effect.

Though an IRF must serve an inpatient population of whom at least 60 percent meet the compliance percentage criteria specified at § 412.29(b), the existing regulation allows for 40 percent of reasonable and necessary admissions to an IRF to fall outside of the 13 qualifying medical conditions. Still, the ''60 percent rule'' is one of the primary ways we distinguish an IRF from an acute care hospital. As Medicare payments for IRF services are generally significantly higher than Medicare payments for similar services provided in acute care hospital settings, we believe that it is important to maintain and enforce the 60 percent rule compliance criteria to ensure that the higher Medicare payments are appropriately allocated to those providers that are providing IRF-level services.

B. Proposed Changes to the ICD–9–CM Codes That Meet the Presumptive Compliance Criteria

The presumptive methodology is one of two ways that contractors may evaluate an IRF's compliance with the 60 percent rule compliance criteria (the other methodology is called the medical review methodology). IRFs may be evaluated using the presumptive methodology only if their Medicare fee-for-service and Medicare Advantage populations combined make-up over half of their total patient populations, so that the Medicare populations can be presumed to be representative of the IRF's total patient population. Thus, if an IRF is eligible to use the presumptive methodology to evaluate its compliance with the IRF 60 percent rule, all of its IRF–PAI assessments from the most recently completed 12 month compliance review period are examined (with the use of a computer program) to determine whether they contain any of the codes listed on the presumptive methodology list. Under the rule, each IRF is given the option of whether the Medicare contractor reviews all IRF discharges from that period, or all admissions from that period. Each selected assessment is presumptively categorized as either meeting or not meeting the IRF 60 percent rule requirements based upon the primary reason for the patient to be treated in the IRF (the impairment group) and the ICD–9–CM codes listed as either the etiologic diagnosis (the etiologic problem that led to the condition for which the patient is receiving rehabilitation) or one of 10 comorbidities on the assessment. An impairment group code is not an ICD–9–CM code, but part of a separate unique set of codes specifically developed for the IRF PPS for assigning the primary reason for admission to an IRF. The ICD–9–CM diagnosis codes that may be used to categorize a patient as meeting the 60 percent rule criteria if those codes appear on the patient's IRF–PAI assessment as either the etiologic diagnosis or as a comorbid condition are listed in ''Appendix C: ICD–9–CM Codes That Meet Presumptive Compliance Criteria.'' This list can be downloaded from the October 1, 2007 IRF Compliance Rule Specification Files on the Medicare IRF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html*.

The underlying premise of the presumptive methodology ICD–9–CM code list is that it represents those codes that would be expected to ''presumptively'' meet the 60 percent rule compliance criteria. That is, it reflects those particular diagnosis codes that, if a patient is coded using one of those codes, would more than likely be expected to meet the requirement either that the patient required intensive rehabilitation services for treatment of one or more of the conditions specified at § 412.29(b)(2) or had a comorbidity that caused significant decline in functional ability such that, even in the

absence of the admitting condition, the patient would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities and cannot be appropriately performed in another care setting.

Recently, we began a close examination of the list of ICD–9–CM codes that are currently deemed to meet the 60 percent rule under the presumptive method to begin the process of converting this code list to ICD–10–CM. Upon this examination, we found that changes over time (including changes in the use of the individual codes, changes in clinical practice, changes in the frequency of various types of illness and disability, and changes to the application of 60 percent rule itself) supported our updating the ICD–9–CM codes that are deemed to count toward a facility's 60 percent rule compliance. Such updates would ensure that the codes better reflect the regulations at § 412.29(b).

Our review included taking a fresh look at the regulations in § 412.29(b), which revealed that the following parts of the regulation were not being adequately addressed in the current application of the presumptive method of calculating compliance with the IRF 60 percent rule:

- The details of the requirements in paragraph § 412.29(b)(1), which specify that the IRF must serve ''an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified . . .'', and
- The details of the requirements regarding the specific conditions under which a patient's comorbidity may be used to show that a patient meets the 60 percent rule criteria, specifically that, ''The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities . . . and that cannot be appropriately performed in another care setting . . .''

These requirements must be met in conjunction with a patient having one of the 13 conditions listed in § 412.29(b)(2) for the case to meet the 60 percent rule compliance criteria. It is not enough for the patient to just have one of the 13 conditions. Mindful of these requirements, we took a fresh look at the ICD–9–CM codes on the presumptive methodology list.

Further, the regulations in § 412.29 also specify that the arthritis conditions only meet the 60 percent rule compliance criteria if certain severity and prior treatment criteria are met. It is impossible to discern from the ICD–9–CM codes themselves whether or not the required severity and prior treatment criteria are met for those patients being treated for arthritis conditions. This type of information can only be assessed on medical review. Thus, we found that the presence of the ICD–9–CM code, by itself, cannot allow us to presume that patients meet all of the requirements for being counted toward a facility's meeting the 60 percent rule requirements. As such, we believe that certain ICD–9–CM codes currently on the presumptive methodology list do not necessarily demonstrate a patient's meeting the requirements for inclusion in a facility's 60 percent compliance threshold, and, as such, should be removed from the list to better reflect the regulations.

Therefore, we performed a clinical analysis of the ICD–9–CM code list to determine the clinical appropriateness of each individual ICD–9–CM code's inclusion on the list, and a statistical analysis of the ICD–9–CM diagnoses code list to enhance our understanding of how individual ICD–9–CM codes are being used by IRFs. Based on these analyses, we are proposing specific revisions to the ICD–9–CM code list that are described below in sections VII.B.1 through VII.B.6 of this proposed rule.

We encourage stakeholders comment on the following proposals. All such public comment(s) will be addressed in the final rule.

1. Non-Specific Diagnosis Codes

We believe that highly descriptive codes provide the best and clearest way to ensure the appropriateness of a given patient's inclusion in the presumptive method of calculating a facility's compliance percentage. Therefore, whenever possible, we believe that the most specific code that describes a medical disease, condition, or injury should be documented on the IRF–PAI. Generally, ''unspecified'' codes are used when there is lack of information about location or severity of medical conditions in the medical record. However, site and/or severity of condition is an important determinant in assessing whether a patient's principal or secondary diagnosis falls into the 13 qualifying conditions and, as such, should count toward the facility's compliance with the 60 percent rule. For this reason, and in accordance with ICD–9–CM coding guidelines, we believe that specific diagnosis codes that narrowly identify anatomical sites where disease, injury, or condition exist should be required when coding patients' conditions on the IRF–PAI whenever such codes are available. Furthermore, on the same note, we believe that one should also include on the IRF–PAI the more descriptive ICD–9–CM code that indicates the degree of injury in instances of burns. In accordance with these principles, we propose to remove non-specific codes from Appendix C whenever more specific codes are available as we believe imprecise codes would inappropriately categorize an overly broad segment of the patient population as having the conditions required for inclusion in a facility's compliance percentage. If the IRF does not have enough information about the patient's condition to code the more specific codes on the IRF–PAI, we would expect the IRF to seek out additional information from the patient's acute care hospital medical record to determine the appropriate, more specific code to use.

For example, the current ICD–9–CM codes 820.8 ''Unspecified part of neck of femur, closed'' and 820.9 ''Unspecified part of neck of femur, open'', which indicate hip fractures, could be replaced with more specific codes (820.01–820.09, 820.11–820.19, 820.21–820.22, or 820.31–820.32). We believe that the proposed removal of the unspecified codes listed in Table 7, ''Proposed ICD–9–CM Codes To Be Removed From the Appendix C: ICD–9–CM Codes That Meet Presumptive Compliance Criteria,'' would not negatively impact a provider's ability to meet the compliance percentage threshold because these diagnoses could be coded under the aforementioned more specific codes. More specific codes will aid us in determining (by the nature of the site, severity, degree of injury, etc.) whether a patient's principal or secondary diagnosis falls into the 13 qualifying conditions and should count toward the 60 percent rule.

2. Arthritis Codes

Our analysis of the list of ICD–9–CM codes that are currently deemed to meet the 60 percent rule required us to reexamine the overall application of the compliance criteria in regards to the arthritis codes. Utilization patterns for the arthritis codes indicated that some of the codes in this category are coded far more frequently than we had anticipated, given the severity and prior treatment requirements outlined in regulation. When we adopted the arthritis conditions in the FY 2004 final rule (69 FR 25752), we did so because we believed that these conditions were appropriate for treatment in an IRF. However, we limited the arthritis conditions to those that were sufficiently severe and in which

intensive inpatient rehabilitation would be an appropriate modality of treatment. We anticipated that less severe arthritic conditions could be satisfactorily managed outside of IRFs since these cases would not require the intensive therapy provided in the inpatient rehabilitation setting. Likewise, we expected that even in cases where patients with arthritis conditions severe enough to require intensive inpatient rehabilitation, some patients would improve after an appropriate, aggressive, and sustained course of treatment in an outpatient setting. ''An appropriated, aggressive, and sustained course of treatment in an outpatient setting'' is defined in Chapter 3, section 140.1.1.C of the Medicare Claims Processing Manual (Pub. 100–04). We believe that there may be arthritis ICD–9–CM codes entered on the IRF–PAI for cases that do not meet the severity and prior treatment requirements outlined in regulation. Thus, after reexamining our application of the compliance criteria in regards to the arthritis codes, we determined that factors beyond the ICD–9–CM code should be reviewed to establish whether these IRF patients should be included in the IRF's compliance percentage.

In the regulations at § 412.29(b)(2)(x) through § 412.29(b)(2)(xii), we describe 3 medical conditions that, if present, make a patient eligible for inclusion in the calculation of the compliance percentage if additional circumstances are met. The 3 medical conditions are as follows:

- Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
- Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
- Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

As stated above, the inclusion of patients with these medical conditions in the compliance percentage is conditioned on those patients meeting certain severity and prior treatment requirements. However, the ICD–9–CM diagnosis codes that reflect these arthritis and arthropathy conditions do not provide any information about whether or not these additional eligibility requirements were met. We believe that a qualitative assessment (such as a medical review) is necessary to determine if the medical record would support inclusion of individuals with the arthritis and arthropathy conditions outlined in our regulations at § 412.29(b)(2)(x) through § 412.29(b)(2)(xii) in a facility's compliance percentage. Thus, we propose to remove the ICD–9–CM diagnosis codes associated with the medical conditions outlined in our regulations at § 412.29(b)(2)(x) through § 412.29(b)(2)(xii) from the presumptive method ICD–9–CM code list in Appendix C.

We expect that the FI/MAC will be able, upon medical review, to include those patients in a facility's 60 percent rule compliance percentage in accordance with chapter 3, § 140.1.4 of the Medicare Claims Processing Manual (Pub. 100–04) after it has confirmed the severity and prior treatment requirements. So IRFs will continue to be able to include these individuals in their compliance percentages. In Table 7, we list the ICD–9–CM codes associated with the medical conditions listed at § 412.29(b)(2)(x) through § 412.29(b)(2)(xii) that we propose to remove from Appendix C.

3. Some Congenital Anomaly Diagnosis Codes

Though congenital deformity is one of the 13 medical conditions that may generally qualify for inclusion in the presumptive method for calculating compliance with the 60 percent rule, we find that some of the specific ICD–9–CM diagnosis codes in Appendix C for congenital anomalies represent such serious conditions that a patient with one of these conditions would be unlikely to be able to meaningfully participate in an intensive rehabilitation therapy program. For example, Craniorachischisis (ICD–9–CM code 740.1) is a congenital malformation where the neural tube from the midbrain down to the upper sacral region of the spinal cord remains open. The neural tube is the embryo's precursor to the central nervous system, which comprises the brain and spinal cord. Similarly, Iniencephaly (ICD–9–CD code 740.2) is a congenital malformation in which parts of the brain do not form and the patient does not have a neck. If a patient with one of these conditions were able to participate in the intensive rehabilitation services provided in an IRF, then the FI/MAC would be able to count that case toward an IRF's 60 percent rule compliance calculation upon medical review. However, because beneficiaries with these diagnoses likely would not be able to actively participate in an intensive rehabilitation program, we do not believe that we can presumptively include such cases in an IRF's compliance percentage. Thus, we propose to remove these congenital deformity codes, and others like them, from Appendix C. All of the congenital anomaly diagnosis codes that we propose to remove from appendix C are listed in Table 7.

4. Unilateral Upper Extremity Amputations Diagnosis Codes

Though amputation is generally one of the 13 medical conditions that qualify for inclusion in the presumptive method for calculating compliance with the 60 percent rule, we propose the removal of certain ICD–9–CM codes for unilateral upper extremity amputations from Appendix C because we believe that it is impossible to determine, from the presence of such ICD–9–CM codes alone, whether a patient with such a unilateral upper extremity amputation has a condition for which he or she would qualify for treatment in an IRF. Some patients with upper extremity amputations will not require close medical supervision by a physician or weekly interdisciplinary team

conferences to achieve their goals, while others may require these services. We believe that rehabilitation associated with unilateral upper extremity amputations does not necessarily need to be accompanied by the close medical management provided in IRFs, as long as the patient does not have any additional comorbidities that have caused significant decline in his or her functional ability that, in the absence of the unilateral upper extremity amputation, would necessitate treatment in an IRF. That is to say, a patient's need for intensive rehabilitation services provided in an IRF may depend on other conditions which cannot be solely identified through the presence of a unilateral upper extremity amputation ICD–9–CM code. If the patient has comorbidities that would necessitate treatment in an IRF, then those comorbidities could qualify the patient for inclusion in the presumptive method of calculating compliance with the 60 percent rule requirements. If the codes for such a patient's comorbidities do not appear in Appendix C, they could be found on medical review to meet the criteria for inclusion in the IRF's 60 percent rule compliance rate. Thus, we propose to remove the unilateral upper extremity amputation ICD–9–CM codes listed in Table 7.

5. Miscellaneous Diagnosis Codes That Do Not Require Intensive Rehabilitation Services For Treatment

We have identified additional ICD–9–CM diagnosis codes in Appendix C that should not be included in the listing because as single conditions, they do not serve as an indication of a patient qualifying for inclusion in an IRF's compliance percentage under the presumptive method for calculating compliance with the 60 percent rule. These patients generally do not require intensive rehabilitation services or cannot be shown to have undergone appropriate diagnostic testing based on the ICD–9–CM code alone. For the reasons discussed below, we propose to remove the following ICD–9–CM codes from Appendix C. (These ICD–9–CM codes are also listed in Table 7):

• *Tuberculous (abscess, meningitis, and encephalitis or myelitis) and Tuberculoma (of the meninges, brain, or spinal cord) where a bacterial or histological examination was not done (see Table 7 for specific codes)*—Appropriate patient care dictates that the IRF physician must document the means by which the organism, whether it be bacteriologic or histologic, was tested. We are proposing to remove these codes from the list in Appendix C because the subclassification indicates that a bacteriologic or histologic examination has not been performed.

• *Postherpetic polyneuropathy* (053.13)—This is a condition characterized by severe pain, which typically requires pain medication or other pain control therapies but does not typically require the intensive inpatient rehabilitation services of an IRF. In fact, the prescriptive hands-on therapeutic interventions provided in an IRF could exacerbate the patient's pain. For these reasons, we are proposing to remove this code from Appendix C.

• *Louping ill* (063.1)—This ICD–9–CM code refers to an acute viral disease primarily of sheep that is not endemic to the United States. Louping ill disease has been recognized in Scotland for centuries, but only 39 cases of human infection have been described and none of these cases have been observed in the United States. Louping ill is a disease which has many manifestations, not all requiring inpatient rehabilitation hospital services. We believe that the ICD–9–CM code for this diagnosis does not provide the information necessary for us to determine presumptively if the patient should count toward the IRF's compliance threshold. However, as with all of the codes that we are proposing to remove from appendix C, if someone with this diagnosis were to be admitted to an IRF, where appropriate, it could be found by an FI/MAC to meet the 60 percent rule requirements on medical review.

• *Brain death* (348.82)—We believe that it is unlikely that a patient with this condition would require the intensive inpatient rehabilitation services provided in an IRF. For this reason, we propose to remove this code from Appendix C.

• *Myasthenia gravis without (acute) exacerbation* (358.00)—Although we believe that a patient experiencing an acute attack of Myasthenia Gravis could potentially require the services of an IRF (see ICD–9 code 358.01 ''Myasthenia gravis with (acute) exacerbation''), the ICD–9–CM code that we propose to remove from appendix C is used for patients who are not experiencing an acute exacerbation of the condition and most likely do not require the intensive inpatient rehabilitation services provided in an IRF.

• *Other specified myotonic disorder* (359.29)—Myotonia fluctuans, myotonia permanens, and paramyotonia congenital reflect conditions that are exacerbated by exercise. Therefore, these conditions would not likely require the intensive inpatient rehabilitation services of an IRF. Therefore, we are proposing to remove it from the list in appendix C.

• *Periodic paralysis* (359.3)—The treatment for periodic paralysis involves pharmaceutical interventions and lifestyle changes that control exercise and activity, but patients with this condition do not generally require the intensive inpatient rehabilitation services of an IRF. In fact, it is unclear how the intensive inpatient rehabilitation services provided in an IRF would effectively treat this condition. Thus, we propose to remove this code from the list in Appendix C.

• *Brachial plexus lesions* (353.0)—Care and treatment for this condition affecting an upper extremity do not typically require close medical supervision by a physician or weekly interdisciplinary team meetings to reach the patient's goals. Thus, patients with this condition do not typically require the intensive inpatient rehabilitation services provided in an IRF. Therefore, we propose to remove this code from the list in appendix C.

• *Neuralgic amyothrophy* (353.5)—This condition is also known as Parsonage-Turner syndrome or brachial plexus neuritis. It is a distinct peripheral nervous system disorder characterized by attacks of extreme neuropathic pain and rapid multifocal weakness and atrophy in the upper limbs. Patients with this condition do not typically require close medical supervision by a physician or weekly interdisciplinary team meetings to reach the patient's therapy goals. Thus, patients with this condition do not typically require the intensive inpatient rehabilitation services provided in an IRF. Therefore, we propose to remove this code from the list Appendix C.

• *Other nerve root and plexus disorders* (353.8)—More descriptive codes provide the clearest way to ensure the appropriateness of a patient's inclusion in the compliance percentage. For example, Lumbosacral plexus lesions (353.1) could substitute for Other nerve root and plexus disorders (353.8). Thus, patients with this condition do not typically require the intensive inpatient rehabilitation services provided in an IRF. Therefore, we propose to remove this code from the list in Appendix C.

6. Additional Diagnosis Codes

During our review of the diagnosis codes that meet the 60 percent compliance criteria, we did not identify any ICD–9–CM codes that would be appropriate to add to the list. However, we welcome public comment regarding ICD–9–CM diagnosis codes that are not currently on the presumptive

methodology list of codes that stakeholders believe should be added to the list and that specifically identify one of the conditions listed at § 412.29(b)(2), that require intensive inpatient rehabilitation, and can be presumptively identified by a ICD–9–CM code.

