CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 938

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 5, 2006

Change Request 5016

SUBJECT: The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

I. SUMMARY OF CHANGES: IRF PPS instructions are revised to 1) manualize the IRF compliance percentage as adopted by Congress in the Deficit Reduction Act of 2005; 2) provide clarification with respect to the use of medical record review in determining the IRF compliance percentage; and, 3) effect new policy on the IRF compliance percentage when patients are admitted due to the declaration of a Public Health Emergency under section 319 of the Public Health Service Act by the Secretary of Health and Human Services.

NEW/REVISED MATERIAL

EFFECTIVE DATE: August 7, 2006

IMPLEMENTATION DATE: August 7, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/140/1.1/Criteria That Must Be Met By Inpatient Rehabilitation Hospitals
R	3/140/1.2/Counting a Comorbidity as one of the Listed Medical Conditions
R	3/140/1.4/Verification Process Used To Determine if the Inpatient Rehabilitation Facility Met the Classification Criteria
R	3/140/1.7/New and Converted Inpatient Rehabilitation Facility Units

R	3/140/Appendix A/Verification of Compliance Using ICD-9-CM and Impairment Group Codes

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 938	Date: May 5, 2006	Change Request 5016

SUBJECT: The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

I. GENERAL INFORMATION

A. Background: IRF PPS instructions are revised to 1) adopt the IRF compliance percentage as set forth by Congress in the Deficit Reduction Act of 2005; 2) provide clarification with respect to the use of medical record review in determining the IRF compliance percentage; and, 3) effect new policy on the IRF compliance percentage when patients are admitted due to the declaration of a Public Health Emergency under §319 of the Public Health Service Act by the Secretary of Health and Human Services.

B. Policy:

A rehabilitation hospital is excluded from the acute care hospital PPS if it meets certain specified criteria, including what is commonly referred to as a compliance percentage. The Deficit Reduction Act of 2005 set forth an extended phase-in of the IRF compliance percentage as follows:

> for cost reporting periods--
> (1) beginning during the 12-month period beginning on July 1, 2006, is 60 percent;
> (2) beginning during the 12-month period beginning on July 1, 2007, is 65 percent; and
> (3) beginning on or after July 1, 2008, is 75 percent.

Due to the change of the phase-in of the IRF compliance percentage, a patient's comorbidity will not be included in the patient population used to determine the compliance percentage for cost reporting periods beginning on or after July 1, 2008.

In certain specified instances, an Intermediary may utilize record review in determining whether or not an IRF met the compliance percentage for the applicable cost reporting period. In doing so, Intermediaries shall adopt and adhere to written policies that describe the reasons that the Intermediary chose to use a random sample of medical records to determine the compliance percentage where the Intermediary has already determined that the IRF met the compliance percentage by using the presumptive method. In addition, Intermediaries shall submit a standardized report for reporting the IRF compliance percentage to the RO by the 15th day of each month. The report format, instructions, and where to send it is found on the CMS website **http://www.cms.hhs.gov./InpatientRehabFacPPS/03_Criteria.asp.**

Lastly, an exception to the general guideline regarding the submission of a listing of the IRF's patients, has been established to exclude those national emergency or disaster inpatients admitted as a consequence of a declaration by the Secretary of Health and Human Services under §319 of the Public Health Service Act or another appropriate statute of a Public Health Emergency.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5016.1	The Intermediary shall determine that the IRF Compliance Percentage Requirement found in Pub 100-04, Chapter 3, §140.1.1 is attained during the respective cost reporting period.	X								
5016.2	The Intermediary shall ensure that a patient's comorbidity is not included in the patient population used to determine the compliance percentage for cost reporting periods beginning on or after July 1, 2008.	X								
5016.3	The Intermediary shall ensure that an IRF's national emergency or disaster inpatients are not included as part of the IRF's total patient population when determining the IRF Compliance Percentage.	X								
5016.4	For the period from August 24, 2005, through the implementation date of this transmittal, contractors need not search their files to determine whether national emergency or disaster inpatients were excluded as part of the IRF's total patient population in determining the IRF Compliance Percentage, but may review cases that are called to their attention.	X								
5016.5	The Intermediary shall adopt and adhere to written policies that describe the reasons for the Intermediary to use a random sample of medical records to determine the compliance percentage threshold where the Intermediary has already determined that the IRF met the compliance percentage threshold by using the presumptive method.	X								
5016.6	The Intermediary shall submit a report by the 15th day of each month in accordance with the requirements set forth at www.cms.hhs.gov/InpatientRehabFacPPS/03_Criteria.asp.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5016.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: August 7, 2006 **Implementation Date:** August 7, 2006 **Pre-Implementation Contact(s):** Pedro Diaz (410) 786-1235 **Post-Implementation Contact(s):** Regional Office	No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

***Unless otherwise specified, the effective date is the date of service.**

140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Hospitals

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A rehabilitation hospital is excluded from the acute care hospital PPS if it meets all of the following criteria.

A. The hospital has in effect an agreement to participate as a hospital.

B. During a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) the hospital treated an inpatient population that met or exceeded the following percentages:

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2007, the hospital must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at §140.1.1C.

3. For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the hospital must have served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at §140.1.1C.

4. For cost reporting periods beginning on or after July 1, 2008, the hospital must have served an inpatient population of whom of at least 75 percent required intensive rehabilitative services for the treatment of one or more of the medical conditions specified below at §140.1.1C.

(a) Section 140.1.4B3(a) specifies that in certain situations some inpatients will not be considered part of the IRF's total inpatient population when the determination is being made regarding compliance with the requirements specified above in §140.1.1B1 to 140.1.1B4.

