

IRF Reimbursement

Dollar for Dollar: How IRF Reimbursement Works

The Operator's Economic Model

Payment and Cost Must Be Managed as Separate Equations

1 **Establish Expected Reimbursement**

Payer, CMG, tier, facility factors and case-payment policy

2 **Protect Revenue Accuracy**

IRF-PAI, diagnoses, functional data, authorization and discharge status

3 **Manage Cost Per Case**

Labor, pharmacy, supplies, diagnostic use and avoidable transfers

4 **Control Clinically Unnecessary Days**

Daily barriers, outside services, staffing productivity and discharge readiness

IRF PPS in one page

Medicare pays one prospective amount for the covered IRF stay



Operator Implication

Revenue is largely set by the patient and facility profile. Margin improves when the team protects payment accuracy, avoids preventable payment reductions, and delivers the clinically necessary stay with less operational waste.

FY 2027: CMS finalized a 2.3% IRF PPS rate increase and maintained outlier payments at 3.0% of total payments. CMS fiscal year is October 1- September 30

Payment Classification Inputs

Clinical category

Impairment group and etiologic diagnosis place the case in a rehabilitation impairment category.

Functional status

Admission performance data help assign the CMG. Coding must follow the IRF-PAI manual.

Age

Age contributes to selected CMG assignments and expected resource use.

Comorbidity tier

Qualifying secondary conditions may increase payment through tier assignment.

Control point: admission documentation, therapy assessment, GG scores, and coding review must describe the same patient.

Facility-Level Payment Adjustments

Wage index	Adjusts the labor share for local wage differences	Validate provider location and annual CMS file changes
Low-income patient	Reflects the facility's share of low-income patients	Forecast using current SSI and Medicaid data
Teaching	Uses interns and residents relative to average daily census	Reconcile approved programs and FTE data
Rural	Applies under CMS rural policy and phase-out rules	Model the annual transition by provider
Quality reporting	Failure reduces the annual increase factor by 2 percentage points	Own submission controls and acceptance reports

Worked example: Medicare FFS payment calculation



Estimated payment **\$25,650**

Less patient-specific operating cost determines contribution margin. The payment amount alone does not show case profitability.

Illustrative calculation only. Use the CMS IRF Pricer and current provider-specific data for an actual claim.

FY2025 CMG Matrix for [REDACTED]													
	CMG	Payment Weight				ALOS				Federal Rate (adj. for fac*)			
		1	2	3	0	1	2	3	0	1	2	3	0
Stroke	0101	0.9790	0.8491	0.7759	0.7394	10	10	9	8	\$18,271.17	\$15,846.85	\$14,480.70	\$13,799.50
	0102	1.2423	1.0774	0.9845	0.9383	11	11	11	10	\$23,185.17	\$20,107.62	\$18,373.82	\$17,511.59
	0103	1.6012	1.3887	1.2690	1.2093	14	15	13	13	\$29,883.36	\$25,917.45	\$23,683.47	\$22,569.29
	0104	2.0435	1.7722	1.6195	1.5434	17	17	16	16	\$38,138.06	\$33,074.76	\$30,224.90	\$28,804.63
	0105	2.5553	2.2161	2.0251	1.9300	22	22	20	20	\$47,689.83	\$41,359.30	\$37,794.64	\$36,019.79
	0106	2.9064	2.5206	2.3034	2.1951	24	24	23	23	\$54,242.44	\$47,042.21	\$42,988.59	\$40,967.38

	Description	Start Date	End Date	Wage Index	SSI Ratio	Medicaid Days Ratio	Rural Adjustment	Capital Indirect Medical Education Ratio (IME)	QRP Penalty?	Computed Facility Adjuster
☐	FY2026 (CMS)	10/01/2025	09/30/2026	1.0022	0.0127	0.0603				1.024311
☐	FY2025	09/15/2025	09/30/2025	0.9858	0.0127	0.0603				1.011833

Cases That Do Not Receive the Standard Full Payment

Short stays

Less than 3 days

Transfer Penalties

Institutional discharge before the CMG average LOS threshold

Interrupted stays

Discharge and return within the policy window

Deaths

Payment varies under CMS death policy

High-cost cases

Outlier add-on when estimated cost exceeds the threshold

Daily discharge planning should protect the patient and anticipate payment consequences. Payment never determines an unsafe discharge date.