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA

ICD–9–CM Code	Diagnosis
013.00	Tuberculous meningitis, unspecified.
013.01	Tuberculous meningitis, bacteriological or histological examination not done.
013.10	Tuberculoma of meninges, unspecified.
013.11	Tuberculoma of meninges, bacteriological or histological examination not done.
013.20	Tuberculoma of brain, unspecified.
013.21	Tuberculoma of brain, bacteriological or histological examination not done.
013.30	Tuberculous abscess of brain, unspecified.
013.31	Tuberculous abscess of brain, bacteriological or histological examination not done.
013.40	Tuberculoma of spinal cord, unspecified.
013.41	Tuberculoma of spinal cord, bacteriological or histological examination not done.
013.50	Tuberculous abscess of spinal cord, unspecified.
013.51	Tuberculous abscess of spinal cord, bacteriological or histological examination not done.
013.60	Tuberculous encephalitis or myelitis, unspecified.
013.61	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done.
047.9	Unspecified viral meningitis.
049.9	Unspecified non-arthropod-borne viral diseases of central nervous system.
053.13	Postherpetic polyneuropathy.
062.9	Mosquito-borne viral encephalitis, unspecified.
063.1	Louping ill.
063.9	Tick-borne viral encephalitis, unspecified.
320.9	Meningitis due to unspecified bacterium.
322.9	Meningitis, unspecified.
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis.
324.9	Intracranial and intraspinal abscess of unspecified site.
335.10	Spinal muscular atrophy, unspecified.
335.9	Anterior horn cell disease, unspecified.
336.9	Unspecified disease of spinal cord.
341.9	Demyelinating disease of central nervous system, unspecified.
342.00	Flaccid hemiplegia and hemiparesis affecting unspecified side.
342.10	Spastic hemiplegia and hemiparesis affecting unspecified side.
342.80	Other specified hemiplegia and hemiparesis affecting unspecified side.
342.90	Hemiplegia, unspecified, affecting unspecified side.
342.91	Hemiplegia, unspecified, affecting dominant side.
342.92	Hemiplegia, unspecified, affecting nondominant side.
343.3	Congenital monoplegia.
343.9	Infantile cerebral palsy, unspecified.
344.00	Quadriplegia, unspecified.
344.5	Unspecified monoplegia.
348.82	Brain death.
353.0	Brachial plexus lesions.
353.2	Cervical root lesions, not elsewhere classified.
353.3	Thoracic root lesions, not elsewhere classified.
353.4	Lumbosacral root lesions, not elsewhere classified.
353.5	Neuralgic amyotrophy.
353.8	Other nerve root and plexus disorders.
354.5	Mononeuritis multiplex.
356.9	Unspecified hereditary and idiopathic peripheral neuropathy.
358.00	Myasthenia gravis without (acute) exacerbation.
359.29	Other specified myotonic disorder.
359.3	Periodic paralysis.
432.9	Unspecified intracranial hemorrhage.
438.20	Late effects of cerebrovascular disease, hemiplegia affecting unspecified side.
438.30	Late effects of cerebrovascular disease, monoplegia of upper limb affecting unspecified side.
438.31	Late effects of cerebrovascular disease, monoplegia of upper limb affecting dominant side.
438.32	Late effects of cerebrovascular disease, monoplegia of upper limb affecting nondominant side.
438.40	Late effects of cerebrovascular disease, monoplegia of lower limb affecting unspecified side.
438.50	Late effects of cerebrovascular disease, other paralytic syndrome affecting unspecified side.
433.91	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction.
434.91	Cerebral artery occlusion, unspecified with cerebral infarction.
446.0	Polyarteritis nodosa.
711.20	Arthropathy in Behcet's syndrome, site unspecified.
711.21	Arthropathy in Behcet's syndrome, shoulder region.
711.22	Arthropathy in Behcet's syndrome, upper arm.
711.23	Arthropathy in Behcet's syndrome, forearm.
711.24	Arthropathy in Behcet's syndrome, hand.
711.25	Arthropathy in Behcet's syndrome, pelvic region and thigh.

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA—Continued

ICD–9–CM Code	Diagnosis
711.26	Arthropathy in Behcet's syndrome, lower leg.
711.27	Arthropathy in Behcet's syndrome, ankle and foot.
711.28	Arthropathy in Behcet's syndrome, other specified sites.
711.29	Arthropathy in Behcet's syndrome, multiple sites.
713.0	Arthropathy associated with other endocrine and metabolic disorders.
713.1	Arthropathy associated with gastrointestinal conditions other than infections.
713.2	Arthropathy associated with hematological disorders.
713.3	Arthropathy associated with dermatological disorders.
713.4	Arthropathy associated with respiratory disorders.
713.6	Arthropathy associated with hypersensitivity reaction.
713.7	Other general diseases with articular involvement.
714.0	Rheumatoid arthritis.
714.1	Felty's syndrome.
714.2	Other rheumatoid arthritis with visceral or systemic involvement.
714.32	Pauciarticular juvenile rheumatoid arthritis.
714.81	Rheumatoid lung.
714.89	Other specified inflammatory polyarthropathies.
714.9	Unspecified inflammatory polyarthropathy.
715.11	Osteoarthrosis, localized, primary, shoulder region.
715.12	Osteoarthrosis, localized, primary, upper arm.
715.15	Osteoarthrosis, localized, primary, pelvic region and thigh.
715.16	Osteoarthrosis, localized, primary, lower leg.
715.21	Osteoarthrosis, localized, secondary, shoulder region.
715.22	Osteoarthrosis, localized, secondary, upper arm.
715.25	Osteoarthrosis, localized, secondary, pelvic region and thigh.
715.26	Osteoarthrosis, localized, secondary, lower leg.
715.31	Osteoarthrosis, localized, not specified whether primary or secondary, shoulder region.
715.32	Osteoarthrosis, localized, not specified whether primary or secondary, upper arm.
715.35	Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh.
715.36	Osteoarthrosis, localized, not specified whether primary or secondary, lower leg.
716.01	Kaschin-Beck disease, shoulder region.
716.02	Kaschin-Beck disease, upper arm.
716.05	Kaschin-Beck disease, pelvic region and thigh.
716.06	Kaschin-Beck disease, lower leg.
716.11	Traumatic arthropathy, shoulder region.
716.12	Traumatic arthropathy, upper arm.
716.15	Traumatic arthropathy, pelvic region and thigh.
716.16	Traumatic arthropathy, lower leg.
716.21	Allergic arthritis, shoulder region.
716.22	Allergic arthritis, upper arm.
716.25	Allergic arthritis, pelvic region and thigh.
716.26	Allergic arthritis, lower leg.
716.51	Unspecified polyarthropathy or polyarthritis, shoulder region.
716.52	Unspecified polyarthropathy or polyarthritis, upper arm.
716.55	Unspecified polyarthropathy or polyarthritis, pelvic region and thigh.
716.56	Unspecified polyarthropathy or polyarthritis, lower leg.
719.30	Palindromic rheumatism, site unspecified.
719.31	Palindromic rheumatism, shoulder region.
719.32	Palindromic rheumatism, upper arm.
719.33	Palindromic rheumatism, forearm.
719.34	Palindromic rheumatism, hand.
719.35	Palindromic rheumatism, pelvic region and thigh.
719.36	Palindromic rheumatism, lower leg.
719.37	Palindromic rheumatism, ankle and foot.
719.38	Palindromic rheumatism, other specified sites.
719.39	Palindromic rheumatism, multiple sites.
720.0	Ankylosing spondylitis.
720.81	Inflammatory spondylopathies in diseases classified elsewhere.
720.89	Other inflammatory spondylopathies.
721.91	Spondylosis of unspecified site, with myelopathy.
722.70	Intervertebral disc disorder with myelopathy, unspecified region.
740.1	Craniorachischisis.
740.2	Iniencephaly.
741.00	Spina bifida with hydrocephalus, unspecified region.
741.90	Spina bifida without mention of hydrocephalus, unspecified region.
742.1	Microcephalus.
754.30	Congenital dislocation of hip, unilateral.
754.31	Congenital dislocation of hip, bilateral.
754.32	Congenital subluxation of hip, unilateral.
755.20	Unspecified reduction deformity of upper limb.

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA—Continued

ICD–9–CM Code	Diagnosis
755.21	Transverse deficiency of upper limb.
755.22	Longitudinal deficiency of upper limb, not elsewhere classified.
755.23	Longitudinal deficiency, combined, involving humerus, radius, and ulna (complete or incomplete).
755.24	Longitudinal deficiency, humeral, complete or partial (with or without distal deficiencies, incomplete).
755.25	Longitudinal deficiency, radioulnar, complete or partial (with or without distal deficiencies, incomplete).
755.26	Longitudinal deficiency, radial, complete or partial (with or without distal deficiencies, incomplete).
755.27	Longitudinal deficiency, ulnar, complete or partial (with or without distal deficiencies, incomplete).
755.28	Longitudinal deficiency, carpals or metacarpals, complete or partial (with or without incomplete phalangeal deficiency).
755.30	Unspecified reduction deformity of lower limb.
755.4	Reduction deformities, unspecified limb.
755.51	Congenital deformity of clavicle.
755.53	Radioulnar synostosis.
755.61	Coxa valga, congenital.
755.62	Coxa vara, congenital.
755.63	Other congenital deformity of hip (joint).
756.50	Congenital osteodystrophy, unspecified.
800.00	Closed fracture of vault of skull without mention of intracranial injury, unspecified state of consciousness.
800.09	Closed fracture of vault of skull without mention of intracranial injury, with concussion, unspecified.
800.10	Closed fracture of vault of skull with cerebral laceration and contusion, unspecified state of consciousness.
800.19	Closed fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified.
800.20	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
800.29	Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
800.30	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
800.39	Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
800.40	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness.
800.49	Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
800.50	Open fracture of vault of skull without mention of intracranial injury, unspecified state of consciousness.
800.59	Open fracture of vault of skull without mention of intracranial injury, with concussion, unspecified.
800.60	Open fracture of vault of skull with cerebral laceration and contusion, unspecified state of consciousness.
800.69	Open fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified.
800.70	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
800.79	Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
800.80	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
800.89	Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
800.90	Open fracture of vault of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness.
800.99	Open fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
801.00	Closed fracture of base of skull without mention of intracranial injury, unspecified state of consciousness.
801.09	Closed fracture of base of skull without mention of intracranial injury, with concussion, unspecified.
801.10	Closed fracture of base of skull with cerebral laceration and contusion, unspecified state of consciousness.
801.19	Closed fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified.
801.20	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
801.29	Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
801.30	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
801.39	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
801.40	Closed fracture of base of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness.
801.49	Closed fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
801.50	Open fracture of base of skull without mention of intracranial injury, unspecified state of consciousness.
801.59	Open fracture of base of skull without mention of intracranial injury, with concussion, unspecified.
801.60	Open fracture of base of skull with cerebral laceration and contusion, unspecified state of consciousness.
801.69	Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified.
801.70	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
801.79	Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
801.80	Open fracture of base of skull with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
801.89	Open fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified.
801.90	Open fracture of base of skull with intracranial injury of other and unspecified nature, unspecified state of consciousness.
801.99	Open fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified.
803.00	Other closed skull fracture without mention of intracranial injury, unspecified state of consciousness.
803.09	Other closed skull fracture without mention of intracranial injury, with concussion, unspecified.
803.10	Other closed skull fracture with cerebral laceration and contusion, unspecified state of consciousness.
803.19	Other closed skull fracture with cerebral laceration and contusion, with concussion, unspecified.
803.20	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
803.29	Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
803.30	Other closed skull fracture with other and unspecified intracranial hemorrhage, unspecified state of unconsciousness.
803.39	Other closed skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified.
803.40	Other closed skull fracture with intracranial injury of other and unspecified nature, unspecified state of consciousness.
803.49	Other closed skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified.
803.50	Other open skull fracture without mention of injury, unspecified state of consciousness.
803.59	Other open skull fracture without mention of intracranial injury, with concussion, unspecified.
803.60	Other open skull fracture with cerebral laceration and contusion, unspecified state of consciousness.
803.69	Other open skull fracture with cerebral laceration and contusion, with concussion, unspecified.

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA—Continued

ICD–9–CM Code	Diagnosis
803.70	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
803.79	Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
803.80	Other open skull fracture with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
803.89	Other open skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified.
803.90	Other open skull fracture with intracranial injury of other and unspecified nature, unspecified state of consciousness.
803.99	Other open skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified.
804.00	Closed fractures involving skull or face with other bones, without mention of intracranial injury, unspecified state of consciousness.
804.09	Closed fractures involving skull of face with other bones, without mention of intracranial injury, with concussion, unspecified.
804.10	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified state of consciousness.
804.19	Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified.
804.20	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
804.29	Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
804.30	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
804.39	Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified.
804.40	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified state of consciousness.
804.49	Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified.
804.60	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, unspecified state of consciousness.
804.69	Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified.
804.70	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, unspecified state of consciousness.
804.79	Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified.
804.80	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, unspecified state of consciousness.
804.89	Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified.
804.90	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, unspecified state of consciousness.
804.99	Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified.
806.00	Closed fracture of C1–C4 level with unspecified spinal cord injury.
806.05	Closed fracture of C5–C7 level with unspecified spinal cord injury.
806.10	Open fracture of C1–C4 level with unspecified spinal cord injury.
806.15	Open fracture of C5–C7 level with unspecified spinal cord injury.
806.20	Closed fracture of T1–T6 level with unspecified spinal cord injury.
806.25	Closed fracture of T7–T12 level with unspecified spinal cord injury.
806.30	Open fracture of T1–T6 level with unspecified spinal cord injury.
806.35	Open fracture of T7–T12 level with unspecified spinal cord injury.
806.60	Closed fracture of sacrum and coccyx with unspecified spinal cord injury.
806.70	Open fracture of sacrum and coccyx with unspecified spinal cord injury.
820.00	Closed fracture of intracapsular section of neck of femur, unspecified.
820.10	Open fracture of intracapsular section of neck of femur, unspecified.
820.30	Open fracture of trochanteric section of neck of femur, unspecified.
820.8	Closed fracture of unspecified part of neck of femur.
820.9	Open fracture of unspecified part of neck of femur.
839.10	Open dislocation, cervical vertebra, unspecified.
850.5	Concussion with loss of consciousness of unspecified duration.
851.00	Cortex (cerebral) contusion without mention of open intracranial wound, unspecified state of consciousness.
851.09	Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified.
851.10	Cortex (cerebral) contusion with open intracranial wound, unspecified state of consciousness.
851.19	Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified.
851.20	Cortex (cerebral) laceration without mention of open intracranial wound, unspecified state of consciousness.
851.29	Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified.
851.30	Cortex (cerebral) laceration with open intracranial wound, unspecified state of consciousness.
851.39	Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified.
851.40	Cerebellar or brain stem contusion without mention of open intracranial wound, unspecified state of consciousness.
851.49	Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified.
851.50	Cerebellar or brain stem contusion with open intracranial wound, unspecified state of consciousness.
851.59	Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified.
851.60	Cerebellar or brain stem laceration without mention of open intracranial wound, unspecified state of consciousness.
851.69	Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified.

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA—Continued

ICD–9–CM Code	Diagnosis
851.70	Cerebellar or brain stem laceration with open intracranial wound, unspecified state of consciousness.
851.79	Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified.
851.80	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, unspecified state of consciousness.
851.89	Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified.
851.90	Other and unspecified cerebral laceration and contusion, with open intracranial wound, unspecified state of consciousness.
851.99	Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified.
852.00	Subarachnoid hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness.
852.09	Subarachnoid hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified.
852.10	Subarachnoid hemorrhage following injury with open intracranial wound, unspecified state of consciousness.
852.19	Subarachnoid hemorrhage following injury with open intracranial wound, with concussion, unspecified.
852.20	Subdural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness.
852.29	Subdural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified.
852.30	Subdural hemorrhage following injury with open intracranial wound, unspecified state of consciousness.
852.39	Subdural hemorrhage following injury with open intracranial wound, with concussion, unspecified.
852.40	Extradural hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness.
852.49	Extradural hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified.
852.50	Extradural hemorrhage following injury with open intracranial wound, unspecified state of consciousness.
852.59	Extradural hemorrhage following injury with open intracranial wound, with concussion, unspecified.
853.00	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, unspecified state of consciousness.
853.09	Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with concussion, unspecified.
853.10	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, unspecified state of consciousness.
853.19	Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with concussion, unspecified.
854.00	Intracranial injury of other and unspecified nature without mention of open intracranial wound, unspecified state of consciousness.
854.09	Intracranial injury of other and unspecified nature without mention of open intracranial wound, with concussion, unspecified.
854.10	Intracranial injury of other and unspecified nature with open intracranial wound, unspecified state of consciousness.
854.19	Intracranial injury of other and unspecified nature with open intracranial wound, with concussion, unspecified.
887.0	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, without mention of complication.
887.1	Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated.
887.2	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication.
887.3	Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated.
887.4	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, without mention of complication.
887.5	Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated.
941.00	Burn of unspecified degree of face and head, unspecified site.
941.02	Burn of unspecified degree of eye (with other parts of face, head, and neck).
941.09	Burn of unspecified degree of multiple sites [except with eye] of face, head, and neck.
942.00	Burn of unspecified degree of trunk, unspecified site.
942.01	Burn of unspecified degree of breast.
942.02	Burn of unspecified degree of chest wall, excluding breast and nipple.
942.03	Burn of unspecified degree of abdominal wall.
942.04	Burn of unspecified degree of back [any part].
942.05	Burn of unspecified degree of genitalia.
942.09	Burn of unspecified degree of other and multiple sites of trunk.
943.00	Burn of unspecified degree of upper limb, except wrist and hand, unspecified site.
943.01	Burn of unspecified degree of forearm.
943.02	Burn of unspecified degree of elbow.
943.03	Burn of unspecified degree of upper arm.
943.04	Burn of unspecified degree of axilla.
943.05	Burn of unspecified degree of shoulder.
943.06	Burn of unspecified degree of scapular region.
943.09	Burn of unspecified degree of multiple sites of upper limb, except wrist and hand.
943.30	Full-thickness skin [third degree, not otherwise specified] of upper limb, unspecified site.
943.40	Deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part, of upper limb, unspecified site.
943.50	Deep necrosis of underlying tissues [deep third degree] with loss of a body part, of upper limb, unspecified site.
944.30	Full-thickness skin loss [third degree, not otherwise specified] of hand, unspecified site.
944.40	Deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part, hand, unspecified site.
944.50	Deep necrosis of underlying tissues [deep third degree] with loss of a body part, of hand, unspecified site.
945.00	Burn of unspecified degree of lower limb [leg], unspecified site.
945.01	Burn of unspecified degree of toe(s) (nail).
945.02	Burn of unspecified degree of foot.
945.03	Burn of unspecified degree of ankle.
945.04	Burn of unspecified degree of lower leg.
945.05	Burn of unspecified degree of knee.
945.06	Burn of unspecified degree of thigh [any part].
945.09	Burn of unspecified degree of multiple sites of lower limb(s).

TABLE 7—PROPOSED ICD–9–CM CODES TO BE REMOVED FROM APPENDIX C: ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA—Continued

ICD–9–CM Code	Diagnosis
945.20	Blisters, epidermal loss [second degree] of lower limb [leg], unspecified site.
945.40	Deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part, lower limb [leg], unspecified site.
945.50	Deep necrosis of underlying tissues [deep third degree] with loss of a body part, of lower limb [leg], unspecified site.
949.4	Deep necrosis of underlying tissue [deep third degree] without mention of loss of a body part, unspecified.
949.5	Deep necrosis of underlying tissues [deep third degree] with loss of a body part, unspecified.
997.60	Unspecified complication of amputation stump.

VIII. Proposed Non-Quality Related Revisions to IRF–PAI Sections

Under section 1886(j)(2)(D) of the Act, the Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under subsection P. The collection of patient data is indispensable for the successful development and implementation of the IRF payment system. In the August 7, 2001 final rule, the inpatient rehabilitation facility patient assessment instrument (IRF–PAI) was adopted as the standardized patient assessment instrument under the IRF prospective payment system (PPS). The IRF–PAI was established for, and is still used to gather data to classify patients for payment under the IRF PPS. As discussed in section XII. of this proposed rule, it is also now used to collect certain data for the IRF Quality Reporting Program. IRFs are currently required to complete an IRF–PAI for every Medicare Part A, B or C patient who is admitted to, or discharged from an IRF.

Although there have been significant advancements in the industry, no IRF PPS payment-related changes have been made to the IRF–PAI form since its implementation—in FY 2002. We are proposing to amend certain response options, add additional data points, remove certain outdated items and change certain references to ensure that our policies reflect the current data needs of the IRF PPS program.

A. Proposed Updates

We propose to amend the response codes on the following items in the IRF–PAI:

- Item 15A: Admit From (Formerly item 15)
- Item 16A: Pre-Hospital Living Situation (Formerly item 16)
- Item 44D: Patient's Discharge Destination/Living Setting (Formerly item 44A)

To minimize possible confusion due to the use of different sets of status codes on the IRF–PAI and the CMS–1450 (also referred to as the UB–04) claim form, we believe that the IRF–PAI status codes should be changed to mirror those used on the CMS–1450 claim form. We believe this proposed update would help decrease the rate of coding errors on CMS–1450 claim forms. We believe this proposal would provide response options that mirror another commonly used instrument in the Medicare context allowing providers to use only one common set of response codes. We propose to amend the response options for the three items listed above to:

- 01—Home (private home/apt., board/care, assisted living, group home)
- 02—Short-term General Hospital
- 03—Skilled Nursing Facility (SNF)
- 50—Hospice
- 62—Another Inpatient Rehabilitation Facility
- 63—Long-Term Care Hospital (LTCH)
- 64—Medicaid Nursing Facility
- 65—Inpatient Psychiatric Facility
- 66—Critical Access Hospital
- 99—Not Listed

We also propose to update the options for responding to item 20B: Secondary Source. We find that the current response options for this data element exceed what we need to operate IRF PPS. Therefore, to decrease burden on IRFs through the implementation of simplified response options, we propose to limit secondary source response options to the following:

- 02—Medicare—Fee for Service
- 51—Medicare—Medicare Advantage
- 99—Not Listed

B. Proposed Additions

Further, we propose to add (or expand) the following items to the IRF–PAI:

- Item 25A: Height
- Item 26A: Weight
- Item 24: Comorbid Conditions (15 additional spaces)
- Item 44C: Was the patient discharged alive?
- Signature of Persons Completing the IRF–PAI

Items ''25A: Height'' and ''26A: Weight,'' are important items to collect for use in the classification of facilities for payment under the IRF–PPS as well as for the risk adjustment of quality measures (as described in section XII. of this proposed rule). In the regulations at § 412.29(b)(2), we specify a list of comorbid conditions that, if certain conditions are met, may qualify a patient for inclusion in an IRF's 60 percent rule compliance percentage. For example, a patient with a lower-extremity joint replacement comorbidity would qualify if the patient had a bilateral joint replacement, is over the age of 85, and/or has a BMI greater than 50. BMI is calculated using height and weight. As such, by adding a patients' height and weight information to the IRF–PAI we expect that the FI/MAC will be able, upon medical review, to include these patients in a facilities' 60 percent rule compliance percentage in accordance with chapter 3, § 140.14 of the Medicare Claims Processing Manual (Pub. 100.4), after it has confirmed any other severity and prior treatment requirements that may apply.

