Billing for Inpatient Rehabilitation Stays

Clarification of MS-DRG billing for inpatient rehabilitation stays

Due to the change to ICD-10-CM, there was confusion on the correct way to code inpatient rehabilitation stays. Since correct coding is essential to determine the appropriate payment, the Centers for Medicare & Medicaid Services (CMS) offered the following guidance:

- MS-DRG 945 or 946 (Rehabilitation with CC/MCC and without CC/MCC, respectively) is assigned if the patient has a principal diagnosis on the MDC 23 (Factors influencing Health Status and Other Contacts with Health Services) list and a rehabilitation procedure code listed under MS-DRGs 945 or 946.
- If the patient has a rehabilitation procedure code but does not have a principle diagnosis code from MDC 23, the principle diagnosis would determine the MS-DRG used.

The CMS explanation can be found at the following link: Federal Register/Vol. 81, No. 162/Monday, August 22, 2016/Rules and Regulations/11. pages 56826 & 56827.

The complete list of MDC 23 principal diagnosis codes can be found on the ICD-10-CM/PCS MS-DRG v35.0 Definitions Manual page of the CMS website.

The complete list of Rehabilitation procedures can be found on the ICD-10-CM/PCS MS-DRG v35.0 Definitions Manual page of the CMS website.

Always use the correct version based on the date of discharge.

For managed care organization (MCO) billing, providers can contact the appropriate MCO Customer Service Department with any questions regarding DRG billing.