Short Stay- Reduction Examples

IGC	RIC	CMI	Expected Reimb. *	Full Reimb. *	Reduced \$\$	LOS	CMG ALOS	Short Stay
8.51	8	0.171	\$3,426.04	\$20,972.94	(\$17,546.90)	3	11	Y
16	20	0.171	\$3,426.04	\$20,027.27	(\$16,601.23)	1	11	Y
14.2	18	0.171	\$3,426.04	\$20,013.25	(\$16,587.21)	2	11	Y
8.11	7	0.171	\$3,426.04	\$34,168.18	(\$30,742.14)	2	17	Y
3.9	6	0.171	\$3,426.04	\$21,283.49	(\$17,857.45)	3	11	Y
3.1	6	0.171	\$3,426.04	\$23,599.56	(\$20,173.52)	2	12	Y
3.4	19	0.171	\$3,426.04	\$51,671.01	(\$48,244.97)	1	25	Y
1.1	1	0.171	\$3,426.04	\$46,149.28	(\$42,723.24)	3	23	Y
8.61	8	0.171	\$3,426.04	\$23,495.38	(\$20,069.34)	2	12	Y
8.11	7	0.171	\$3,426.04	\$31,567.60	(\$28,141.56)	1	16	Y
2.22	2	0.171	\$3,368.44	\$14,147.42	(\$10,778.98)	3	8	Y
1.4	1	0.171	\$3,368.44	\$14,565.02	(\$11,196.58)	3	8	Y
16	20	0.171	\$3,368.44	\$18,573.65	(\$15,205.21)	3	10	Y
1.2	1	0.171	\$3,368.44	\$24,997.31	(\$21,628.87)	2	13	Y

Transfer Penalties- Reduction Examples

IGC	RIC	CMI	Expected Reimb.	Full Reimb.	Disch. Living Setting	LOS	CMG ALOS	Payment Reduced By	Days Short
2.22	2	0.2469	\$4,864.39	\$42,806.65	2	2	22	\$37,942.26	20
2.22	2	0.1549	\$3,050.47	\$36,605.59	2	1	18	\$33,555.12	17
14.2	18	0.923	\$18,182.23	\$51,338.05	3	8	24	\$33,155.82	16
2.1	3	0.1546	\$3,045.84	\$34,519.53	2	1	17	\$31,473.69	16
2.1	3	0.4579	\$9,019.68	\$34,074.34	2	4	17	\$25,054.66	13
8.9	9	0.4497	\$8,857.65	\$31,493.85	2	4	16	\$22,636.20	12
9	14	0.148	\$2,915.44	\$25,267.18	2	1	13	\$22,351.74	12
3.3	6	0.2669	\$5,257.59	\$27,339.45	2	2	13	\$22,081.86	11
2.1	3	0.6614	\$13,028.42	\$34,074.34	2	6	17	\$21,045.92	11
3.1	6	0.2454	\$4,833.91	\$23,202.78	2	2	12	\$18,368.87	10
2.22	2	1.3335	\$26,267.72	\$42,806.65	2	13	22	\$16,538.93	9
8.2	7	0.7386	\$14,548.52	\$31,036.85	2	7	16	\$16,488.33	9
2.1	3	0.2306	\$4,543.22	\$16,355.60	2	2	9	\$11,812.38	7
16	20	1.0826	\$22,193.07	\$33,818.01	2	10	16	\$11,624.94	6
3.8	6	1.9301	\$38,019.15	\$49,056.97	2	15	20	\$11,037.82	5
5.4	10	1.2782	\$25,179.23	\$34,243.75	2	12	17	\$9,064.52	5
8.4	17	1.5398	\$30,331.69	\$37,180.78	3	15	19	\$6,849.09	4
3.8	6	1.4908	\$29,367.26	\$33,197.77	3	11	13	\$3,830.51	2
11	21	1.6143	\$31,800.00	\$34,690.91	3	16	18	\$2,890.91	2
16	20	1.6056	\$31,627.92	\$32,648.18	3	15	16	\$1,020.26	1
8.11	7	1.6552	\$32,605.66	\$33,593.71	3	16	17	\$988.05	1