We also propose adding 15 additional spaces for providers to document patients' comorbid medical conditions at item 24: Comorbid Conditions (located in the medical information section of the IRF–PAI). The IRF–PAI currently has ten spaces available for providers to enter ICD codes for comorbid conditions. If finalized, the IRF–PAI would have a total of 25 spaces. Such expansion would support IRFs as they seek to code with greater specificity to support presumptive compliance percentage findings, and would be in keeping with recent industry-driven changes.

In response to the industry's request to update the claim form to allow for better accounting for patients comorbidities, added 15 additional spaces were added to the claim form for

providers to document ICD codes. We believe that the number of data elements allowed on the IRF–PAI should mirror the number allowed on the claim. Additionally, the ICD–10 coding scheme, which will be used beginning on October 1, 2014 is much more specific than the current ICD–9 coding. Therefore, when the agency moves from ICD–9 to ICD–10 coding, providers may need the additional spaces to code because of the greater specificity under ICD–10.

Furthermore, we propose to add a new item 44C: ''Was the patient discharged alive?'' to the discharge information section on the IRF–PAI. Adding this item as a standalone item would allow facilities that reply ''no'' to 44C to skip items 44D, 44E, and 45, which describe a living patient's discharge destination. This will reduce the burden on the time it takes to complete the IRF–PAI. Facilities that respond ''yes'' to item 44C will complete items 44D, 44E and 45 as they apply to the patient. We believe that adding this question as a standalone item would provide greater clarity for providers when documenting patient information on the IRF–PAI.

We propose adding a page to the IRF–PAI dedicated as the signature page for persons completing the IRF–PAI. As of the effective date of the IRF Coverage Requirements, see the August 7, 2009 FY 2010 IRF PPS final rule (74 FR 39762), the IRF–PAI forms must be maintained in the patient's medical record at the IRF (either in electronic or paper format), and information in the IRF–PAI must correspond with all of the information provided in the patient's IRF medical record. We received multiple public comments on the FY 2010 IRF PPS proposed rule regarding the requirement to include that IRF–PAI in the medical record questioning whether IRFs would need to adhere to the conditions of participation in § 482.24(c)(1) that require all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. When CMS responded (at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/IRF-Training-call_version_1.pdf*) that IRFs would need to adhere to § 482.24(c)(1), providers responded by asking for a place on the IRF–PAI where they would be able to document the required authentication. The proposed addition of a page for signatures of persons completing the IRF–PAI would fulfill providers' request to have an organized way to document who in the IRF has completed the assessment of the patient and when that assessment took place. We also believe that having a signature page for those completing the IRF–PAI will ensure that providers are satisfying both the IRF coverage requirements and the conditions of participation requirements.

C. Proposed Deletions

We propose to delete the following items from the IRF–PAI:

- Item 18: Pre-Hospital Vocational Category
- Item 19: Pre-Hospital Vocational Effort
- Item 25: Is patient comatose at admission?
- Item 26: Is patient delirious at admission?
- Item 28: Clinical signs of dehydration

We no longer believe that these items are necessary and in the interest of reducing burden on providers we would like to delete them.

Items 18: Pre-Hospital Vocational Category and 19: Pre-Hospital Vocational Effort (which are currently located in the admission identification section on the IRF–PAI) are not used for payment or quality purposes. While these items will, if finalized, be dropped from the IRF–PAI form, however, we would note that these data elements could be significant in a treatment context, in which case we would expect them to appear in the patient's medical record. For example, we believe that these data elements could be relevant during the care planning/discharge process as well as during interdisciplinary team meetings.

We also note, that items 25: Is patient comatose at admission, 26: Is patient delirious at admission, and 28: Clinical signs of dehydration (which are currently located in the medical information section on the IRF–PAI) are voluntary items that are not used for our payment or quality program purposes. Therefore, we do not believe it is necessary to collect this information on the IRF–PAI. Furthermore, to the extent such information would be relevant to the provision of patient care; this information should be captured in either the transfer documentation from the referring physician, or the patients' initial assessment documentation. As such, continuing to require this information on the IRF–PAI would be duplicative since the items should be well documented in the patients' medical record from their stay at the facility.

D. Proposed Changes

We are proposing to replace all references to the ICD–9–CM code(s) in the IRF–PAI with references to ICD code(s). This change would allow CMS to forgo making additional changes to the IRF–PAI when the adopted ICD code(s) change.

Proposed Technical Correction

We are proposing a technical correction at items 44D, 44E and 45 to conform to the additions proposed above. We believe that adding language to these items indicating that the question can be skipped depending upon how item 44C is answered, will help reduce submission errors for providers when filling out the IRF–PAI.

A draft of the IRF–PAI, with the proposed revisions discussed throughout this proposed rule is available for download on the IRF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

IX. Proposed Technical Corrections to the Regulations at § 412.130

In the FY 2012 IRF PPS final rule (76 FR 47869 through 47873), we revised the regulations for inpatient rehabilitation facilities at § 412.23(b), § 412.25(b), § 412.29, and § 412.30 to update and simplify the policies, to eliminate unnecessary repetition and confusion, and to enhance consistency with the IRF coverage requirements. Among other revisions, we removed the regulations that were formerly in § 412.30, and revised and consolidated the requirements regarding ''new'' IRFs and ''new'' IRF beds that previously existed in § 412.30 into the revised regulations at § 412.29(c). However, we have recently discovered that § 412.130, which outlines the policies regarding retroactive adjustments for incorrectly excluded hospitals and units, was not updated to reflect the changes to § 412.30 and § 412.29. Specifically, § 412.130 still references regulations in § 412.30 that were revised and consolidated into § 412.29(c). Further, it still references regulations that were formerly in § 412.23(b)(2), but were moved into § 412.29(b) in the FY 2012 IRF PPS final rule (76 FR 47869 through 47873).

Thus, in this proposed rule, we propose to make the following technical corrections to the regulations in § 412.130 to conform with the revisions to the regulations in § 412.23(b), § 412.29, and § 412.30 that were implemented in the FY 2012 IRF PPS final rule (76 FR 47869 through 47873):

- Replace the current reference to ''§ 412.23(b)(8)'' in § 412.130(a)(1) with the new reference to § 412.29(c),
- Replace all of the current references to ''§ 412.23(b)(2)'' in § 412.130(a)(1), (2), and (3) with the new reference to § 412.29(b),
- Replace the current reference to ''§ 412.30(a)'' in § 412.130(a)(2) with the new reference to § 412.29(c), and
- Replace the current reference to ''§ 412.30(c)'' in § 412.130(a)(3) with the new reference to § 412.29(c).

X. Proposed Revisions to the Conditions of Payment for IRF Units Under the IRF PPS

The regulations at § 412.25 specify the requirements for an IRF unit to be excluded from the inpatient prospective payment system (IPPS) specified in § 412.1(a)(1) and to instead be paid under the IRF PPS specified in § 412.1(a)(3). The requirements at § 412.25 are unique to IRF units of hospitals, whereas the requirements at § 412.29 apply to both freestanding IRF hospitals and IRF units of hospitals. Among the requirements at § 412.25 is the requirement (at § 412.25(a)(1)(iii)) that the institution of which the IRF unit is a part must have ''enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by § 413.24(c) of this chapter.'' We have not previously specified how many such beds the hospital, of which the IRF unit is a part, must have to meet this requirement. However, we have recently received questions from providers about whether one or two hospital beds that are certified for payment under the IPPS, in some cases beds that are rarely used for patient care, would meet the requirement at § 412.25(a)(1)(iii). We believe this does not meet the requirement at § 412.25(a)(1)(iii), which provides for the hospital of which the IRF unit is a part to be an IPPS hospital, which we believe is not demonstrated by the presence of just one or two hospital beds.

Further, we are unclear how the IRF unit that is part of a hospital with only one or two beds would be able to meet another requirement, at § 412.25(a)(7), that specifies that an IRF unit must have beds that are ''physically separate from (that is, not commingled with) the hospital's other beds.'' The requirement at § 412.25(a)(7) means that there is some sort of physical separation (such as a different floor, a different wing, and different building, etc.) that separates the IRF unit from the rest of the hospital beds. We believe that it is unlikely that this requirement would be met in the situation in which the hospital of which the IRF unit is a part only has one or two beds, in some cases beds that are rarely used for patient care.

Thus, we propose to specify at § 412.25(a)(1)(iii) a minimum number of hospital beds that the IPPS hospital must have to meet the requirements at § 412.25(a)(1)(iii) for having an IRF unit. We note that, though § 412.25(a)(1)(iii) also applies to inpatient psychiatric facilities (IPFs), these facilities have their own requirements at § 412.27 for payment under the IPF PPS that we are not proposing to change in this proposed rule. IPFs should continue following the regulations at § 412.27.

We propose to specify in § 412.25(a)(1)(iii) that the institution of which the IRF unit is a part must have at least 10 staffed and maintained hospital beds that are not excluded from the IPPS, or at least 1 staffed and maintained hospital bed for every 10 certified IRF beds, whichever number is greater. If the institution is not able to meet this proposed requirement, then we propose that the IRF unit should instead be classified as an IRF hospital. We also propose to exclude CAHs that have IRF units from these requirements, as CAHs already have very specific bed size restrictions. We welcome stakeholder comments on the specific minimum hospital bed requirements for IRFs that we are proposing in this rule.

XI. Proposed Clarification of the Regulations at § 412.630

In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. See 66 FR 41316, 41319 (August 7, 2001). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at section 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are proposing to clarify our regulation at § 412.630 by deleting the word ''unadjusted'' so that the regulation would clearly preclude review of ''the Federal per discharge payment rates.'' This clarification will better conform the regulation to the statutory language.

As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are proposing to revise the regulations at § 412.630 to clarify that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

XII. Proposed Revision to the Regulations at § 412.29

According to the regulations at § 412.29(d), to be excluded from the inpatient prospective payment system (IPPS) and instead be paid under the IRF PPS, a facility must ''have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.'' The latter sentence of this regulation is based on the preadmission screening requirement for Medicare coverage of IRF services in § 412.622(a)(4)(i)(D). The requirement was repeated in both places for consistency.

However, in § 412.622(a)(4)(i)(D), we specify that this requirement applies to patients ''for whom the IRF seeks payment'' from Medicare. We believe that the analogous requirement in § 412.29(d) should also clearly state that it applies only to patients for whom the IRF is seeking payment directly from Medicare. Other payer sources, such as private insurance, have their own IRF admission requirements, and we do not believe that it would be appropriate to interfere with or duplicate the requirements that other payer sources may already have in place. Thus, we propose to amend § 412.29(d) to clarify that the IRF's preadmission screening procedure must ensure that the preadmission screening for a Medicare Part A fee-for-service patient is reviewed and approved by a

rehabilitation physician prior to the patient's admission to the IRF. We continue to believe that the basic preadmission screening procedure itself is an important element of providing quality IRF care to all patients and, thus, we propose to require that the basic preadmission screening procedure requirement remain in place for all patients regardless.

XIII. Proposed Revisions and Updates to the Quality Reporting Program for IRFs

A. Background and Statutory Authority

Section 3004(b) of the Affordable Care Act added section 1886(j)(7) to the Act, which requires the Secretary to implement a quality reporting program (QRP) for IRFs. This program applies to freestanding IRF hospitals, IRF units that are affiliated with an acute care facility, and IRF units affiliated with a critical access hospital (CAH).

Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the reduction of the applicable IRF PPS annual increase factor, as previously modified under section 1886(j)(3)(D) of the Act, by 2 percentage points for any IRFs that fail to submit data to the Secretary in accordance with requirements established by the Secretary for that fiscal year. Section 1886(j)(7)(A)(ii) of the Act notes that this reduction may result in the increase factor being less than 0.0 for a fiscal year, and in payment rates under this subsection for a fiscal year being less than the payment rates for the preceding fiscal year. Any reduction based on failure to comply with the reporting requirements is, in accordance with section 1886(j)(7)(B) of the Act, limited to the particular fiscal year involved. The reductions are not to be cumulative and will not be taken into account in computing the payment amount under subsection (j) for a subsequent fiscal year.

Section 1886(j)(7)(C) of the Act requires that each IRF submit data to the Secretary on quality measures specified by the Secretary. The required quality measure data must be submitted to the Secretary in a form, manner and time, specified by the Secretary.

The Secretary is generally required to specify measures that have been endorsed by the entity with a contract under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF), which is a voluntary consensus standard-setting organization. The NQF was established to standardize health care quality measurement and reporting through its consensus development process.

We have generally adopted NQF-endorsed measures in our reporting programs. However, section 1886(j)(7)(D)(ii) of the Act provides that ''in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed, so long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary.'' Under section 1886(j)(7)(D)(iii) of the Act, the Secretary was required to publish the selected measures that will be applicable to the FY 2014 IRF PPS no later than October 1, 2012.

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making data submitted under the IRF QRP available to the public. The Secretary must ensure that each IRF is given the opportunity to review the data that is to be made public prior to the publication or posting of this data.

We seek to promote higher quality and more efficient health care for all patients who receive care in acute and post-acute care settings. Our efforts are, in part, effectuated by quality reporting programs coupled with the public reporting of data collected under those programs. The initial framework of the IRF QRP was established in the FY 2012 IRF PPS final rule (76 FR 47873).

B. Quality Measures Previously Finalized and Currently in Use for the IRF Quality Reporting Program

1. Background

In the FY 2012 IRF PPS final rule, we adopted applications of 2 quality measures for use in the first data reporting cycle of the IRF QRP: (1) An application of ''Catheter-Associated Urinary Tract Infection [CAUTI] for Intensive Care Unit Patients'' [1] (NQF#0138); and (2) an application of ''Percent of Residents with Pressure Ulcers that Are New or Worsened (short-stay)'' (NQF #0678). We adopted applications of these two measures because neither of them, at the time, was endorsed by the NQF for the IRF setting. We also discussed our plans to propose a 30-Day All Cause Risk Standardized Post IRF Discharge Hospital Readmission Measure at a later date (76 FR 47874 through 47878).

In the CY 2013 OPPS/ASC proposed rule (77 FR 45193 through 45196), we proposed: (1) To adopt updates to the CAUTI measure that had been adopted by NQF after we had adopted an application of the prior version of the measure for the IRF QRP; (2) to adopt a policy that would allow any measure adopted for use in the IRF QRP to remain in effect until the measure was actively removed, suspended, or replaced (we also proposed to apply this proposal to the CAUTI and pressure ulcer measures that had already been adopted for use in the IRF QRP); and (3) to utilize a subregulatory process to incorporate NQF updates to IRF quality measure specifications that do not substantively change the nature of the measure. We also informed stakeholders that CMS had submitted an ad hoc request for NQF review of the pressure ulcer measure with a request to endorse the measure's use in two additional care settings—Long-Term Care Hospitals (LTCHs) and IRFs. Assuming that the review resulted in no substantive changes to the pressure ulcer measure, we noted that, if adopted, we would use the proposed subregulatory process to incorporate any NQF updates and revisions to the pressure ulcer measure specifications for the IRF QRP Program (77 FR 45196).

In the CY 2013 OPPS/ASC final rule (77 FR 68500 through 68507), we adopted the policies and measures as proposed, with one exception. At the time of the CY 2013 OPPS/ASC final rule, the NQF had endorsed the pressure ulcer measure for the IRF setting, and re-titled it to cover both residents and patients within LTCH and IRF settings, in addition to the Nursing Home/Skilled Nursing Facility setting. Although the measure had been expanded to the IRF setting, we concluded that it was not possible to adopt the NQF endorsed measure ''Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (short-stay)'' (NQF #0678). Public comments revealed that the ''Quality Indicator'' section of the IRF–PAI did not contain the data elements that would be needed to calculate a risk-adjusted measure. As a result, we decided to: (1) Adopt an application of NQF #0678 that was a

[1] The version of the CAUTI measure that was adopted in the FY 2012 IRF PPS final rule (76 FR 47874 through 47876) was titled ''Catheter-Associated Urinary Tract Infection [CAUTI] Rate Per 1,000 Urinary Catheter Days for ICU patients. However, shortly after the FY 2012 IRF PPS final rule was published, this measure was submitted by the CDC (measure steward) to the NQF for a measure maintenance review, The CDC asked for changes to the measure, including expansion of the scope of the measure to non-ICU patient care locations and additional healthcare facility settings, including IRFs. The name of the measure was changed to reflect the character of the revised CAUTI measure. This measure is now titled ''National Health Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure.''

non-risk-adjusted pressure ulcer measure (numerator and denominator data only); (2) collect the data required for the numerator and the denominator using the current version of the IRF–PAI; (3) delay public reporting of pressure ulcer measure results until we could amend the IRF–PAI to add the data elements necessary for risk-adjusting NQF #0678, and then (4) adopt the NQF-endorsed version of the measure covering the IRF setting through rulemaking (77 FR 68507).

2. Previously Finalized IRF QRP Quality Measures

i. National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)

In the FY 2013 OPPS/ASC final rule we adopted the current version of NQF #0138 NHSN Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (replacing an application of this measure which we initially adopted in the FY 2012 IRF PPS (76 FR 47874 through 47886)). The NQF endorsed measure applies to the FY 2015 IRF PPS annual increase factor and all subsequent payment determinations (77 FR 68504 through 68505).

Since the publication of the FY 2013 OPPS/ASC final rule, the NHSN CAUTI measure has not changed. Furthermore, we have not removed, suspended, or replaced this measure and it remains an active part of the IRF QRP. Additional information about this measure can be found at *http://www.qualityforum.org/QPS/0138*. Our procedures for data submission for this measure have also remained the same. IRFs should continue to submit their CAUTI measure data to the Centers for Disease Control and Prevention (CDC) NHSN. Details regarding submission of IRF CAUTI data to NHSN can be found at the NHSN Web site at *http://www.cdc.gov/nhsn/inpatient-rehab/index.html*.

ii. Application of Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (short-stay) (NQF #0678)

In the CY 2103 OPPS/ASC final rule (77 FR 68500 through 68507) we finalized adoption of a non-risk-adjusted application of this measure using the current version of the IRF–PAI. We also stated that we would not begin public reporting of this measure until we had adopted the NQF-endorsed version of this measure. To adopt the NQF-endorsed version of this measure, we had to update the existing IRF–PAI to include the additional data elements necessary to risk adjust this measure. We also delayed public reporting of pressure ulcer measure results until we could use notice and comment rulemaking to amend the IRF–PAI to add the data elements necessary for risk adjusting NQF #0678 (77 FR 68507). We are not proposing any changes to the application of measure #0678 finalized in the FY 2013 OPPS/ASC final rule for the FY 2015 and FY 2016 IRF PPS annual increase factor. Furthermore, we have not removed, suspended, or replaced this measure and it remains an active part of the IRF QRP. Additional information about this measure can be found at *http://www.qualityforum.org/QPS/0678*. Our procedures for data submission for this measure also have remained the same. IRFs should continue to collect and submit pressure ulcer measure data during CY 2013 using the IRF–PAI released on October 1, 2012 for the FY 2015 IRF PPS annual increase factor. Further, IRFs should continue to collect and submit pressure ulcer measure data during the first three quarters of CY 2014 using the IRF–PAI released on October 1, 2012 for the FY 2016 IRF PPS annual increase factor.

However, we propose to adopt a revised version of the IRF–PAI starting October 1, 2014. This revised version of the IRF–PAI would allow collection of data elements necessary for risk adjustment of NQF #0678; therefore, we are proposing to adopt the NQF #0678 as specified (for example, including risk-adjustment) for the FY 2017 payment determination and subsequent fiscal year payment determinations.

TABLE 8—QUALITY MEASURES FINALIZED IN THE CY 2013 OPPS/ASC FINAL RULE AFFECTING THE FY 2015 IRF ANNUAL INCREASE FACTOR AND SUBSEQUENT YEAR INCREASE FACTORS

NQF Measure ID	Measure title
NQF #0138	National Health Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure +
Application of NQF #0678	Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short-Stay) *

+ Using CDC/NHSN.
* Using October 1, 2012 release of IRF–PAI.

C. Proposed New IRF QRP Quality Measures Affecting the FY 2016 and FY 2017 IRF PPS Annual Increase Factor, and Subsequent Year Increase Factors

1. General Considerations Used For Selection of Quality Measures for the IRF QRP

The successful development of an IRF quality reporting program that promotes the delivery of high quality healthcare services in IRFs is our paramount concern. We seek to adopt measures for the IRF QRP that promote better, safer, and more efficient care. Our measure selection activities for the IRF QRP must take into consideration input we receive from a multi-stakeholder group, the Measure Applications Partnership (MAP), which is convened by the NQF as part of a pre-rulemaking process that we have established and are required to follow under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened by the NQF for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide MAP input to CMS. We have taken the MAP's input into consideration in selecting measures for this proposed rule. Input from the MAP is located at *http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx*. For more details about the pre-rulemaking process, see the FY 2013 IPPS/LTCH PPS final rule (77 FR 53376).

We also take into account national priorities, such as those established by the National Priorities Partnership (NPP) at *http://www.qualityforum.org/npp/*, the HHS Strategic Plan *http://www.hhs.gov/secretary/about/priorities/priorities.html* and the National Strategy for Quality Improvement in Healthcare located at (*http://www.healthcare.gov/news/reports/nationalqualitystrategy032011.pdf*).

To the extent practicable, we have sought to adopt measures that have been endorsed by a national consensus organization, recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

For the FY 2016 IRF PPS annual increase factor, in addition to retaining the previously discussed CAUTI and Pressure Ulcer measures, we are proposing to adopt one new measure: Influenza Vaccination Coverage among Healthcare Personnel Measure (NQF #0431). For the FY 2017 IRF PPS annual increase factor we are proposing to adopt three quality measures: (1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities, (2) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), and (3) the NQF endorsed version of Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678). We discuss each in turn below.

2. New Quality Measures Proposed for Quality Data Reporting Affecting the FY 2016 IRF PPS Annual Increase Factor

i. Proposed IRF QRP Measure #1: Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

We propose to adopt the CDC developed Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure that is currently collected by the CDC via the NHSN. This measure reports on the percentage of health care personnel who receive the influenza vaccination. This measure was included on the CMS' List of Measures under Consideration for December 1, 2012 that CMS made publicly available. The measure was reviewed by the MAP and was included in the MAP input that was transmitted to CMS on February 1, 2013, as required by section 1890A(a)(3) of the Act. The MAP fully supported the use of this measure in the IRF setting, indicating it promotes alignment across quality reporting programs (for example, with Long-Term Care Hospital Quality Reporting Program (LTCHQR Program) and Hospital Inpatient Quality Reporting Program (Hospital IQR)) and addresses a core measure concept.

Health care personnel are at risk for both acquiring influenza from patients and transmitting it to patients, and health care personnel often come to work when ill.[2] One early report of health care personnel influenza infections during the 2009 H1N1 influenza pandemic estimated 50 percent of infected health care personnel had contracted the influenza virus from patients or coworkers in the healthcare setting.[3]

The CDC Advisory Committee on Immunization Practices (ACIP) guidelines recommend that all health care personnel get an influenza vaccine every year to protect themselves and patients.[4] Even though levels of influenza vaccination among health care personnel have slowly increased over the past 10 years, less than 50 percent of health care personnel each year received the influenza vaccination until the 2009 and 2010 seasons, when an estimated 62 percent of health care personnel got a seasonal influenza vaccination. In the 2010 and 2011 season, 63.5 percent of health care personnel reported influenza vaccination. Increased influenza vaccination coverage among health care personnel is expected to result in reduced morbidity and mortality related to influenza virus infection among patients, aligning with the NQS's aims of better care and healthy people/communities. This measure has been finalized for reporting in the Hospital IQR Program, LTCHQR Program, and the Ambulatory Surgical Center Quality Reporting Program (ASCQR Program).

We refer readers to the NHSN Manual, Healthcare Personnel Safety Component Protocol Module, Influenza Vaccination and Exposure Management Modules, which is available at the CDC Web site at *http://www.cdc.gov/nhsn/inpatient-rehab/hcp-vacc/index.html* for measure specifications and additional details.

We propose that, for the IRF QRP, the Influenza Vaccination Coverage Among Healthcare Personnel measure (NQF #0431) have its own reporting period to align with the influenza vaccination season, which is defined by the CDC as October 1st (or when the vaccine becomes available) through March 31st. IRFs will submit their data for this measure to the NHSN (*http://www.cdc.gov/nhsn/*). It is a secure Internet based surveillance system maintained by the CDC, and can be utilized by all types of health care facilities in the United States, including IRFs. NHSN collects data via a web based tool hosted by the CDC. Information on the NHSN system, including protocols, report forms, and guidance documents can be found at the provided web link: *http://www.cdc.gov/nhsn/*. NHSN will submit data to CMS on behalf of the facility.

For the FY 2016 IRF PPS annual increase factor, we propose that the data collection will cover the period from October 1, 2014 (or when the vaccine becomes available) through March 31, 2015. Details related to the use of NHSN for data submission and information on definitions, numerator data, denominator data, data analyses, and measure specifications for the Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure can be found at *http://www.cdc.gov/nhsn/inpatient-rehab/hcp-vacc/index.html*. Because IRFs are already using the NHSN for the submission of CAUTI data, the administrative burden related to data collection and submission for this measure under the IRF QRP should be minimal.

While IRFs can enter information in NHSN at any point during the influenza season for NQF #0431, data submission is only required once per influenza season, unlike the other measure finalized for the IRF QRP that utilizes NHSN (CAUTI measure NQF #0138). For example, IRFs can choose to submit influenza vaccination data on a monthly basis. However, each time an IRF submits these data, it will be asked to provide a cumulative total of vaccinations for the ''current'' influenza season. Thus, entering this information at the end of the influenza season would yield the same total number of vaccinations. The NHSN system will not track the individual number of vaccinations on a monthly basis, but, rather, will track the cumulative total of vaccinations for the ''current'' influenza season. We propose that the final deadline associated with this measure align with another CMS deadline for IRF HAI reporting into NHSN, which is May 15th. IRF QRP data collection timelines and submission deadlines are discussed below.

Also, we note that data collection for this measure is not 12 months, as with other measures, but is approximately 6 months (October 1 (or when the vaccine becomes available) through March 31 of the following year). We note that this data collection period is applicable only to NQF #0431 Influenza Vaccination Coverage Among Healthcare Personnel, and not applicable to any other IRF QRP

[2] Wilde JA, McMillan JA, Serwint J, *et al.* Effectiveness of influenza vaccine in healthcare professionals: A randomized trial. JAMA. 1999; 281: 908–913.

[3] Harriman K, Rosenberg J, Robinson S, *et al.* Novel influenza A (H1N1) virus infections among health-care personnel—United States, April–May 2009. MMWR Morb Mortal Wkly Rep. 2009; 58(23): 641–645.

[4] Fiore AE, Uyeki TM, Broder K, *et al.* Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR Recomm Rep. 2010. 59(08): 1–62.

measures, proposed or adopted, unless explicitly stated. The measure specifications for this measure can be found at *http://www.cdc.gov/nhsn/inpatient-rehab/hcp-vacc/index.html* and at *http://www.qualityforum.org/QPS/0431*.

We are seeking comments on the proposed use of the Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure for the FY 2016 IRF PPS annual increase factor and subsequent years.

TABLE 9—SUMMARY OF FY 2016 IRF PPS ANNUAL INCREASE FACTOR

Continued Data Collection:
• NQF #0138: National Health Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure +
• Application of NQF #0678: Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay) *
Proposed New IRF QRP Measures Affecting the FY 2016 IRF PPS Annual Increase Factor and Subsequent Year Increase Factors:
• NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel +

+ Using CDC NHSN.
* Using October 1, 2012 release of IRF–PAI.

3. Quality Measures Proposed for Quality Data Reporting Affecting the FY 2017 IRF PPS Annual Increase Factor and Subsequent Years

We are proposing to adopt two additional quality measures, and replace an existing quality measure for the IRF QRP for the FY 2017 payment determination and subsequent payment determinations. The new measures being proposed are (1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities, and (2) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680). In addition, we propose to replace the application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (short-stay) (NQF #0678), with adoption of the NQF endorsed version of this measure. We discuss each in turn below.

i. Proposed IRF QRP Measure #1: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From Inpatient Rehabilitation Facilities

We propose to adopt the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities. This measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases discharged from an IRF who were readmitted to a short-stay acute care hospital or LTCH, within 30 days of an IRF discharge. This is a claims-based measure not requiring reporting of new data by IRFs, and hence, will not be used to determine IRF reporting compliance for the IRF QRP.

Addressing unplanned hospital readmissions is a high priority for HHS and CMS as our focus continues on promoting patient safety, eliminating healthcare associated infections, improving care transitions, and reducing the cost of healthcare. Readmissions are costly to the Medicare program and have been cited as sensitive to improvements in coordination of care and discharge planning for patients.[5] Although the literature on readmissions is mainly concerned with discharges from short-term acute hospitals, the same issues of discharge planning, communications and coordination arise at discharge from other inpatient facilities.

IRFs provide intensive rehabilitation services to patients after an injury, illness, or surgery. According to MedPAC, the average length of stay for most patients in an IRF is 13.1 days.[6] In 2010, almost 360,000 Medicare fee-for-service (FFS) beneficiaries received care in IRFs and cost the Medicare FFS program over $6 billion dollars. The unadjusted readmission rate to an IPPS hospital in the 30 days following an IRF discharge was about 15 percent.[7] With such a large proportion of patients being readmitted to a hospital level of care, we are proposing a risk-adjusted measure of readmission rate, the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities. An IRF's readmission rate is affected by complex and critical aspects of care such as communication between providers or between providers and patients; prevention of, and response to, complications; patient safety; and coordinated transitions to the community or a less intense level of care. While disease-specific measures of readmission are useful in identifying deficiencies in care for specific groups of patients, they account for only a small minority of total readmissions. By contrast, a facility-wide, all-cause readmission reflects a broader assessment of the quality of care in IRFs, and may consequently better promote quality improvement and inform consumers about quality.

While some readmissions are unavoidable, such as those resulting from the inevitable progression of disease or worsening of chronic conditions, readmissions may also result from poor quality of care or inadequate transitions between care settings. Randomized controlled trials in short-stay acute care hospitals have shown that improvement in the following areas can directly reduce hospital readmission rates: quality of care during the initial admission; improvement in communication with patients, their caregivers and their clinicians; patient education; pre-discharge assessment; and coordination of care after discharge. Successful randomized trials have reduced 30-day readmission rates by 20–40 percent.[8] [9] [10] [11] [12] [13] [14] and a 2011 meta-analysis of randomized clinical trials found evidence that interventions associated with discharge planning helped to reduce readmission rates,[15]

[5] **Federal Register**/Vol. 76, No. 160/Thursday, August 18, 2011/Rules and Regulations, C1a.

[6] MedPAC, Report to Congress, Medicare Payment Policy, March, 2012. *http://www.medpac.gov/chapters/Mar12_Ch09.pdf*.

[7] Bernard SL, Dalton K, Lenfestey NF, Jarrett NM, Nguyen KH, Sorensen AV, Thaker S, West ND. Study to support a CMS Report to Congress: Assess feasibility of extending the hospital-acquired conditions—present on admission IPPS payment policy to non-IPPS payment environments. Prepared for the Centers for Medicare & Medicaid Services (CMS Contract No. HHSM–500–T00007). 2011.

[8] Jack BW, Chetty VK, Anthony D, Greenwald JL, Sanchez GM, Johnson AE, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med 2009;150(3):178–87.

[9] Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriatr Soc 2004;52(11):1817–25.

[10] Courtney M, Edwards H, Chang A, Parker A, Finlayson K, Hamilton K. Fewer emergency readmissions and better quality of life for older adults at risk of hospital readmission: a randomized controlled trial to determine the effectiveness of a 24-week exercise and telephone follow-up program. J Am Geriatr Soc 2009;57(3):395–402.

[11] Garasen H, Windspoll R, Johnsen R. Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomized controlled trial. BMC Public Health 2007;7:68.

[12] Koehler BE, Richter KM, Youngblood L, Cohen BA, Prengler ID, Cheng D, et al. Reduction of 30-day post discharge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle. J Hosp Med 2009;4(4):211–218.

[13] Naylor M, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, Pauly M. Comprehensive discharge planning for the hospitalized elderly. A randomized clinical trial. Ann Intern Med 1994;120(12):999–1006.

[14] Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. Jama 1999;281(7):613–20.

[15] Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB.The Importance of Transitional Care

illustrating how hospitals may influence readmission rates through best practices.

Because many studies have shown readmissions to be related to quality of care, and that interventions have been able to reduce 30-day readmission rates, we believe it is appropriate to include an all-condition readmission rate as a quality measure in the IRF QRP. Promoting quality improvements leading to successful transitions of care for patients moving from the IRF setting to the community or another post-acute care setting, and reducing preventable facility-wide readmission rates, is consistent with the National Quality Strategy priorities of safer, better coordinated care and lower costs.

CMS's approach to developing this measure is consistent with NQF-endorsed Hospital-Wide (HWR) Risk-Adjusted All-Cause Unplanned Readmission Measure (NQF #1789) (*http://www.qualityforum.org/Publications/2012/07/Patient_Outcomes_All-Cause_Readmissions_Expedited_Review_2011.aspx*) finalized for the Hospital IQR Program in the FY 2013 IPPS/LTCH PPS Final Rule (FR 77 53521 through 53528). To the extent appropriate, the proposed IRF measure is being harmonized with the HWR measure and other measures of readmission rates developed for post-acute care (PAC) settings, including LTCHs.

The All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities measure assesses returns to short-stay acute care hospitals or LTCHs within 30 days of discharge from an IRF to the community or another care setting of lesser intensity. Patient readmissions are tracked using Medicare claims data for 30 days after discharge, to the date of patient death, if the patient dies within 30 days of discharge. Because patients differ in complexity and morbidity, the measure is risk-adjusted for patient case-mix. The measure also excludes planned readmissions, because these are not considered to be indicative of poor quality of care on the part of the IRF.

A model developed by a CMS measure development contractor predicts admission rates while accounting for patient demographics, primary condition in the prior short stay, comorbidities, and a few other patient factors. While estimating the predictive power of the patient characteristics, the model also estimates a facility specific effect common to patients treated at that facility. Similar to the Hospital IQR Program hospital-wide readmission measure, the proposed IRF QRP measure is the ratio of the number of risk-adjusted predicted unplanned readmissions for each individual IRF, including the estimated facility effect, to the average number of risk-adjusted predicted unplanned readmissions for the same patients treated across IRFs. A ratio above one indicates a higher than expected readmission rate, or lower level of quality, while a ratio below one indicates a lower than expected readmission rate, or higher level of quality (The methodology report detailing the development of the IPPS hospital-wide measure and the NQF report may be downloaded from: *http://www.qualityforum.org/Publications/2012/07/Patient_Outcomes_All-Cause_Readmissions_Expedited_Review_2011.aspx*.)

The patient population includes IRF patients who:

- Were discharged alive from the IRF
- Had 12 months of Medicare Part A, fee-for-service coverage prior to the IRF stay
- Had 30 days of Medicare Part A, fee-for-service coverage post discharge.
- Had an IPPS hospital stay within the 30 days prior to the IRF stay.
- Were aged 18 years or above when admitted to the IRF.

As with the Hospital IQR Program hospital-wide readmission measure, patients whose principal diagnosis was cancer and whose treatment was non-surgical are excluded. Studies of this population that were reviewed for the Hospital IQR Program readmission measure showed them to have a different trajectory of illness and mortality than other patient populations.[16] The measure also excludes patients who died during the IRF stay, IRF patients under the age of 18, or IRF patients discharged against medical advice (AMA).

Readmissions that are not included in the measure are:

- Transfers from an IRF to another IRF or IPPS hospital
- Readmissions within the 30 day window that are usually considered planned due to the nature of the procedures and principal diagnoses of the readmission.
- IRF stays that are problematic (e.g., with stays that overlap wholly or in part)

The planned readmission list includes the planned procedures specified in the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF #1789) used in the Hospital IQR Program, plus other procedures that were determined in consultation with technical expert panels. In addition to the list of planned procedures is a list of diagnoses which, if found as the principal diagnosis on the readmission claim, would indicate that the procedure occurred during an unplanned readmission.

A discharged patient is tracked until one of the following occurs: (1) The 30-day period ends; (2) the patient dies; or (3) the patient is readmitted to an acute level of care (short or long term). If multiple readmissions occur, only the first is considered for this measure. If the readmission is unplanned, it is counted as a readmission in the measure rate. If the readmission is planned, the readmission is not counted in the measure rate. The occurrence of a planned readmission ends the 30-day window of the index discharge from the IRF.

Readmission rates are risk-adjusted for patient case-mix characteristics, independent of quality. The risk-adjustment model accounts for demographic characteristics, principal diagnosis, co-morbidities, length of stay in the prior IPPS hospital, critical care days in the prior IPPS hospital, number of IPPS hospital stays in the prior year, and the occurrence of various surgery types in the prior IPPS hospital stay. In modeling IRF readmissions, all patients are included in a single model modeling separate patient types separately as was done in the IPPS measure, an approach different from the five-cohort approach of the HWR measure, adapted to account for a substantially smaller patient population.

While the HWR measure used one year of data, the smaller IRF patient population leads us to propose merging two years of data for the IRF QRP. This approach is similar to that used by the Hospital IQR Program condition-specific readmission measures, which use three years of claims data. Merging multiple years produces more precise estimates of the effects of all the risk adjusters, and increases the sample size associated with each facility. Larger patient samples are better to be able to meaningfully to distinguish facility performance. Under the exception authority in section 1886(m)(5)(D)(ii) of the Act, we are proposing to use this measure in the IRF QRP. This section provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a

in Achieving Health Reform. Health Affairs 2011; 30(4):746–754.

[16] National Quality Forum. ''Patient Outcomes: All-Cause Readmissions Expedited Review 2011''. July 2012. pp12

contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

We were not able to identify an appropriate readmission measure for IRFs. In 2012, NQF endorsed two hospital-wide readmission measures, the National Committee for Quality Assurance (NCQA) measure intended for health plans, Plan All-Cause Readmissions (NQF #1768), and CMS' Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF #1789), of which the latter is the basis of the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities measure being proposed here. This measure was present on CMS's List of Measures Under Consideration, and the most recent MAP Pre-Rulemaking Report noted that ''readmission measures are also examples of measures that MAP recommends be standardized across settings, yet customized to address the unique needs of the heterogeneous Post-Acute Care/Long-Term Care (PAC/LTC) population. (*http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-February_2013.aspx pp. 177-180*). Although supported the direction of this measure, they cautioned that required further development. MAP has also continually noted the need for care transition measures in PAC/LTC performance measurement programs. Setting-specific admission and readmission measures under consideration would address this need''.[17]

We intend to seek NQF endorsement of the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities measure. As this is a claims-based measure not requiring reporting of new data by IRFs, this measure will not be used to determine IRF reporting compliance for the IRF QRP. We are proposing to begin reporting feedback to IRFs on performance of this measure in CY 2016. The initial provider feedback will be based on CY 2013 and CY 2014 Medicare FFS claims data related to IRF readmissions. The readmission measure will be part of the IRF public reporting program once public reporting is instated. Additional Details pertaining to this measure can be found on the IRF Quality Reporting Program Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*. We intend to provide details pertaining to the public reporting, such as provider preview of performance results, of this measure in our upcoming rules.

We seek public comment on our proposal to adopt the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities.

ii. Proposed IRF QRP Quality Measure #2: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

We are proposing to add the NQF# 0680 Percent of Residents or Patients who were assessed and Appropriately Given the Seasonal Influenza Vaccination (Short-Stay) measure to the IRF QRP, and we propose to collect the data for this measure through the addition of data items to the Quality Indicator section of the IRF–PAI. This measure was on CMS's list of measures under consideration that were reviewed by the MAP and was included in the MAP input that was transmitted to CMS, as required by the pre-rulemaking process in section 1890A(a)(3) of the Act. The MAP panel supported the use of this measure in the IRF setting, noting that it promotes alignment across settings and addresses a core measure concept. A MAP finding of ''supported'' indicates the measure is appropriate for immediate inclusion in the program measure set. (MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS, Pages 20 and 178, February 2013).