Transfer penalties are not penalties for late payment but rather a reduction of the per diem payment rate when an IRF patient is discharged earlier than the ALOS for the CMG. CMS pays a reduced per diem rate for these early transfers to other IRFs, inpatient hospitals, nursing homes, or LTACs rather than the full CMG payment

New Threat: Transfer Penalties- Home Health

RIC	Discharges	Reduction In Payments	Unreimbursed Days	ALOS Home With Home Health	Final Rule ALOS
All RICs	371	\$-1,222,485	\$156,640	12.50	14.56
01 Stroke	48	\$-266,226	\$10,423	13.10	16.69
02 Traumatic brain injury	19	\$-111,099	\$0	12.63	16.58
03 Nontraumatic brain injury	26	\$-74,267	\$13,884	12.50	14.15
04 Traumatic spinal cord injury	2	\$-9,870	\$0	11.50	15.00
05 Nontraumatic spinal cord injury	23	\$-75,638	\$6,382	13.70	15.83
06 Neurological	36	\$-106,307	\$13,736	12.08	13.83
07 Fracture of LE	42	\$-98,375	\$11,968	13.19	14.76
08 Replacement of LE joint	29	\$-106,436	\$1,716	9.21	11.72
09 Other orthopedic	49	\$-145,422	\$15,361	11.55	13.47
10 Amputation, lower extremity	10	\$-31,241	\$16,880	14.30	15.70
11 Amputation, other	1	\$-19,682	\$0	7.00	17.00
14 Cardiac	8	\$-10,523	\$1,718	13.88	14.75
15 Pulmonary	1	\$-905	\$0	15.00	16.00
17 Major multiple trauma, no brain injury or spinal cord injury	10	\$-22,371	\$6,902	13.80	15.10
20 Miscellaneous	67	\$-144,124	\$57,668	13.00	14.12

Interrupted Stays



Prior to and After First Midnight - All outside procedures, transportation and hospital visits (i.e., CT scans, diagnostic tests completed during a Dr. appointment, G-tube placement, MBS, dialysis, etc.) are paid by the IRF. No extra payment is provided outside of the CMG payment. ***If patient is sent to acute care hospital they are considered LOA and it is counted as an interrupted stay**



Prior to Second Midnight- All outside procedures, transportation and hospital visits are paid by the IRF. **After a Second Midnight-** all procedures and hospital charges are paid directly to the acute care hospital and not paid out of the IRF CMG. The patient remains on LOA status at the IRF and the time is documented as an interrupted stay.



After Third Midnight- The patient is no longer on LOA status or considered as having an interrupted stay. The patient is discharged from the IRF. All charges accrued on days 1, 2, 3 are billed and paid directly to the acute care hospital. The IRF receives a reduced payment for the midnights they were physically in a bed at the IRF.