Although influenza is prevalent among all population groups, the rates of death and serious complications related to influenza are highest among those ages 65 and older and those with medical complications that put them at higher risk. The CDC reports that an average of 36,000 Americans die annually from influenza and its complications, and most of these deaths are among people 65 years of age and over.[18] In 2004, approximately 70,000 deaths were caused by influenza and pneumonia, and more than 85 percent of these deaths were among the elderly.[19] Given that many individuals receiving health care services in IRFs are elderly and/or have several medical conditions, many IRF patients are within the target population for the influenza immunization.[20] [21]

We propose to add the data elements needed for this measure, as an influenza data item set, to the Quality Indicator section of the IRF–PAI. This item set is described below entitled, ''*Proposed Changes to the IRF–PAI That Are Related to the IRF Quality Reporting Program.*'' We are proposing that data for this measure will be collected using a revised version of the IRF–PAI that includes a new data item set designed to assess patients' influenza vaccination status. The revised IRF–PAI would be effective on October 1, 2014. These proposed data set items are harmonized with data elements (O0250: Influenza Vaccination Status) from the Minimum Data Set (MDS) 3.0 and LTCH CARE Data Set item sets.[22] [23] The specifications and data elements for this proposed measure are available in the MDS 3.0 QM User's Manual available on our Web site at *https://www.cms.gov/NursingHomeQualityInits/Downloads/MDS30QM-Manual.pdf*.

For purposes of this measure, the influenza vaccination season consists of October 1st (or when the vaccine becomes available) through March 31st each year. We are proposing that while an IRF's compliance with reporting quality data for this measure will be based on the calendar year, the measure calculation and public reporting of this

[17] National Quality Forum. *Measure Applications Partnership Pre-Rulemaking Report: 2013 Recommendations of Measures Under Consideration by HHS: February 2013.* Available at *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72738.*

[18] Centers for Medicare & Medicaid Services (2011, May). Adult Immunization: Overview. Retrieved from *https://www.cms.gov/Immunizations/.*

[19] Gorina Y, Kelly T, Lubitz J, *et al.* (2008, February). Trends in influenza and pneumonia among older persons in the United States. Aging Trends no. 8. Retrieved from *http://www.cdc.gov/nchs/data/ahcd/agingtrends/08influenza.pdf.*

[20] Centers for Disease Control and Prevention. (2008, September). Influenza e-brief: 2008–2009 flu facts for policymakers. Retrieved from *http://www.cdc.gov/washington/pdf/flu_newsletter.pdf.*

[21] Zorowitz, RD. Stroke Rehabilitation Quality Indicators: Raising the Bar in the Inpatient Rehabilitation Facility. Topics in Stroke Rehabilitation 2010; 17 (4):294–304.

[22] Centers for Medicare & Medicaid Services. MDS 3.0 Item Subsets VI.10.4 for the April 1, 2012 Release. Retrieved from *https://www.cms.gov/NursingHomeQualityInits/30_NHOIMDS30TechnicalInformation.asp.*

[23] The LTCH CARE Data Set Version 2.00, the data collection instrument for the submission of the Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short-Stay) measure and the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) measure, is currently under review by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (PRA) *http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02155.pdf.* The LTCH CARE Data Set Version 1.01 was approved on April 24, 2012 by OMB in accordance with the PRA. The OMB Control Number is 0938–1163. Expiration Date April 30, 2013.

measure (once public reporting is instated) will be based on the influenza vaccination season starting on October 1 (or when vaccine becomes available) and ending on March 31 of the subsequent year.

The IRF–PAI Training Manual will indicate how providers should complete these items during the time period outside of the vaccination season (October 1 (or when vaccine becomes available) through March 31). The measure specifications for this measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), can be found on the CMS Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html*. Measure specifications are located in the download titled: MDS 3.0 QM User's Manual V6.0. Additional information on this measure can also be found at *http://www.qualityforum.org/QPS/0680*. Additional discussion related to the timing and submission of this measure is provided in this proposed rule.

We invite public comment on our proposal to use the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680) measure for the FY 2017 IRF PPS annual increase factor and subsequent years.

iii. Proposed IRF QRP Quality Measure #3: Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)—Proposal To Adopt the NQF Endorsed Version of This Measure

In the CY 2013 OPPS/ASC final rule (77 FR 68507) we finalized adoption of a non-risk-adjusted application of this measure, using the IRF–PAI released on October 1, 2012 for data collection. Although the measure was expanded to the IRF setting in 2012, the existing IRF–PAI needed to be updated to include the additional data elements required to risk adjust the measure prior to adopting the NQF measure. We also stated that we would not begin public reporting of this measure until we had adopted the NQF-endorsed version of this measure, and we would use the rulemaking process to solicit public comments on changes made to the IRF–PAI to collect elements necessary for risk adjustment of NQF #0678 (77 FR 68507).

If these proposed data elements related to risk adjustment data element are finalized, we also propose to remove the use of the currently adopted non-risk adjusted application of the measure and adopt the NQF-endorsed version of NQF #0678 for the FY 2017 IRF PPS increase factor. NQF #0678 underwent review for expansion to the IRF setting by the NQF Consensus Standards Approval Committee (CSAC) on July 11, 2012 and was subsequently ratified by the NQF Board of Directors for expansion to IRF settings on August 1, 2012.[24] [25] The title of the measure was changed to Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (short-stay) to reflect this expansion. Updated specifications, reflecting the expansion, are available on the NQF Web site at *http://www.qualityforum.org/QPS/0678*. We further propose to collect data for this measure using a revised version of the IRF–PAI beginning on October 1, 2014 for the FY 2017 IRF PPS annual increase factor. Our proposals related to a revised IRF–PAI are discussed in this proposed rule. The measure specifications for this NQF endorsed measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (short-stay) (NQF #0678) can be found on the CMS Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html*. Measure specifications are located in the download titled: MDS 3.0 QM User Manual V6.0. Additional information about the measure can also be found at *http://www.qualityforum.org/QPS/0678*.

In summary, we propose to adopt the NQF-endorsed version of NQF #0678, with data collection beginning October 1, 2014 using the revised version of IRF–PAI, for quality reporting affecting the FY 2017 IRF PPS annual increase factor. Further, we propose to remove the current non-risk adjusted application of this measure when the revised IRF–PAI is implemented on October 1, 2014. Note that until September 30, 2014, IRFs should continue to submit pressure ulcer data using the IRF–PAI released on October 1, 2012 for the purposes of data submission requirements for the FY 2015 and FY 2016 IRF PPS increase factor. Changes to the IRF–PAI and additional information regarding data submission are discussed in this proposed rule.

We invite public comment regarding our proposed removal of the currently adopted non-risk adjusted application of the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (short-stay) (NQF #0678) and the adoption of the NQF endorsed version of the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678).

TABLE 10—SUMMARY OF FY 2017 IRF PPS ANNUAL INCREASE FACTOR

Continued Data Collection:
- NQF #0138: National Health Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure +

Continued Data Collection of Proposed New IRF QRP Measures Affecting the FY 2016 IRF PPS Annual Increase Factor:
- NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel +

Proposed New IRF QRP Measures Affecting the FY 2017 IRF PPS Annual Increase Factor:
- All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities ^
- NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) *
- NQF #0678: Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short-Stay) *

+ Using CDC/NHSN.
* Using the IRF–PAI released October 1, 2014.
caret; Medicare Fee-For-Service claims data.

[24] National Quality Forum, Consensus Standards Approval Committee Wednesday, July 11, 2012. Transcript. Available: *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71612*.

[25] Press Release: NQF Removes Time-Limited Endorsement Status for 13 Measures, Measures Now Have Endorsed Status. August 1, 2012. Available: *http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Removes_Time-Limited_Endorsement_for_13_Measures;_Measures_Now_Have_Endorsed_Status.aspx*.

D. Proposed Changes to the IRF–PAI That Are Related to the IRF Quality Reporting Program

1. General Background

A version of the IRF–PAI has been in use in the IRF setting since January 1, 2002, when IRFs first began receiving payment under the IRF PPS. IRFs must submit a completed IRF–PAI for each Medicare Part A, B, and C patient that is admitted and discharged from the IRF.

The IRF PPS utilizes information from the IRF–PAI to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html*.

We are proposing to release an updated version of the IRF–PAI on October 1, 2014. Proposed revisions include data elements that will (1) Allow for risk adjustment of the NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay), (2) allow for more detailed data collection related to NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay), and (3) allow for data collection for NQF #0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay). We also propose to adopt a new numbering schema for the IRF–PAI.

Note that we are proposing both mandatory and voluntary additions to the IRF–PAI. Collection of voluntary data elements by IRFs will have no impact on measure calculations or on our determination of whether the IRF has met the reporting requirements under the IRF QRP. In contrast, failure to complete any adopted mandatory data elements may result in non-compliance with the IRF QRP requirements and subject the facility to a 2 percentage point reduction in its annual increase factor. In addition to clearly indicating which items are mandatory and which are voluntary in this proposal, we will post on our Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html* a detailed matrix that identifies which data elements will be required, and which will be voluntary.

The October 1, 2012 release of the IRF–PAI, the proposed October 1, 2014 release of the IRF–PAI, inclusive of all the changes proposed here, and information about the IRF–PAI submission process can be found at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*. A PRA package for the revised IRF–PAI discussed here has been submitted for the Office of Management and Budget's (OMB) review and approval.

2. Background Related To Collection of Pressure Ulcer Data Elements Using the IRF–PAI

In the FY 2012 IRF PPS final rule, we finalized a proposal to adopt an application of the NQF #0678 ''Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)'' measure for use in the IRF QRP, beginning with the IRF PPS annual increase factor for FY 2014. We also finalized our proposal to collect the data for this pressure ulcer measure using the IRF–PAI. To do this, we deleted the set of voluntary quality questions that had been located in the ''Quality Indicator'' section of the IRF–PAI and replaced them with a new required set of pressure ulcer quality measure data items, numbered 48A to 50D. These revisions to the IRF–PAI went into effect on October 1, 2012.

Since the publication of the FY 2012 IRF PPS final rule we have received numerous comments about the current version of the IRF–PAI from IRF providers, provider organizations, and advocacy groups. In the CY 2013 OPPS/ASC final rule, we discussed a number of specific public comments related to pressure ulcer data that we received in response to the CY 2013 OPPS/ASC IRF proposed rule (77 FR 68506). Commenters expressed specific concerns regarding the ability of the data elements in the IRF–PAI to sufficiently risk-adjust the measure. We agreed that there were limitations related to the risk adjustment data items that are on the IRF–PAI that went into effect on October 1, 2012, impacting the ability to calculate the measure using all of the risk adjustment related covariates. As a result, the CY 2013 OPPS/ASC final rule adopted an application of #0680 without risk-adjustment for FY 2015 and subsequent years (77 FR 68507).

In response to the comments and feedback received in previous rules discussed above, we propose modifications to the data items in both the admission and discharge IRF–PAI assessments.

3. Proposed Revisions to the IRF–PAI To Add Mandatory Risk Adjustment Data Items for NQF #0678 Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay)

We are proposing to update the current IRF–PAI to include data elements that are necessary to risk adjust the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678). These include the addition of the following indicator boxes to the IRF–PAI admission assessment: (1) Peripheral Vascular Disease, (2) Peripheral Arterial Disease, and (3) Diabetes. The additions would be placed in the Quality Indicators section of the revised IRF–PAI.

We further determined that risk adjustment factors related to height and weight had inadvertently been left off of the revised version of the IRF–PAI that became effective on October 1, 2012. We are now proposing to add height and weight to the IRF–PAI to correct this oversight.

We further propose adding the height and weight items into the ''Medical Information'' section if the IRF–PAI. As a general rule, we would place all data items related to quality reporting and quality measures within the Quality Indicator section of the IRF–PAI. However, the height and weight items have a dual purpose because they can be used for the calculation of Body Mass Index (BMI), which is used as one part of the analysis for compliance with the 60 percent rule. Even though the height and weight items are placed in the ''Medical Information'' section of the IRF–PAI, they are also being added to the IRF–PAI for calculating risk adjustment for the pressure ulcer measure. Failure to provide height and weight could result in a finding of non-compliance with the reporting requirements.

We invite public comment on our proposal to include data elements required for risk-adjustment of #0678 Percent of Patients with Pressure Ulcers That Are New or Worsened Measure as mandatory data collection elements in the revised IRF–PAI.

4. Proposed Revisions to the IRF–PAI To Add Voluntary Data Items Related to NQF #0678 Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay)

The pressure ulcer measure numerator for the NQF #0678 endorsed version of the ''Percent of Patients with Pressure Ulcers That Are New or Worsened'' measure looks at the number

of patients with a target assessment during the selected time window who have one or more Stage 2 through 4 pressure ulcer(s) that are new or that have worsened compared with the previous assessment. According to the NQF Web site, in its description of NQF #0678, ''Stage 1 pressure ulcers are excluded from this measure because recent studies have identified difficulties in objectively measuring them across different populations.'' The measure numerator also does not include unstageable pressure ulcers. The data that is mandatory for IRFs to report under the IRF QRP are those that meet the requirements of the application of NQF #0678 that we finalized in the CY 2013 OPPS/ASC Final Rule. As noted above, we are proposing to add additional mandatory data items to accommodate this. If our proposal to adopt the NQF-endorsed version of this measure is finalized, the mandatory data would remain the same.

We are also proposing to add voluntary data items to the IRF–PAI Quality Indicators section, designed to address commenters' concerns about the adequacy of current pressure ulcer data items. Some commenters expressed concern that the current data items would not allow for documentation of all relevant categories of pressure ulcers, such as unstageable pressure ulcers. As modified, our proposed admission assessment consists of 2 main topics: (1) Unhealed Pressure Ulcers; and (2) Pressure Ulcer Risk Conditions. Also, the discharge assessment consists of 2 main topics: (1) Unhealed Pressure Ulcers; and (2) Healed Pressure Ulcers. Within each main topic there are sub-topics that contain a set of questions. The provider is asked to document how many pressure ulcers, if any, the patient has at each stage upon admission. We have added new questions that extend beyond stages 2 through 4 pressure ulcers, covering the presence of stage 1 pressure ulcers, as well as unstageable pressure ulcers that are due to a non-removable device or dressing, to slough or eschar, or deep tissue injury. We note that the discharge assessment differs somewhat from the admission assessment with regard to the pressure ulcer questions. A copy of the proposed new IRF–PAI can be found at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

We have added greater specificity to the pressure ulcer items to allow providers to document pressure ulcers in more detail. In describing the inadequacy they perceived in the present pressure ulcer items, providers described such situations as those in which a patient is admitted into an IRF with an unstageable pressure ulcer that is a suspected deep tissue injury (DTI). During the course of the IRF stay the DTI evolves into a stage 3 and, after several days, worsens to a stage 4. On the current version of the IRF–PAI, providers have no ability to document the presence of an unstageable pressure ulcer that existed when the patient was admitted. Whether or not the IRF believes there is an unstageable pressure ulcer, the IRF must document that the patient had no pressure ulcers on the admission assessment. However later, after the DTI worsens to a stage 3, if the IRF judges from the nature of the pressure ulcer that it was extremely likely to have been present at admission, the IRF would have to go back and change their documentation on the admission assessment to reflect that the patient actually had a stage 3 pressure ulcer upon admission. Upon discharge, the IRF would document that the patient has a stage 4 pressure ulcer. With the new proposed pressure ulcer data items, the IRF would be able to document the presence of the unstageable pressure ulcer or suspected DTI on the admission assessment. The proposed revisions to the IRF–API would allow the IRF to give a more complete and accurate picture of the progression of this pressure ulcer when the patient is discharged.

While Stage 1 and unstageable pressure ulcers are not part of the NQF #0678 endorsed version of the ''Percent of Patients with Pressure Ulcers That Are New or Worsened,'' and are not mandatory, we nonetheless believe that it is appropriate and important for us to collect this information. As the measure steward for this measure, CMS would like to gather and analyze data regarding Stage 1 and unstageable pressure ulcers to help determine if any modification to the existing measure should be made. This data could also help us determine if any additional pressure ulcer measures should be developed. For example, collecting data about Stage 1 pressure ulcers could provide us with information that would allow us to assess whether these pressure ulcers can now be objectively measured across different populations.

Additionally, some pressure ulcers that are present on admission can become stageable and then worsen to a higher stage during the IRF stay. Access to data on this scenario would assist us in determining whether including unstageable and Stage 1 measures in the measure results may be appropriate in the future. We might accomplish this by expanding the current measure or developing an entirely new pressure ulcer measure.

We invite public comment on our proposed revisions to the IRF–PAI related to voluntary items for NQF #0678 Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay).

5. Proposed Revisions to the IRF–PAI to Add Mandatory Data Items related to NQF #0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)

We are also proposing changes to the IRF–PAI discharge assessment to include the addition of the data elements necessary to report the data necessary for the proposed measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680). These items will be based on the items from the MDS 3.0 and LTCH CARE Data Set items.[26] [27] There are three data elements collected in relation to this measure: Two are used to calculate the measure and a third is used to ensure internal consistency and data accuracy. The items are as follows: Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season? Date influenza vaccine was received; and, If influenza vaccine not received, state reason. These questions allow the IRF to report if and when an influenza vaccine was given at the facility. It also allows the IRF to indicate why a vaccine was not given if that is the case. Further details on the specifications and data elements for this measure are available in the MDS 3.0 QM User's Manual available on our Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html*. Measure specifications are located in the download titled: MDS 3.0 QM User's

[26] Centers for Medicare & Medicaid Services. MDS 3.0 Item Subsets V1.10.4 for the April 1, 2012 Release. Retrieved from *https://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp*.

[27] The LTCH CARE Data Set Version 2.00, the data collection instrument for the submission of the Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (Short-Stay) measure and the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) measure, is currently under review by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (PRA) *http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02155.pdf*. The LTCH CARE Data Set Version 1.01 was approved on April 24, 2012 by OMB in accordance with the PRA. The OMB Control Number is 0938–1163. Expiration Date April 30, 2013.

Manual V6.0. Measure information is also available at *http://www.qualityforum.org/QPS/0680*.

We invite public comment on our proposed revisions to the IRF–PAI related to NQF #0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay).

6. Proposed Revisions to the IRF–PAI Related to Numbering of Quality Indicator Items.

Finally, in the revised IRF–PAI, we include changes in the numbering scheme used in the Quality Indicator section of the IRF–PAI from a ''consecutive numbering scheme'' for numbering assessment items to a numbering scheme that allows greater flexibility for item removal and insertion. Problems arise with a consecutive numbering scheme when items are removed or new ones are inserted because this changes the numbers of some or all of the items around them. Other CMS post-acute care data collection vehicles, such as the MDS 3.0, and the LTCH CARE Data Set, have adopted a more flexible numbering schema that allows insertion or removal of items without requiring renumbering of the remaining items. We propose adopting a similar numbering schema in the revised IRF–PAI. A less flexible numbering system that necessitates renumbering items on the IRF–PAI in the event of such changes will result in a given item number having very different meanings on different versions of the IRF–PAI item set.

For more details about our plans for changes to the IRF–PAI, see *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

We invite public comments about our proposed changes to the numbering schema of the IRF–PAI.

E. Proposed Change in Data Collection and Submission Periods for Future Program Years

The FY 2012 IRF PPS final rule included an initial framework for the IRF QRP. In that rule we also finalized the initial quality measures to be used in the IRF QRP, stated how data for these measures would to be collected, and selected the time periods for the data collection and reporting of the quality data.

The FY 2012 IRF PPS final rule finalized the initial IRF QRP data reporting cycle, affecting the FY 2014 payment determination, as beginning on October 1, 2012 and ending on December 31, 2012. Beginning in 2013 for the FY 2015 payment determination, and for subsequent years, we finalized that quality reporting cycles be based on a full calendar year (CY) cycle (76 FR 47879).

When there are new measures added to the quality reporting program that will be collected on the IRF–PAI, that data collection instrument must be updated accordingly. The next update to the IRF–PAI will take place on October 1, 2014. Under current policy, the IRF QRP data collection cycle for the FY 2016 payment determination will not begin until January 1, 2014.

To accommodate the revised data collection instrument, we are proposing to change the IRF–PAI data collection periods for the FY 2016 and FY 2017 payment determinations in order to align with the release of the new version of the IRF–PAI on October 1, 2014. We propose to shorten the data collection period impacting the FY 2016 IRF PPS annual increase factor to nine months, so that the next reporting period may begin on October 1, 2014 using the new version of the IRF–PAI. Under this proposal, the next data collection period would run from January 1, 2014 to September 30, 2014 and affect the IRF PPS annual increase factor for FY 2016.

Starting October 1, 2014, we propose to start fiscal year data collection periods, such that data collected for discharges during October 1, 2014 to September 30, 2015 will affect the FY 2017 IRF PPS annual increase factor. We further propose that data collection continue on FY cycles unless there is an event that requires that this cycle be amended. We intend to provide public announcements in the event the established cycles must be changed.

Note that, as a result of this proposal, data submitted on the IRF–PAI and data submitted using the NHSN will have two separate data collection and submission schedules. We provide more details on this distinction below. We invite public comment on our proposal to alter the IRF–PAI data collection periods impacting the FY 2016 and FY 2017 increase factors in a way that aligns with the release of the next version of the IRF–PAI instrument.

1. Proposed Implementation of Quarterly Data Submission Deadlines for the IRF QRP

In the FY 2012 IRF PPS rule we stated that ''details regarding data submission and reporting requirements for this measure will be posted on the CMS Web site at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html* no later than January 31, 2012'' (FR 76 47879). Further data submission details for the IRF QRP were posted on the CMS IRF QRP Web site on January 31, 2012, as promised. In addition, data submission details were disseminated to IRFs at various times from January 31, 2012 to December 31, 2012, through an in-person training held on May 2, 2012, Open Door Forums, list-serve announcements, IRF QRP Web page postings and responses to IRF QRP Helpdesk inquiries. In these communications, we announced that the final data submission deadline for the IRF QRP would be May 15th for all measures finalized for the FY 2014 payment determination and each subsequent payment determination.

We realize the value in providing clear submission deadlines for the IRF QRP and we believe that we should provide deadlines that clearly distinguish between data submitted using the NHSN and data submitted using the IRF–PAI. Further, it is important to have distinct deadlines at which point data submitted afterward, including data modifications and corrections, could not be used for reporting or IRF PPS annual increase factor determinations. For purposes of the FY 2016 and subsequent year IRF PPS annual increase factors, and for the purposes of applying quarterly deadlines for public reporting purposes, we propose the inclusion of quarterly data submission deadlines in addition to the previously finalized deadlines. We believe that this will ensure timely submission of data.

2. Quarterly Submission Timelines of Data Reported Using the IRF–PAI

For the purposes of quality data reported using the IRF–PAI for the IRF QRP, we have proposed timeframes described below that we believe will provide sufficient time for IRFs and CMS to meet quality reporting requirements and allow CMS to harmonize IRF QRP data submission deadlines with the LTCHQR Program and Hospital IQR. Beginning with data collection and reporting impacting the FY 2016 annual increase factor, we propose that IRFs follow the deadlines presented in the tables below to complete submission of data for each quarter. For each quarter outlined in the tables below during which IRFs are required to collect data, we propose a final deadline occurring approximately 135 days after the end of each quarter by which all data collected during that quarter must be submitted. We believe that this is a reasonable amount of time to allow IRFs to submit data and make any necessary corrections. We have summarized these deadlines in the tables below.

TABLE 11—PROPOSED TIMELINES FOR SUBMISSION OF IRF QRP PROGRAM QUALITY DATA USING IRF–PAI * FOR FY 2016 IRF PPS ANNUAL INCREASE FACTOR +: APPLICATION OF NQF #0678 PERCENT OF RESIDENTS OR PATIENTS WITH PRESSURE ULCERS THAT ARE NEW OR WORSENED (SHORT-STAY)

Quarter	IRF–PAI data collection period	IRF–PAI data submission deadline for corrections of the IRF QRP
FY 2016 Annual Increase Factor		
Quarter 1	January 1, 2014–March 31, 2014	August 15, 2014.
Quarter 2	April 1, 2014–June 30, 2014	November 15, 2014.
Quarter 3	July 1, 2014–September 30, 2014	February 15, 2015.

* Using October 1, 2012 release of IRF–PAI.
+ FY 2016 APU determination is based on 3 quarters of data submission for the pressure ulcer measure.

TABLE 12—PROPOSED TIMELINES FOR SUBMISSION OF IRF QRP PROGRAM QUALITY DATA USING IRF–PAI * FOR FY 2017 IRF PPS ANNUAL INCREASE FACTOR: NQF #0678 PERCENT OF RESIDENTS OR PATIENTS WITH PRESSURE ULCERS THAT ARE NEW OR WORSENED (SHORT-STAY), AND NQF #0680 PERCENT OF RESIDENTS OR PATIENTS WHO WERE ASSESSED AND APPROPRIATELY GIVEN THE SEASONAL INFLUENZA VACCINE (SHORT-STAY)

Quarter	IRF–PAI data collection period	IRF–PAI data submission deadline for corrections of the IRF QRP
FY 2017 Annual Increase Factor		
Quarter 1	October 1, 2014–December 31, 2014	May 15, 2015.
Quarter 2	January 1, 2015–March 31, 2015	August 15, 2015.
Quarter 3	April 1, 2015–June 30, 2015	November 15, 2015.
Quarter 4	July 1, 2015–September 30, 2015	February 15, 2016.

* Using October 1, 2014 release of IRF–PAI.

3. Quarterly Submission Timelines of Data Reported Using NHSN

For the purposes of reporting quality data using the NHSN, specifically CAUTI reporting and reporting of the staff influenza immunization measure, we are specifically proposing to align with CMS's established submission deadlines in the Hospital IQR and the LTCHQR Programs. The CDC recommends that a facility report Healthcare Acquired Infection (HAI) events such as CAUTI, as close to the time of the event as is possible, and certainly within 30 days. CMS recommends adherence to this approach. In addition, we propose that IRFs report CAUTI events, including null events, on a monthly level using the NHSN.

For the purposes of continuity, we propose to continue the calendar year basis of reporting CAUTI, using quarterly deadlines as established by the Hospital IQR program. Final submission deadlines for measures collected through the NHSN are shown in the tables below.

TABLE 13—PROPOSED TIMELINES FOR SUBMISSION OF IRF QRP PROGRAM QUALITY DATA USING CDC/NSHN FOR FY 2016 AND FY 2017 IRF PPS ANNUAL INCREASE FACTOR: NATIONAL HEALTH SAFETY NETWORK (NHSN) CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI) OUTCOME MEASURE

Quarter	CDC/NHSN data collection period	CDC/NHSN data submission deadline
FY 2016 Annual Increase Factor		
Quarter 1	January 1, 2014–March 31, 2014	August 15, 2014.
Quarter 2	April 1, 2014–June 30, 2014	November 15, 2014.
Quarter 3	July 1, 2014–September 30, 2014	February 15, 2015.
Quarter 4	October 1, 2014–December 31, 2014	May 15, 2015.
FY 2017 Annual Increase Factor		
Quarter 1	January 1, 2015–March 31, 2015	August 15, 2015.
Quarter 2	April 1, 2015–June 30, 2015	November 15, 2015.
Quarter 3	July 1, 2015–September 30, 2015	February 15, 2016.
Quarter 4	October 1, 2015–December 31, 2015	May 15, 2016.

Further, we propose to apply to IRF QRP the same deadlines established for the reporting of the Influenza Vaccination Coverage Among Health Personnel (NQF #0431) measure in the Hospital IQR Program and proposed in the LTCH QRP.

TABLE 14—PROPOSED TIMELINES FOR SUBMISSION OF IRF QRP PROGRAM QUALITY DATA USING CDC/NSHN FOR FY 2016 AND FY 2017 IRF PPS ANNUAL INCREASE FACTOR: NQF #0431 INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL

Data collection timeframe	CDC/NHSN Data submission deadline
FY 2016 Annual Increase Factor	
October 1, 2014 (or when the influenza vaccine becomes available)—March 31, 2015	May 15, 2015.
FY 2017 Annual Increase Factor	
October 1, 2015 (or when the influenza vaccine becomes available)—March 31, 2016	May 15, 2016.

We invite public comment on the proposed data submission quarterly and final deadlines for the purposes of reporting data using the IRFPAI and for the purposes of reporting data using the NHSN.

F. Proposed Reconsideration and Appeals Process

At the conclusion of any given data reporting period, we will review the data received from each IRF during that reporting period to determine if the IRF has reported the required amount and type of data. IRFs that are found to be non-compliant with the reporting requirements set forth for that reporting cycle could receive a reduction in the amount of 2 percentage points to their IRF PPS increase factor for the upcoming payment year.

We are aware that there may be situations in which an IRF provider has evidence to dispute a finding of non-compliance. We further understand that there may be times when a provider may be prevented from submitting quality data due to the occurrence of extraordinary circumstances beyond their control (for example, natural disasters). It is our goal not to penalize IRF providers in these circumstances or to unduly increase their burden during these times.

We are also aware, for the purposes of the IRF Quality Reporting Program, that we will be making compliance determinations for the FY 2014 payment determination in the coming months and believe that providers should have the opportunity to request a reconsideration if the circumstances warrant. In addition, adding a reconsideration process to the IRF Quality Reporting program will make it consistent with other established quality reporting programs, a number of which already offer this opportunity. We are therefore providing a mechanism that will allow IRFs to request reconsiderations pertaining to their FY 2014 payment determinations and that of subsequent fiscal years.

Specifically, as part of the mechanism to allow for IRFs to request a reconsideration, IRFs found to be non-compliant with the reporting requirements during a given reporting cycle will be notified of that finding. IRFs will be informed: (1) That they have been identified as being non-compliant with the IRF Quality Reporting Program's reporting requirements for the reporting cycle in question; (2) that they will be scheduled to receive a reduction in the amount of 2 percentage points to their PPS increase factor for the upcoming payment year; (3) that they may file a request for reconsideration if they believe that the finding of non-compliance is erroneous, or that if they were non-compliant, they have a valid and justifiable excuse for this non-compliance; and (4) that they must follow a defined process on how to file a request for reconsideration, which will be described in the notification.

Upon the conclusion of our review of each request for reconsideration, we will render a decision. We may reverse our initial finding of non-compliance if: (1) The IRF provides proof of full compliance with all requirements during the reporting period; or (2) the IRF provides adequate proof of a valid or justifiable excuse for non-compliance if the IRF was not able to comply with requirements during the reporting period. We will uphold our initial finding of non-compliance if the IRF cannot show any justification for non-compliance.

We intend to provide details pertaining to the reconsideration process, and the mechanisms related to provider requests for reconsideration of their payment determinations, such as filing requests, required content, supporting documentation, and mechanisms of notification and final determinations on the IRF QRP Web site this spring at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*. We invite public comment on the proposed procedures for reconsideration and appeals.

G. Proposed Policy for Granting of a Waiver of the IRF QRP Data Submission Requirements in Case of Disaster or Extraordinary Circumstances

Our experience with other quality reporting programs has shown that there are times when providers are unable to submit quality data due to the occurrence of extraordinary circumstances beyond their control (for example, natural or man-made disasters). We define a ''disaster'' as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation. Natural disasters could include events such as hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis. Man-made disasters could include such events as terrorist attacks, bombings, floods caused by man-made actions, civil disorders, and explosions. A disaster may be widespread or impact multiple structures or be isolated and impact a single site only.

In certain instances of either natural or man-made disasters, an IRF may have the ability to conduct a full patient assessment, and record and save the associated data either during or before the occurrence of an extraordinary event. In this case, the extraordinary event has not caused the facility's data files to be destroyed, but it could hinder the IRF's ability to meet the quality reporting program's data submission deadlines. In this scenario, the IRF would potentially have the ability to report the data at a later date, after the emergency circumstances have subsided. In such cases, a temporary

waiver of the IRF duty to report quality measure data may be appropriate.

In other circumstances of natural or man-made disaster, an IRF may not have had the ability to conduct a full patient assessment, and record and save the associated data before the occurrence of an extraordinary event. In such a scenario, the facility does not have data to submit to CMS as a result of the extraordinary event. We believe that it is appropriate, in these situations, to grant a full waiver of the reporting requirements.

It is our goal not to penalize IRF providers in these circumstances or to unduly increase their burden during these times. Therefore, we are proposing a process, for payment year 2015 and subsequent years, for IRF providers to request and for CMS to grant waivers with respect to the reporting of quality data when there are extraordinary circumstances beyond the control of the provider. When a waiver is granted, an IRF will not incur payment reduction penalties for failure to comply with the requirements of the IRF QRP.

We are proposing a process that, in the event that an IRF seeks to request a waiver for quality reporting purposes for payment year 2015 and subsequent payment years, the IRF may request a waiver for one or more quarters by submitting a written request to CMS. We are proposing that IRFs compose a letter to CMS that documents the waiver request, with the information described below, and submit the letter to CMS via email to the IRF Help Desk at *IRFQualityQuestions@cms.hhs.gov*. IRFs that have filed a request for an IRF QRP disaster waiver with an IRF–PAI waiver request using the procedure that is described under our regulations at 42 CFR 412.614 can indicate this in their letter to CMS for their request for a waiver for quality reporting purposes.[28]

Note that the subject of the email must read ''Disaster Waiver Request'' and the letter must contain the following information:

- IRF CCN;
- IRF name;
- CEO or CEO-designated personnel contact information including name, telephone number, email address, and mailing address (the address must be a physical address, not a post office box);
- IRF's reason for requesting a waiver;
- Evidence of the impact of extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the IRF believes that it will again be able to submit IRF QRP data and a justification for the proposed date.

We propose that the letter documenting the disaster waiver request be signed by the IRF's CEO, and must be submitted within 30 days of the date that the extraordinary circumstances occurred. Following receipt of the letter, we would: (1) Provide a written acknowledgement, using the contact information provided in the letter, to the CEO or designated contact person, notifying them that the request has been received, and (2) after CMS has made a decision as to whether to grant to waiver request, provide a formal response to the CEO, or designated contact person notifying them of our decision.

This proposal does not preclude CMS from granting waivers to IRFs that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. If we make the determination to grant a waiver to IRFs in a region or locale, we propose to communicate this decision through routine communication channels to IRFs and vendors, including but not limited to issuing memos, emails, and notices on *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html.*

We invite public comment on this proposal.

H. Public Display of Data Quality Measures for the IRF QRP Program

Under section 1886(j)(7)(E) of the Act, the Secretary is required to establish procedures for making data submitted under the IRF QRP available to the public. Section 1886(j)(7)(E) also requires procedures to ensure that each IRF provider has the opportunity to review that data that is to be made public with respect to its facility, prior to such data being made public. Section 1886(j)(7)(E) of the Act requires CMS to report quality measures that relate to services furnished in IRFs on CMS' Web site.

Currently, the Agency is developing plans regarding the implementation of these provisions. We appreciate the need for transparency into the processes and procedures that will be implemented to allow for the public reporting of the IRF QRP data and to afford providers the opportunity to preview that data before it is made public. At this time, we have not established procedures or timelines for public reporting of data, but we intend to include related proposals in future rule making. We welcome public comments on what we should consider when developing future proposals related to public reporting.

I. Method for Applying the Reduction to the FY 2014 IRF Increase Factor for IRFs That Fail To Meet the Quality Reporting Requirements

As previously noted, section 1886(j)(7)(A)(i) of the Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2014 is to be the first year that the mandated reduction will be applied for IRFs that failed to comply with the data submission requirements during the data collection period October 1, 2012 through December 31, 2012. Thus, in compliance with 1886(j)(7)(A)(i) of the Act, we will apply a 2 percentage point reduction to the applicable FY 2014 market basket increase factor (1.7 percent) in calculating an adjusted FY 2014 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements. As noted previously, application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved. Table 15 shows the calculation of the adjusted FY 2014 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from October 1, 2012 through December 31, 2012.

[28] *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-614.pdf.*

TABLE 15—CALCULATIONS TO DETERMINE THE PROPOSED ADJUSTED FY 2014 STANDARD PAYMENT CONVERSION FACTOR FOR IRFS THAT FAILED TO MEET THE QUALITY REPORTING REQUIREMENT

Explanation for adjustment	Calculations	
Standard Payment Conversion Factor for FY 2013		$14,343
Adjusted Market Basket Increase Factor for FY 2014 (2.5 percent), reduced by 0.3 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and a 0.4 percentage point reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	×	0.99800
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×	1.0011
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×	1.0000
Budget Neutrality Factor for the Update to the Rural Adjustment Factor	×	1.0030
Budget Neutrality Factor for the Update to the LIP Adjustment Factor	×	1.0174
Budget Neutrality Factor for the Update to the Teaching Status Adjustment Factor	×	0.9966
Proposed Adjusted FY 2014 Standard Payment Conversion Factor	=	$14,573

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule does not impose any new information collection requirements as outlined in the regulation text. However, this proposed rule does make reference to associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

A. ICRs Regarding IRF QRP

As stated in section XIII. of the preamble of this proposed rule, we have proposed to introduce one new measure for use in the IRF QRP that will require IRF providers to submit new data beginning on October 1, 2014 and which will affect the increase factor for FY 2016. This quality measure is: Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431). We have also proposed to introduce for FY 2017 an All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities. This measure is a claims-based measure that does not require submission of data by IRF providers. For FY 2017, we have proposed to adopt the Percent of Resident or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF#0680) measure. We have also proposed for FY 2017 to change from the use of a non-risk adjusted pressure ulcer measure, in which only numerator and denominator data is collected, to use of the NQF endorsed measure ''Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)'' (NQF #0678), which is a risk-adjusted measure. Each of these measures will be collected in the manner described below:

1. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

In section XIII. of this proposed rule, we are proposing to add the new measure, Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) to the IRF QRP. IRFs will be required to collect data related to the number of healthcare personnel working at a facility who have been vaccinated against the influenza virus during a given influenza vaccination season. The CDC has determined that the influenza vaccination season begins on October 1st (or when the vaccine becomes available) and ends on the following March 31st each year. This measure requires that the provider submit only one report to NHSN after the close of the data collection period each year.

We believe that it has become a common practice for healthcare facilities, including IRFs, to promote vaccination of employees for the influenza virus and to keep records of which of their staff members received this vaccination each year. Therefore, we do not believe that IRFs will incur any additional burden related to the collection of the data for this measure.

We anticipate that it will take approximately 15 minutes to prepare and transmit the required data for this measure to the CDC each year. The reporting of the data for this measure can be done while the provider is logged onto NHSN for the purpose of entering their CAUTI measure data. We believe that this task can be completed by an administrative person such as a Medical Secretary Medical Data Entry Clerk. The average hourly wage for Medical Records or Health Information Technicians is $15.55.[29] We estimate that the annual cost to each IRF for the reporting of the staff influenza measure will be $3.98.[30] The annual cost across the 1161 IRFs in the U.S. that are reporting data to CMS is estimated to be $4,621.[31]

2. All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From Inpatient Rehabilitation Facilities

As stated in section XIII. of this proposed rule, data for this measure will be collected from Medicare claims and therefore will not add any additional reporting burden for IRFs.

[29] According to the U.S. Bureau of Labor Statistics, the mean hourly wage for a Medical Records & Health Information Technician is $15.55. See: *http://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm.*

[30] 15 minutes administrative staff time to collect and report staff influenza measure @ $15.55 per hour = $3.98 per IRF per year

[31] At the time of the writing of this rule, there were 1161 IRFs reporting quality data to CMS. ($3.98 per IRF per year × 1161 IRFs in U.S.= $4,621).

1. Percent of Residents or Patients With Pressure Ulcers That Are New or Have Worsened (Short-Stay) (NQF #0678)

In section XIII of this proposed rule, we proposed to adopt the NQF endorsed version of the measure titled ''Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)'' (NQF #0678). To support the standardized collection and calculation of this quality measure, we have proposed to modify the current Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI) by replacing the current pressure ulcer items with data elements similar or identical to those collected through the Minimum Data Set 3.0 (MDS 3.0) used in nursing homes. By building upon preexisting resources for data collection and submission, we intend to reduce administrative burden related to data collection and submission. We anticipate that the initial setup and acclimation to pressure ulcer data collection will have already occurred with the adoption of the Pressure Ulcer measure for the IRF QRP for the FY 2014 payment determination. Therefore, we believe the transition to reporting additional data elements for this measure will be less burdensome.

We expect that the admission and discharge pressure ulcer data will be collected by a clinician such as an RN because the assessment and staging of pressure ulcers requires a high degree of clinical judgment and experience. We estimate that it will take approximately 10 minutes of time by the RN to perform the admission pressure ulcer assessment. We further estimate that it will take an additional 15 minutes of time to complete the discharge pressure ulcer assessment. We expect that during these time periods, the RN would be engaged in the collection of data for the purpose of the IRF QRP and would not be engaged in the performance of routine patient care.

We estimate that there are 359,000 IRF–PAI submissions per year [32] and that there are 1161 IRFs in the U.S. reporting quality data to CMS. Based on these figures, we estimate that each IRF will submit approximately 309 IRF–PAIs per year or 26 IRF–PAIs per month.[33]Assuming that each IRF–PAI submission requires 25 minutes of time by an RN at an average hourly wage of $33.23,[34] the yearly cost to each IRF would be $4,278.36 [35] and the annualized cost across all IRFs would be $4,967,176.[36]

We also expect that most IRFs will use administrative personnel, such as a medical secretary or medical data entry clerk, to perform the task of entering the IRF–PAI pressure ulcer assessment data into their electronic health record (EHR) system and/or the CMS JIRVEN program. We estimate that this data entry task will take no more than 3 minutes per each IRF–PAI record or 15.45 hours per each IRF annually or 17,937 hours across all IRFs. As noted above, the average hourly wage for a Medical Records & Health Information Technician is $15.55. As we noted above, there are approximately 359,000 IRF–PAI submissions per year and 1161 IRFs reporting quality data to CMS. Given this wage information, the estimated total annual cost across all reporting IRFs for the time required for entry of pressure ulcer data into the IRF–PAI record is $278,930. We further estimate the average yearly cost to each individual IRF to be $240.25.