QRP 2% Penalties

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Standard Rate with Facility Price Adjuster- 2% Penalty

$$\text{\$19,371} \times 1.024311 = \text{\$19,842} - \text{\$396.84} = \text{\$19,445}$$

Conservative Estimate: \$400 reduction on 1,200 annual discharges would be a \$480,000 loss

Margin Levers to Maximize Reimbursement

Revenue integrity	High control	IRF-PAI accuracy, supported tiers, clean claims, underpayment recovery
LOS execution	High control	Barrier closure, weekend workflow, caregiver training, equipment readiness
Labor efficiency	High control	Census flexing, schedule utilization, overtime and agency management
Payer yield	Moderate control	Contract rate, authorization process, denial terms, payment timeliness
Case mix and demand	Moderate control	Referral relationships, service capability, physician alignment
Federal rate and wage index	Limited control	Forecast annual updates and provider-specific effects

Operators create the largest near-term margin gains through payment accuracy, avoidable-day reduction and labor discipline.

LOS Management Starts Before Admission



The LOS target is a planning hypothesis. The interdisciplinary team revises it when the patient's clinical needs change.

Daily LOS control

A 15-minute operational huddle answers five questions

- 1 What is the planned discharge date?**
- 2 What changed clinically since yesterday?**
- 3 Which barrier can add a day?**
- 4 Who owns the next action and deadline?**
- 5 Does the patient still meet IRF medical necessity?**

Escalation clock

- Same shift: clinical or therapy interruption
- Same day: authorization or equipment issue
- Within 24 hours: caregiver or placement barrier
- Executive review: repeat system failure

The LOS Variance Tree

Clinical		New instability, pain, delirium, bowel or bladder issue
Therapy		Missed minutes, tolerance, scheduling, equipment
Medical workflow		Consult delay, test turnaround, medication plan
Disposition		Caregiver readiness, DME, home access, transportation
Payer		Authorization extension, peer-to-peer, post-acute approval

Track cause, avoidable days, owner and resolution time. Aggregate by week to fix systems instead of revisiting the same case.

Labor Productivity Without Clinical Erosion

Nursing	Hours per patient day by acuity and census	Overtime, agency, 1:1 coverage, avoidable sitter hours
Therapy	Productive minutes and schedule utilization	Late starts, cancellations, weekend capacity, missed minutes
Physicians	Coverage design and response time	Consult lag, documentation completion, preventable transfers
Case management	Cases per FTE and barrier closure	DME lead time, family training, authorization turnaround

Flex staffing to census and acuity while preserving required competencies, coverage and therapy intensity.

Medical Necessity Protects Revenue

The record should make the IRF decision understandable to a reviewer who never met the patient.

- Why the patient needs an interdisciplinary IRF program
- Why a lower level of care cannot meet the need
- Why physician supervision and rehabilitation nursing matter
- How the patient can reasonably benefit from intensive rehabilitation

High-risk patterns

- Generic preadmission language
- Goals disconnected from documented deficits
- Repeated missed therapy without clinical response
- Continued stay based only on placement delay
- Conflicting diagnoses or functional scores

Operator Dashboard

Domain	Daily or weekly	Monthly
Volume	Referrals, accepts, admits, census	Occupancy, conversion, source mix
Revenue	Expected payment, authorization status	Net revenue per discharge, tier and CMG trends
LOS	EDD, barriers, variance days	ALOS by cohort, avoidable days, transfer rate
Cost	Staffing, overtime, high-cost drugs	Labor cost per patient day, contribution margin
Quality	Falls, transfers, missed therapy	Readmission, discharge to community, QRP acceptance
Compliance	Medical necessity risk, 60% mix	Denials, 60% forecast, audit findings

What Changes Reimbursement and What Changes Margin

May change payment

- Accurate CMG assignment
- Supported comorbidity tier
- Facility factors and annual rates
- Transfer, short-stay, death or interrupted-stay policy
- High-cost outlier qualification
- QRP annual update reduction

Usually changes cost, not FFS payment

- Length of stay after full-payment threshold
- Nursing and therapy labor utilization
- Agency, overtime and premium pay
- High-cost drugs, supplies and diagnostics
- Avoidable acute-care transfers
- Discharge-process delay

Key distinction: after payment is fixed, every avoidable dollar of cost reduces contribution margin dollar for dollar.