We estimate that the combined annualized time burden related to the pressure ulcer data item set for work performed, by the both clinical and administrative staff will be 144.20 hours for each individual IRF and 167,416 hours across all IRFs. The total estimated annualized cost for collection and submission of pressure ulcer data is $4,518.61 for each IRF and $5,246,106 across all IRFs. We estimate the cost for each pressure ulcer submission to be $14.61.

We are proposing to revise the IRF–PAI instrument to include the data set associated with this measure.

2. Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

In section XIII. of the of this proposed rule, we have proposed to add the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680) to the IRF QRP. We have further proposed to add a new set of standardized data elements now used in the MDS 3.0 to the IRF–PAI to collect the data required for this measure.

As noted above, IRFs are already required to complete and transmit certain IRF–PAI data on all Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients to receive payment from Medicare. By building upon preexisting resources for data collection and submission, we intend to reduce administrative burden related to data collection and submission. We anticipate that the initial setup and acclimation to data collection through the IRF–PAI for purposes of reporting of IRF quality measure data will have already occurred with the adoption of the Pressure Ulcer measure for the IRF QRP for the FY 2014 payment determination. Therefore, we believe the transition to reporting an additional measure via the IRF–PAI may be less burdensome.

We estimate that completion of the patient influenza measure item set will take approximately 5 minutes to complete. The patient influenza item set consists of three items (questions). Each item is straightforward and does not require physical assessment for completion. We estimate that it will take approximately 0.7 minutes to complete each item, or 2.1 minutes to complete the entire item set. However, in some cases, the person completing this item set may need to consult the patient's medical record to obtain data about the patient's influenza vaccination. Therefore, we have allotted 1.6 minutes per items or a total of 5 minutes to complete the item set.

IRF staff will be required to perform a full influenza assessment only during the influenza vaccination season. The CDC defines that influenza vaccination season as the time period from October 1st (or when the vaccine becomes available) through March 31 each year. From April 1st through September 30th, IRFs are not required to perform full influenza screening and may skip to the next item set after checking the selection which indicates that the patient's IRF stay occurred outside of the influenza vaccination season. Our time estimate reflects the averaged amount of time necessary to complete the influenza item set both during and outside the influenza vaccination season.

We anticipate that the patient influenza item set will be completed by a clinician such an RN, while completing the Quality indicator section of the IRF–PAI. It is most appropriate for an RN to complete the influenza item set because it involves performing

[32] MedPAC, A Data Book: Health Care Spending and the Medicare Program (June 2012), *http://www.medpac.gov/chapters/Jun12DataBookSec8.pdf*.

[33] 359,000 IRF–PAIs per all IRFs per year/1161 IRFs in U.S. = 309 IRF–PAIs per each IRF per year.

309 IRF–PAI reports per IRF per year/12 months per year = 26 IRF–PAI reports per each IRF per year.

[34] According to the U.S. Bureau of Labor Statistics, the mean hourly wage for a Registered Nurse is $33.23. (See *http://www.bls.gov/oes/2011/may/oes291111.htm*) .

[35] 25 minutes × 309 IRF–PAI assessments per each IRF per year = 7,725 minutes per each IRF per year.

7,725 minutes per each IRF per year/60 minutes per hour = 128.75 hours per each IRF per year.

128.75 hours per year × $33.23 per hour = $4,278.36 nursing wages per each IRF per year.

[36] $4,278.36 × 1161 IRF providers = $4,967,176 per all IRFs per year.

a skilled assessment to determine, from a patient' records, whether the patient has received a vaccination and, if not, to discuss with the patient any medications or other related topics such as medication allergies, other vaccinations that the patient may have had, and any contraindications that might exist for receiving the influenza vaccination. The nurse has knowledge and experience to determine the relevance of this information to the patient influenza items and also determine if the patient should be given the influenza vaccination.

As noted above, we estimate that it will take approximately 5 minutes to complete the patient influenza measure item set. We have noted above that there are approximately 359,000IRF–PAIs completed annually across all 1161 IRFs that report IRF quality data to CMS. This breaks down to approximately 309 IRF–PAIs completed by each IRF yearly.[37] We estimate that the annual time burden for reporting the patient influenza vaccination measure data is 29,896 hours across all IRFs in the U.S. and 26 hours for each individual IRF. According to the U.S. Bureau of Labor, the hourly wage for a Registered Nurse is $33.23. Taking all of the above information into consideration, we estimate the annual cost across all IRFs for the submission of the patient influenza measure data to be $993,433. We further estimate the cost for each individual IRF to be $855.67.

B. ICRs Regarding Non-Quality Related Proposed Changes to the IRF–PAI

We propose to revise several items on the IRF–PAI to provide greater clarity for providers. The proposed changes include updating several items regarding the response options available to providers. Additionally, we are proposing to remove several items that we believe are unnecessary for providers to continue documenting on the IRF–PAI since those items are already being documented in the patients' medical record. We are also proposing to add several items, such as a signature page, to fulfill providers' request to have an organized way to document who has assessed the patient and when that assessment took place. We do not estimate any additional burden for IRFs to complete the IRF–PAI as a result of these proposals. We estimate the time that will be needed to complete the new non-quality related proposed items, equals the time that was needed to complete the previous non-quality related items. When the original burden estimates were completed for the IRF–PAI, we estimated that the proposed deletion of the non-quality related items would take approximately 3 minutes to complete. Thus, removing these items the IRF–PAI would decrease the total estimated burden of completing the non-quality related portions of the IRF–PAI by 3 minutes. However, we estimate that it will take about 3 minutes to complete the new non-quality related items that we are proposing to add. Therefore, we estimate no net change in the amount of time associated with completing the non-quality related portions of the IRF–PAI and that the burden for completing these portions of the IRF–PAI will not change.

We will be submitting a revision to the current IRF–PAI collection of information approval under (OMB control number 0938–0842) for OMB review and approval.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, CMS–1448–P,

Fax: (202) 395–6974; or

Email: OIRA_submission@omb.eop.gov.

XV. Response to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XV. Response to Comments

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XVI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2014 as required under section 1886(j)(3)(C) of the Act. It responds to section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF PPS's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

This rule implements sections 1886(j)(3)(C) and (D) of the Act. Section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 through 2019.

This rule also proposes some policy changes within the statutory discretion afforded to the Secretary under section 1886(j) of the Act. We propose to revise the list of diagnosis codes that are eligible under the ''60 percent rule,'' update the IRF facility-level adjustment factors, revise sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument, revise requirements for acute care hospitals that have IRF units, clarify the IRF regulation text regarding limitation of review, and revise and update quality measures under the IRF quality reporting program. We believe that the proposed policy changes would enhance the clarity, accuracy, and fairness of the IRF PPS.

B. Overall Impacts

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 30, 1993, Regulatory Planning and Review), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354)(RFA), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits

[37] 359,000 IRF–PAI reports per all IRFs per year/1161 IRFs in U.S. = 309 IRF–PAI reports per each IRF per year.

(including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for a major proposed rule with economically significant effects ($100 million or more in any one year). We estimate the total impact of the proposed policy updates described in this proposed rule by comparing the estimated payments in FY 2014 with those in FY 2013. This analysis results in an estimated $150 million increase for FY 2014 IRF PPS payments. As a result, this proposed rule is designated as economically ''significant'' under section 3(f)(1) of Executive Order 12866, and hence a major rule under the Congressional Review Act.

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $7 million to $34.5 million in any 1 year, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf*, effective March 26, 2012.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 16, we estimate that the net revenue impact of this proposed rule on all IRFs is to increase estimated payments by approximately 2.0 percent. However, we find that certain categories of IRF providers would be expected to experience revenue impacts in the 3 to 5 percent range. We estimate a 4.3 percent overall impact for teaching IRFs with resident to average daily census ratios of 10 to 19 percent, a 9.3 percent overall impact for teaching IRFs with a resident to average daily census ratio greater than 19 percent, and a 3.5 percent overall impact for IRFs with a DSH patient percentage of 0 percent. As a result, we anticipate this proposed rule would have a positive impact on a substantial number of small entities. Medicare fiscal intermediaries, Medicare Administrative Contractors, and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this proposed rule would not have a significant impact (not greater than 3 percent) on rural hospitals based on the data of the 167 rural units and 18 rural hospitals in our database of 1,132 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately $141 million. This proposed rule will not impose spending costs on State, local, or tribal governments, in the aggregate, or by the private sector, of greater than $141 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. As stated above, this proposed rule will not have a substantial effect on State and local governments, preempt state law, or otherwise have a federalism implication.

C. Detailed Economic Analysis

1. Basis and Methodology of Estimates

This proposed rule sets forth proposed policy changes and updates to the IRF PPS rates contained in the FY 2013 notice (77 FR 44618). Specifically, this proposed rule proposes updates to the CMG relative weights and average length of stay values, the facility-level adjustment factors, the wage index, and the outlier threshold for high-cost cases. This proposed rule also applies a productivity adjustment to the FY 2014 RPL market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.3 percentage point reduction to the FY 2014 RPL market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act. Further, this proposed rule contains proposed changes to the list of ICD–9–CM codes that are used in the 60 percent rule presumptive methodology and, in section XII of this rule. discusses the first implementation (in FY 2014) of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements, in accordance with section 1886(j)(7) of the Act.

We estimate that the impact of the proposed changes and updates described in this proposed rule would be a net estimated increase of $150 million in payments to IRF providers. This estimate does not include the estimated impacts of the proposed changes to the list of ICD–9–CM codes that are used in the 60 percent rule presumptive compliance (as discussed below) or the estimated impacts of the implementation (in FY 2014) of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements (as discussed in below). The impact analysis in Table 16 of this proposed rule represents the projected effects of the proposed updates to IRF PPS payments for FY 2014 compared with the estimated IRF PPS payments in FY 2013. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because

of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2014, we are proposing standard annual revisions described in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the Federal rates). We are also implementing a productivity adjustment to the FY 2014 RPL market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.3 percentage point reduction to the FY 2014 RPL market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act. We estimate the total increase in payments to IRFs in FY 2014, relative to FY 2013, would be approximately $150 million.

This estimate is derived from the application of the FY 2014 RPL market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.3 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act, which yields an estimated increase in aggregate payments to IRFs of $135 million. Furthermore, there is an additional estimated $15 million increase in aggregate payments to IRFs due to the proposed update to the outlier threshold amount. Outlier payments are estimated to increase under this proposal from approximately 2.8 percent in FY 2013 to 3.0 percent in FY 2014. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $150 million from FY 2013 to FY 2014.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 16. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 2.8 percent to 3.0 percent of total estimated payments for FY 2014, consistent with section 1886(j)(4) of the Act.
- The effects of the proposed annual market basket update (using the RPL market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and sections 1886(j)(3)(C) and (D) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(i)(I) of the Act, and a 0.3 percentage point reduction in accordance with sections 1886(j)(3)(C) and (D) of the Act.
- The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The effects of the proposed updates to the Rural, LIP, and Teaching Status adjustment factors, using an updated methodology.
- The total change in estimated payments based on the proposed FY 2014 payment changes relative to the estimated FY 2013 payments.

2. Description of Table 16

Table 16 categorizes IRFs by geographic location, including urban or rural location, and location with respect to CMS's 9 census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of Table 16 shows the overall impact on the 1,132 IRFs included in the analysis.

The next 12 rows of Table 16 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 947 IRFs located in urban areas included in our analysis. Among these, there are 731 IRF units of hospitals located in urban areas and 216 freestanding IRF hospitals located in urban areas. There are 185 IRFs located in rural areas included in our analysis. Among these, there are 167 IRF units of hospitals located in rural areas and 18 freestanding IRF hospitals located in rural areas. There are 299 for-profit IRFs. Among these, there are 260 IRFs in urban areas and 39 IRFs in rural areas. There are 685 non-profit IRFs. Among these, there are 570 urban IRFs and 115 rural IRFs. There are 148 government-owned IRFs. Among these, there are 117 urban IRFs and 31 rural IRFs.

The remaining four parts of Table 16 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH PP. First, IRFs located in urban areas are categorized with respect to their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized with respect to their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each proposed policy described in this proposed rule to the facility categories listed above are shown in the columns of Table 16. The description of each column is as follows:

- Column (1) shows the facility classification categories described above.
- Column (2) shows the number of IRFs in each category in our FY 2012 analysis file.
- Column (3) shows the number of cases in each category in our FY 2012 analysis file.
- Column (4) shows the estimated effect of the proposed adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the proposed update to the IRF PPS payment rates, which includes a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.3 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act.

• Column (6) shows the estimated effect of the proposed update to the IRF labor-related share and wage index, in a budget neutral manner.

• Column (7) shows the estimated effect of the proposed update to the CMG relative weights and average length of stay values, in a budget neutral manner.

• Column (8) shows the estimated effect of the proposed update to the facility adjustment factors using an updated methodology, in a budget neutral manner.

• Column (9) compares our estimates of the payments per discharge, incorporating all of the proposed policies reflected in this proposed rule for FY 2014 to our estimates of payments per discharge in FY 2013.

The average estimated increase for all IRFs is approximately 2.0 percent. This estimated net increase includes the effects of the proposed RPL market basket increase factor for FY 2014 of 2.5 percent, reduced by a productivity adjustment of 0.4 percentage point in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.3 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act. It also includes the approximate 0.2 percent overall estimated increase in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Since we are making the proposed updates to the IRF wage index, the facility-level adjustments, and the CMG relative weights in a budget-neutral manner, they would not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they would be expected to affect the estimated distribution of payments among providers.

TABLE 16—IRF IMPACT TABLE FOR FY 2014

[Columns 4–9 in %]

Facility classification	Number of IRFs	Number of cases	Outlier	Adjusted market basket increase factor for FY 2014 [1]	FY 2014 CBSA wage index and labor-share	CMG	Facility adjust	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total	1,132	380,988	0.2	1.8	0.0	0.0	0.0	2.0
Urban unit	731	180,061	0.3	1.8	0.0	0.0	0.2	2.5
Rural unit	167	26,894	0.2	1.8	0.1	0.1	−2.8	−0.7
Urban hospital	216	168,159	0.1	1.8	−0.1	0.0	0.3	2.1
Rural hospital	18	5,874	0.1	1.8	−0.2	−0.1	−3.4	−1.9
Urban For-Profit	260	142,026	0.1	1.8	−0.2	0.0	0.3	2.0
Rural For-Profit	39	8,184	0.1	1.8	0.0	0.0	−3.3	−1.4
Urban Non-Profit	570	177,533	0.3	1.8	0.2	0.0	0.3	2.5
Rural Non-Profit	115	19,523	0.2	1.8	0.0	0.0	−2.8	−0.8
Urban Government	117	28,661	0.3	1.8	−0.2	0.0	0.3	2.3
Rural Government	31	5,061	0.3	1.8	0.1	0.1	−3.0	−0.7
Urban	947	348,220	0.2	1.8	0.0	0.0	0.3	2.3
Rural	185	32,768	0.2	1.8	0.0	0.0	−2.9	−0.9
Urban by region [2]								
Urban New England	31	16,756	0.1	1.8	0.8	0.0	0.1	2.7
Urban Middle Atlantic	140	59,219	0.2	1.8	0.0	0.0	0.7	2.7
Urban South Atlantic	130	62,331	0.1	1.8	−0.3	0.0	0.1	1.8
Urban East North Central	182	52,383	0.3	1.8	0.2	0.0	0.6	2.9
Urban East South Central	49	24,405	0.1	1.8	−0.8	0.0	0.5	1.6
Urban West North Central	73	17,946	0.2	1.8	0.5	0.0	0.0	2.5
Urban West South Central	171	67,357	0.2	1.8	−0.1	0.0	0.4	2.3
Urban Mountain	72	23,318	0.3	1.8	−0.5	0.0	0.2	1.7
Urban Pacific	99	24,505	0.4	1.8	0.7	0.0	−0.8	2.1
Rural by region [2]								
Rural New England	6	1,395	0.4	1.8	−0.4	−0.1	−2.1	−0.4
Rural Middle Atlantic	15	2,702	0.2	1.8	−0.3	0.0	−2.6	−0.9
Rural South Atlantic	24	5,546	0.1	1.8	0.0	0.1	−2.9	−0.9
Rural East North Central	32	5,576	0.2	1.8	0.3	0.0	−2.8	−0.5
Rural East South Central	22	3,834	0.2	1.8	0.0	0.1	−3.2	−1.2
Rural West North Central	27	3,624	0.3	1.8	−0.7	0.0	−2.7	−1.4
Rural West South Central	48	9,056	0.2	1.8	0.3	0.0	−3.5	−1.3
Rural Mountain	7	660	0.4	1.8	0.3	0.2	−2.0	0.6
Rural Pacific	4	375	0.8	1.8	0.1	−0.1	−1.3	1.3
Teaching Status								
Non-teaching	1,015	332,827	0.2	1.8	0.0	0.0	−0.2	1.8
Resident to ADC less than 10%	68	32,835	0.2	1.8	0.1	0.0	0.6	2.7
Resident to ADC 10%–19%	37	13,743	0.3	1.8	0.1	0.0	2.1	4.3

TABLE 16—IRF IMPACT TABLE FOR FY 2014—Continued

[Columns 4–9 in %]

Facility classification	Number of IRFs	Number of cases	Outlier	Adjusted market basket increase factor for FY 2014 [1]	FY 2014 CBSA wage index and labor-share	CMG	Facility adjust	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Resident to ADC greater than 19%	12	1,583	0.2	1.8	0.4	0.0	6.7	9.3
Disproportionate Share Patient Percentage (DSH PP)								
DSH PP = 0%	39	7,929	0.8	1.8	0.2	0.0	0.7	3.5
DSH PP less than 5%	193	64,712	0.2	1.8	0.0	0.0	0.9	2.8
DSH PP 5%–10%	323	122,318	0.1	1.8	−0.1	0.0	0.4	2.3
DSH PP 10%–20%	349	125,863	0.2	1.8	0.1	0.0	0.0	2.0
DSH PP greater than 20%	228	60,166	0.3	1.8	0.0	0.0	−1.3	0.7

[1] This column reflects the impact of the RPL market basket increase factor for FY 2014 of 1.8 percent, which includes a market basket update of 2.5 percent, a 0.3 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 0.4 percentage point reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

[2] A map of states that comprise the 9 geographic regions can be found at (*http://www.census.gov/geo/www/us_regdiv.pdf.*).

3. Impact of the Proposed Update to the Outlier Threshold Amount

The proposed outlier threshold adjustment is presented in column 4 of Table 16. In the FY 2013 IRF PPS notice (77 FR 44618), we used FY 2011 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2013 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2013.

For this proposed rule, we are proposing to update our analysis using FY 2012 IRF claims data and, based on this updated analysis, we estimate that IRF outlier payments as a percentage of total estimated IRF payments are 2.8 percent in FY 2013. Thus, we are proposing to adjust the outlier threshold amount in this proposed rule to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2014. The estimated change in total IRF payments for FY 2014, therefore, includes an approximate 0.2 percent increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.8 percent to 3 percent.

The impact of this proposed outlier adjustment update (as shown in column 4 of Table 16) is to increase estimated overall payments to IRFs by about 0.2 percent. We estimate the largest increase in payments from the update to the outlier threshold amount to be 0.8 percent for rural IRFs in the Pacific region. We do not estimate that any group of IRFs would experience a decrease in payments from this proposed update.

4. Impact of the Proposed Market Basket Update to the IRF PPS Payment Rates

The proposed market basket update to the IRF PPS payment rates is presented in column 5 of Table 16. In the aggregate the proposed update would result in a net 1.8 percent increase in overall estimated payments to IRFs. This net increase reflects the estimated RPL market basket increase factor for FY 2014 of 2.5 percent, reduced by the 0.3 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act, and further reduced by a 0.4 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

5. Impact of the Proposed CBSA Wage Index and Labor-Related Share

In column 6 of Table 16, we present the effects of the proposed budget neutral update of the wage index and labor-related share. The proposed changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the proposed changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this proposed rule, we propose to decrease the labor-related share from 69.881 percent in FY 2013 to 69.658 percent in FY 2014.

In the aggregate, since these proposed updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these proposed updates would affect overall estimated payments to IRFs. However, we estimate that these proposed updates would have small distributional effects. For example, we estimate the largest increase in payments from the proposed update to the CBSA wage index and labor-related share of 0.8 percent for urban IRFs in the New England region. We estimate the largest decrease in payments from the update to the CBSA wage index and labor-related share to be a 0.8 percent decrease for urban IRFs in the East South Central region.

6. Impact of the Proposed Update to the CMG Relative Weights and Average Length of Stay Values.

In column 7 of Table 16, we present the effects of the proposed budget neutral update of the CMG relative weights and average length of stay values. In the aggregate, we do not estimate that these proposed updates would affect overall estimated payments to IRFs. However, we would expect these proposed update to have small distributional effects. Freestanding rural hospitals will see a 0.1 decrease in payments as a result of these updates. The rural areas affected are New England and Pacific. The largest estimated increase in payments as a result of these updates is a 0.2 increase in the Mountain region.

7. Impact of the Proposed Updates to the Facility-Level Adjustments

In column 8 of Table 16, we present the effects of the proposed budget neutral updates to the IRF facility-level adjustment factors (the rural, LIP, and teaching status adjustment factors) for FY 2014. In the aggregate, we do not estimate that these proposed updates

would affect overall estimated payments to IRFs. However, we estimate that these proposed updates would have distributional effects, as shown in Table 16. The largest estimated decrease in payments as a result of these proposed updates is a 3.5 percent decrease to rural IRFs in the West South Central region. The largest estimated increase in payments as a result of these proposed updates is a 6.7 percent increase for teaching IRFs with a resident to average daily census ratio greater than 19 percent.

8. Impact of the Proposed Refinements to the Presumptive Compliance Criteria Methodology

As discussed in section VII. of this proposed rule, we are proposing changes to the list of ICD–9–CM codes available to meet the presumptive compliance criteria. We believe that these proposed changes would affect all 1,132 IRFs, as these facilities would need to change their coding practices to continue to meet the 60 percent compliance percentage using the presumptive methodology.

We estimate that the financial impact, in the absence of any behavioral responses to these proposed changes on the part of providers, would be a decrease of 6.9 percent (or $520 million) in overall estimated payments to IRFs. However, we believe that IRFs will be able to improve the specificity of their coding practices, alter their admitting practices, meet the 60 percent compliance threshold under medical review, and make other modifications to their operations to continue to meet the 60 percent compliance threshold.

For example, we estimate that about 92 percent of the IRF cases that would potentially be affected by the proposed revisions to the presumptive methodology codes are affected by the removal of the non-specific codes. However, we have been careful to propose removal only of those non-specific codes for which more specific codes for the same conditions will remain on the list of codes that meet the presumptive methodology. Thus, in all of these cases, we believe that the IRF will be able to switch to a more specific code for the same condition, leaving the IRF's admission practices and classification status unaffected. However, we welcome comments on whether there are any particular non-specific codes or situations in which switching to a more specific code would be unusually difficult for an IRF.

Fewer than 1 percent of the cases that we estimate would be affected by the proposed revisions are affected by the Unilateral Upper Extremity Amputation codes, the Congenital Anomaly codes, and the Miscellaneous codes combined. Thus, we do not estimate that the proposed removal of these code groups would have a significant effect on IRF admission or coding practices, or classification status. However, we welcome comments on whether individual IRFs may specialize in any of these conditions and might therefore be disproportionately affected by these proposed revisions.

Finally, approximately 7 percent of the cases that we estimate would be affected by the proposed revisions involve arthritis diagnoses. We estimate that the proposed revisions in this category would have the largest potential effects on providers because, by the very nature of these revisions, IRFs would not have another arthritis code on the list to code instead. We estimate that about 14 percent of all IRF cases are coded with the arthritis codes that we propose to remove from the list, and in 11 percent of these cases, the arthritis code is the only code that would qualify the patient as meeting the 60 percent rule requirements. However, for the arthritis category of codes, we estimate that most of these cases will still be found to meet the 60 percent rule requirements under medical review, so we estimate that these proposed revisions will lead to few if any IRF declassifications. However, we welcome comments on whether there are any reasons to believe that the arthritis cases may not generally be found to count towards the 60 percent rule requirements under medical review.

Historically, we have seen that IRFs adapt quickly to changes in the 60 percent rule, as evidenced by the rapid response to changes over time in the compliance threshold. Thus, we have every reason to believe that they will adapt quickly to the proposed changes to the presumptive methodology list. In addition, the proposed changes would not affect how many patients would ultimately be shown to meet the 60 percent rule criteria on medical review. For these reasons, we believe that our best estimate of the impact on IRFs of these changes is no net change in Medicare reimbursement payments. Instead, IRFs will quickly change their coding practices, admission practices, meet the 60 percent compliance threshold under medical review, and make other changes to their business practice to ensure that they continue to meet the 60 percent rule requirements; although we lack data to more precisely characterize the rule-induced costs, benefits and transfers that would be experienced by IRFs, their patients and other relevant entities, we note that the $520 million estimate appearing earlier in this section represents an upper bound (probably an extreme upper bound) on the costs that would be borne by IRFs.

Should these proposed changes to the 60 percent rule be finalized, we intend to closely monitor provider coding practices to identify whether those patients that we envisioned would be served under the IRF PPS are counting toward the presumptive compliance percentage. We will also monitor whether these proposed changes are having any unintended consequences in terms of limiting access to care.

9. Effects of Proposed Updates to the IRF QRP

In this rule, we are proposing to continue use of the pressure ulcer measure that was adopted in the FY 2012 IRF PPS final rule but have proposed to change this measure for the IRF PPS increase factor for FY 2017, at which time we are proposing to adopt the NQF-endorsed version of this measure. We are further proposing to make revisions to the pressure ulcer items on the IRF–PAI that providers will use to collect data for this measure.

IRFs will incur some financial impact from the use of the pressure ulcer measure item set that will be incorporated into the IRF–PAI. We expect that the admission and discharge pressure ulcer data will be collected by a clinician such as a registered nurse (RN) because the assessment and staging of pressure ulcers requires a high degree of clinical judgment and experience. We estimate that it will take approximately 10 minutes of time by the RN to perform the admission pressure ulcer assessment. We further estimate that it will take 15 minutes of time to complete the discharge pressure ulcer assessment. During these time periods, the RN would be engaged in the collection of data for the purpose of the IRF quality reporting program and would not be performing patient care. An RN or clinician of a similar level of training and expertise should perform the pressure ulcer assessment and record this data on the IRF–PAI.

We believe use of the NQF endorsed pressure ulcer measure will cause IRFs to incur additional annual financial burden in the amount of $4,518.61 and across all IRFs, $5,246,106. This burden is comprised of the clinical and administrative wages. The clinical wages are based on an average hourly

wage rate of $33.23.[38] We estimate that there are 359,000 IRF–PAI submissions per year[39] and that there are 1161 IRFs in the U.S. that have reported quality data to CMS. Based on these figures, we estimate that each IRF will submit approximately 309 IRF–PAIs per year or 25.75 IRF–PAIs per month.[40] Assuming that each IRF–PAI submission requires 25 minutes of time by an RN at an average hourly wage of $33.23, the yearly cost to each IRF would be $4,278.36[41] and the annualized cost across all IRFs would be $4,967,176.[42] To calculate the total amount of administrative staff wages incurred, we estimate that this data entry task will take no more than 3 minutes per each IRF–PAI record or 15.45 hours per each IRF annually or 17,937 hours across all IRFs. According to the U.S. Bureau of Labor, the average hourly wage for Administrative Assistants is $15.55. As noted above, we have estimated that there are approximately 359,000 IRF–PAI submissions per year and 1161 IRFs in the U.S. that are reporting quality data to CMS. Given this wage information, the estimated total annual cost across all IRFs for the time required for entry of pressure ulcer data into the IRF–PAI record is $278,930. We further estimate the average yearly cost to each IRF to be $240.25.

We are also proposing to add 3 new quality measures to the IRF QRP. These proposed measures include: (1) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), which will affect the FY 2017 increase factor; (2) Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431), which will affect the FY 2016 increase factor; and (3) an All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities, which will affect the FY 2017 increase factor. We discuss the impact of each measure upon IRFs below.

We have proposed that IRFs will submit their data for the patient influenza measure (NQF #0680) on the IRF–PAI. We have further proposed to add a new data item set consisting of 3 items to the IRF–PAI to collect the data for this measure. IRF staff will be required to perform a full influenza assessment only during the influenza vaccination season, which has been defined by the CDC as the time period from October 1st (or when the vaccine becomes available) through March 31 each year. From April 1st through September 30th, IRFs are not required to perform a full influenza screening. Our time estimate reflects the averaged amount of time necessary to complete the influenza item set both during and outside the influenza vaccination season.

We believe that it will be most appropriate for a clinician, such as an RN, to complete the influenza items because this assessment requires clinical judgment and knowledge of vaccinations. An administrative employee, such as a medical data entry clerk or administrative assistant would not have this level of knowledge. We do not believe that IRFs will require additional time by administrative staff to encode and transmit this data to CMS, because submission of an IRF–PAI for each patient is already required as a condition for payment.

We estimate that it will take approximately 5 minutes to complete the patient influenza measure item set. According to MedPAC, there are approximately 359,000[43] IRF–PAIs completed annually across 1161 IRFs that reported quality data to CMS. This breaks down to approximately 309 IRF–PAIs completed by each IRF yearly. We estimate that the annual time burden for reporting the patient influenza vaccination measure data is 29,896 hours across all IRFs in the U.S. and 25.75 hours for each individual IRF. According to the U.S. Bureau of Labor, the hourly wage for a Registered Nurse is $33.23. The estimated annual cost across all IRFs in the U.S. for the submission of the patient influenza measure data is $993,433 and $855.67 for each individual IRF.

IRFs will submit their data for the staff immunization measure (NQF #0431) to the CDC's healthcare acquired (HAI) surveillance Web site known as NHSN. Data collection for this measure is only required from October 1st (or when the vaccine becomes available) through March 31st each year, during which IRFs will be required to keep records of which staff members receive the influenza vaccination. However, IRFs are required to make one report to NHSN after the close of the reporting period on March 31st, by May 15th of each year. We do not believe that IRFs will incur any new burden associated with the collection of data during the influenza vaccination season. We believe that most IRFs already keep records related to the influenza vaccination of their staff because this impacts on many aspects of their business, including but not limited to staff absences, and transmission of illness to other staff and patients.

We estimate that it will take each IRF approximately 15 minutes of time once per year to gather the data that was collected during the influenza vaccinations season, and prepare to make their report to NHSN. We do not estimate that it will take IRFs additional time to input their data into NHSN, once they have logged onto the system for the purpose of submitting their monthly CAUTI report. We believe that this task can be completed by an administrative person such as a Medical Secretary Medical Data Entry Clerk. As noted above, the average hourly wage for Medical Records or Health Information Technicians is $15.55.[44] We estimate that the average yearly cost to each IRF for the reporting of this measure will be $3.98[45] and the cost across all IRFs will be $4,621.[46]

The proposed readmission measure is a claims based measure and, therefore, IRFs are not required to submit any data for this measure. We do not anticipate that IRFs will be impacted by any financial or time burdens as a result of the use of this measure for the IRF QRP.

The IRF QRP was established under section 3004 of the Affordable Care Act (which added Section 1886(j)(7)(A)(i) to the Act). Section 1886(j)(7)(A)(i) requires the reduction of the applicable IRF PPS increase factor, as previously modified under section 1886(j)(3)(D) of the Act, by 2 percentage points for any IRFs that fail to submit data to the Secretary in accordance with

[38] According to the U.S. Bureau of Labor Statistics, the mean hourly wage for a Registered Nurse is $33.23. (See *http://www.bls.gov/oes/2011/may/oes291111.htm*).

[39] MedPAC, A Data Book: Health Care Spending and the Medicare Program (June 2012), *http://www.medpac.gov/chapters/Jun12DataBookSec8.pdf*.

[40] 359,000 IRF–PAI reports per all IRFs per year/1161 IRFs in U.S. = 309 IRF–PAI reports per each IRF per year. 309 IRF–PAI reports per IRF per year/12 months per year = 26 IRF–PAI reports per each IRF per year.

[41] 25 minutes × 309 IRF–PAI assessments per each IRF per year = 7,725 minutes per each IRF per year. 7,725 minutes per each IRF per year/60 minutes per hour = 128.75 hours per each IRF per year. 128.75 hours per year × $33.23 per hour = $4,278.36 nursing wages per each IRF per year.

[42] $4,278.36 × 1161 IRF providers = $4,967,176 per all IRFs per year.

[43] MedPAC, A Data Book: Health Care Spending and the Medicare Program (June 2012), Page 129 ().(*http://www.medpac.gov/chapters/Jun12DataBookSec8.pdf*).

[44] According to the U.S. Bureau of Labor Statistics, the mean hourly wage for a Medical Records & Health Information Technician is $15.55. See: *http://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm*.

[45] 15 minutes Admin staff time to collect and report staff influenza measure @ $15.55 per hour = $3.98 per IRF per year.

[46] $3.98 per IRF per year × 1161 IRFs in U.S.= $4,621.

requirements established by the Secretary for that fiscal year.

Over the past 18 months, we have received a great deal of positive feedback from IRFs about the IRF QRP, and overall, IRFs have been very receptive to the introduction of the ACA 3004 IRF QRP into the IRF setting. The IRF provider community has shared many suggestions and ideas related to the IRF QRP. Outreach activities, such as a one day in-person training, and six open door forums were well attended. Given the amount of positive feedback and willingness to participate in the IRF QRP that has been demonstrated by IRFs, we anticipate that there will be a relatively small number of IRFs that fail to report the required type and amount of quality data. If finalized, our proposed reconsideration process would allow IRFs that receive an initial finding of non-compliance an opportunity to file a request for reconsideration of this finding.

10. Impact of the Implementation of the 2 Percentage Point Reduction in the Increase Factor for Failure to Meet the IRF Quality Reporting Requirements

As discussed in section XIII. of this proposed rule and in accordance with section 1886(j)(7) of the Act, we will implement a 2 percentage point payment reduction in FY 2014 for IRFs that fail to report the required quality reporting data to us during the first IRF quality reporting period (from October 1, 2012 through December 31, 2012). In section XIII., we discuss how the 2 percentage point payment reduction will be applied. Currently, we cannot estimate the overall financial impacts of the application of this reduction on aggregate IRF PPS payments or on the distribution of IRF PPS payments among providers because we cannot predict the number of or types of IRFs that will fail to report the required quality reporting data. IRFs are currently required to complete the non-quality portions of the IRF–PAI to receive payment for all Medicare fee-for-service admissions. Therefore, we estimate that the number of IRFs that would fail to submit the additional quality reporting data on the IRF–PAI form is very low. Additionally, the Catheter Associated Urinary Tract Infections (CAUTI) quality reporting requirement would require IRFs to register with the National Healthcare Safety Network (NHSN) to submit the required data. At this time, we cannot predict how many IRFs would fail to register.

The official reporting period end date for the first IRF quality reporting period is May 15, 2013. We expect a preliminary report of the IRFs that have failed to report the required data during the first quality reporting period to be developed by mid-June 2013. However, that list could change substantially during the proposed reconsideration process (described in section XIII. of this proposed rule) that would occur between June 2013 and September 2013. Therefore, we intend to closely monitor the effects of this new quality reporting program on IRF providers as we cannot predict the number of, or types of IRFs that would fail to report the required quality reporting data for the first quality reporting period.

D. Alternatives Considered

As stated in section XV.B. of this proposed rule, we estimate that the proposed changes discussed in the rule would result in a significant economic impact on IRFs. The overall impact on all IRFs is an estimated increase in FY 2014 payments of $150 million (2.0 percent), relative to FY 2013. The following is a discussion of the alternatives considered for the proposed IRF PPS updates contained in this proposed rule.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services. Thus, we did not consider alternatives to updating payments using the estimated RPL market basket increase factor for FY 2014. However, as noted previously in this proposed rule, section 1886(j)(3)(C)(ii)(I) requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2014 and sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act require the Secretary to apply a 0.3 percentage point reduction to the market basket increase factor for FY 2014. Thus, in accordance with section 1886(j)(3)(C) of the Act, we proposed to update IRF federal prospective payments in this proposed rule by 1.8 percent (which equals the 2.5 percent estimated RPL market basket increase factor for FY 2014 reduced by 0.3 percentage points, and further reduced by a 0.4 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2014. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to propose to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered maintaining the current facility-level adjustment factors (that is, the rural factor at 18.4 percent, the LIP factor at 0.4613, and teaching status adjustment factor at 0.6876) for an additional year. However, as discussed in more detail in section IV.B. of this proposed rule, our recent research efforts have shown significant differences in cost structures between freestanding IRFs and IRF units of acute care hospitals (and CAHs). We have found that these cost structure differences substantially influence the estimates of the adjustment factors. For this reason, our regression analysis found that the proposed inclusion of the control variable for a facility's status as either a freestanding IRF hospital or an IRF unit of an acute care hospital (or a CAH) would greatly enhance the accuracy of the adjustment factors for FY 2014, as we incorporate updated data. Further, as noted previously, we received comments from an IRF industry association on the FY 2012 IRF PPS proposed rule suggesting this enhancement to the methodology. Thus, we believe that the best approach at this time is to propose to update the facility-level adjustment factors for FY 2014 using this proposed enhancement to the methodology. However, we welcome comments on this approach and on whether or not the facility-level adjustment factors need updating at this time or should be frozen at their current levels for an additional year.

We considered maintaining the existing outlier threshold amount for FY 2014. However, analysis of updated FY 2012 data indicates that estimated outlier payments would be lower than 3 percent of total estimated payments for FY 2013, by approximately 0.2 percent, unless we updated the outlier threshold amount. Consequently, we propose adjusting the outlier threshold amount in this proposed rule to reflect a 0.2 percent increase thereby setting the total outlier payments equal to 3 percent, instead of 2.8 percent, of aggregate estimated payments in FY 2014.

Finally, we considered maintaining the current list of ICD–9–CM codes used to determine an IRF's compliance with the 60 percent rule under the presumptive methodology, or maintaining some of the categories of codes that we are proposing to remove from the list in this proposed rule. However, we believe that the specific ICD–9–CM code removals that we are

proposing in section VII. of this proposed rule would result in a list that better reflects the 60 percent rule regulations. For example, the proposed removal of the non-specific diagnosis codes (as discussed in section VII. of this proposed rule) is in accordance with the trend toward requiring more specific coding in other Medicare payment settings, such as the IPPS. We believe that the incentives to use more specific codes, whenever possible, will also lead to improvements in the quality of care for patients by providing more detailed information that medical personnel can use to enhance the specificity of patients' care plans. In addition, the proposed removal of the arthritis diagnosis codes (as discussed in section VII. of this proposed rule) would enable CMS to ensure that we only count patients as meeting the 60 percent rule requirements if they have met the necessary severity and prior treatment requirements, information which is not discernible from the ICD–9–CM codes themselves. With respect to the other code categories that we are proposing to remove from the presumptive methodology list, we do not believe that patients who are coded with these codes would typically require treatment in an IRF, as described in more detail in section VII. of this proposed rule. However, we welcome comments on whether there are any specific reasons that we may not have previously considered that would argue for keeping certain of these codes on the presumptive methodology list.

E. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf*), in Table 17, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 17 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for 1,132 IRFs in our database.

TABLE 17—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2013 IRF PPS FISCAL YEAR TO THE 2014 IRF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$150 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.
Estimated annualized cost to the federal government for the administration of the IRF quality reporting program.	$2 million. (This cost is attributed to various sources, including but not limited to the CCSQ IRF measure developer contractor and the Division of National Systems).

F. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2014 are projected to increase by 2.0 percent, compared with the estimated payments in FY 2013, as reflected in column 9 of Table 16. IRF payments per discharge are estimated to increase 2.3 percent in urban areas and decrease 0.9 percent in rural areas, compared with estimated FY 2013 payments. Payments per discharge to rehabilitation units are estimated to increase 2.5 percent in urban areas and decrease 0.7 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.1 percent in urban areas and decrease 1.9 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in this proposed rule. The largest payment increase is estimated to be a 2.9 percent increase for urban IRFs located in the East North Central region. This is due to the large positive effect of the facility adjustment updates for urban IRFs in this region.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Sections 1102, 1862, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1395hh).

■ 2. Section 412.25 is amended by revising paragraph (a)(1)(iii) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) * * *

(1) * * *

(iii) Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are not excluded from the inpatient prospective payment system, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater. Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an IPF unit, the hospital must have enough beds that are not excluded from the inpatient prospective payment system to permit the provision of adequate cost information, as required by § 413.24(c) of this chapter.

* * * * *

■ 3. Section 412.29 is amended by revising paragraph (d) to read as follows:

§ 412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

* * * * *

(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening for each Medicare Part A fee-for-service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

* * * * *

■ 4. Section 412.130 is amended by revising paragraphs (a)(1), (a)(2) and (a)(3) to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) * * *

(1) A hospital that was excluded from the prospective payment systems

specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(3), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.29(c) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.29(b).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(3), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.29(b).

(3) A hospital that added new beds to its existing rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of § 412.29(b).

* * * * *

■ 5. Section 412.630 is revised to read as follows:

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 16, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 25, 2013.

Kathleen Sebelius,

Secretary.

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