Revenue integrity workflow



Admission

Validate impairment group, etiologic diagnosis and documented function



Concurrent

Capture clinically supported comorbidities and changing conditions



Pre-bill

Reconcile IRF-PAI, physician documentation, UB claim and discharge status



Post-pay

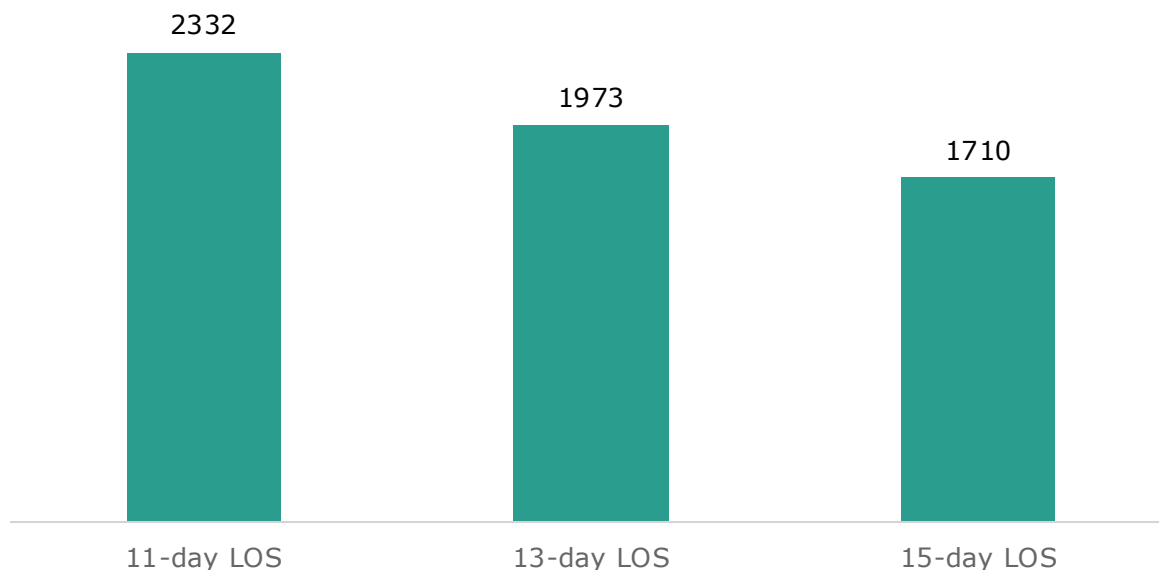
Analyze denials, underpayments, late charges and recoupments

Audit for accuracy in both directions. Unsupported tier capture creates repayment risk; missed supported diagnoses leave earned revenue unbilled.

Net revenue per day

Net revenue per day = expected net revenue ÷ length of stay

Illustrative case with \$25,650 expected net revenue



How operators improve the metric

Improve the numerator

- Accurate CMG and supported tier capture
- Prevent denials and recover underpayments
- Improve payer yield and contract terms

Remove avoidable days

- Close medical and discharge barriers earlier
- Protect therapy scheduling and weekend workflow
- Prevent delays in DME, training and authorization

Use NRPD with contribution margin, outcomes and readmissions. A higher ratio does not justify ending clinically necessary IRF care.

Guardrails for compliant margin improvement



Clinical need governs admission and discharge

Payment consequences inform planning but never replace clinical judgment.



Documentation follows the facts

Code only diagnoses and functional status supported by the record.



Targets include balancing measures

Pair LOS and productivity goals with transfers, readmissions, falls, outcomes and staff indicators.



Variance triggers learning

Use case review to fix process failures, not pressure teams to fit a number.

The management equation

Accurate payment + Reliable care delivery + Daily LOS control

Sustainable operating margin

The next step is to replace the illustrative economics with your facility's payer, case-mix, LOS and cost data.