C. List of Medical Conditions:

1. Stroke.

2. Spinal cord injury.

3. Congenital deformity.

4. Amputation.

5. Major multiple trauma.

6. Fracture of femur (hip fracture).

7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

9. Burns.

10. 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. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

11. 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. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

12. 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. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current

clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. (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.)

For the medical conditions specified above in subsections 10, 11, and 12, the FI has the discretion to review documentation in order to assure that an inpatient has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. We expect that the IRF will obtain copies of the therapy notes from the outpatient therapy or therapy in another less intensive setting and place it in the patient's inpatient chart (in a section for prior records). We believe that these prior records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available to FI staff who review the medical records for compliance with the requirements specified above in §140.1.1B.

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

D. A hospital that seeks classification as an IRF for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the requirements specified above in §140.1.1B, instead of showing that it has treated the inpatient population specified above in §140.1.1B during its most recent 12-month cost reporting period. The written certification is also effective for a cost reporting period of not less than 1 month and not more than 11 months occurring between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period. However, if the hospital does not actually meet the requirements specified above in §140.1.1B during any cost reporting period that it has certified it

would meet the requirements specified above in §140.1.1B, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.8.

E. The hospital has 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 rehabilitation program or assessment.

F. The hospital ensures that patients receive close medical supervision and furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services.

G. The hospital has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

H. The hospital uses a coordinated multi-disciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record, to note the patient's status in relationship to goal attainment, and ensures that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.

I. The hospital has a director of rehabilitation who provides services to the hospital and its inpatients on a full time basis, is a Doctor of Medicine or Osteopathy, is licensed under state law to practice medicine or surgery, and has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

140.1.2—Counting a Comorbidity as one of the Listed Medical Conditions

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay. A patient with a comorbidity may be counted as part of the inpatient population that counts towards the required applicable percentage specified above in §140.1.1B if:

A. The patient is admitted for inpatient rehabilitation for a medical condition that is not one of the conditions specified in above in sub-section 140.1.1C.

B. The patient has a comorbidity that falls in one of the medical conditions specified above in sub-section 140.1.1C; and

C. The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid

under the IRF PPS, and that cannot be appropriately performed in another care setting covered under Medicare.

For cost reporting periods beginning on or after July 1, 2008, a patient's comorbidity is not included in the inpatient population that is used to determine the compliance percentage specified above in §140.1.1B.

140.1.4 - Verification Process Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A. Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period. In general, the RO and FI will use data from a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and FI will notify the facility regarding which most recent, consecutive, and appropriate 12-month period will be used as the review time period when they determine if the criteria used to classify a facility as an IRF was met. The RO and FI will begin 4 months prior to the start of the facility's next cost reporting time period the process necessary to verify all of the criteria used to classify a facility as an IRF. If for any reason the RO or FI require additional time to complete their compliance review, the RO and FI must consult with the facility prior to changing the compliance time period subject to review, and before using patient data that may overlap patient data from the previous 12-month review period.

The table below entitled "Table Of Compliance Review Periods" illustrates the time spans associated with an IRF's compliance review period and the compliance percentage threshold that must be met during each compliance review period. Depending on the specific compliance review period, a compliance review period may include a span of time from only one cost reporting period, or a compliance review period may span periods of time from two cost reporting periods.

For cost reporting periods that start on or after *July 1, 2008*, the compliance percentage threshold that the IRF must meet is 75 percent. However, for cost reporting periods that start on or after July 1, 2004, and on or before *June 30, 2008*, the compliance percentage threshold that an IRF must meet changes in accordance with the requirements specified in §140.1.1B. Accordingly, how the compliance percentage threshold is calculated will vary.

(a) When the cost reporting period starts on or after July 1, 2004, and the compliance review period is associated with only one cost reporting period.

When an IRF has a cost reporting period that starts on or after July 1, 2004, and the compliance review period is associated with only one cost reporting period (for example, but not only, a new IRF), the compliance percentage is the percentage of the cases in the total compliance review period that met at least one of the medical conditions listed in §140.1.1C. For example, for an IRF that has a cost reporting period than started on July 1, 2004, and ends on June 30, 2005, the compliance review period is July 1, 2004, to February 28, 2005, and the compliance percentage is the percentage of cases from July 1,

2004, to February 28, 2005, that met at least one of the medical conditions listed in §140.1.1C.

(b) When the cost reporting periods starts on or after July 1, 2004, and on or before June 30, 2005 and the compliance review period spans two cost reporting periods.

When an IRF has a cost reporting period that starts on or after July 1, 2004, and on or before June 30, 2005, and the compliance review period has portions of time that are associated with two cost reporting periods, the compliance percentage is the percentage of the cases in the total compliance review period that met at least one of the medical conditions listed in §140.1.1C. For example, for an IRF that has a cost reporting period than starts on January 1, 2005, and ends on December 31, 2005, the compliance review period is September 1, 2004, to August 31, 2005, and the compliance percentage is the percentage of cases from September 1, 2004, to August 31, 2005, that met at least one of the medical conditions listed in §140.1.1C.

(c) When the cost reporting periods starts on or after July 1, 2005, and the compliance review period spans two cost reporting periods.

When an IRF has a cost reporting period that starts on or after July 1, 2005, and the compliance review period has portions of time that are associated with two cost reporting periods, and the IRF had a patient population in each portion of the compliance review period, each portion of the compliance review period must separately meet the compliance percentage threshold of the cost reporting period that includes that portion of time of the compliance review period, in order for a determination to be made that the compliance percentage was met for the entire compliance percentage review period. Part of the above calculation method may be used to determine what compliance percentage was met in each portion of the entire compliance review period. For example, as illustrated in the table below entitled "Table Of Compliance Review Periods," an IRF that has a cost reporting period that started on July 1, 2004, must meet, as described more fully above in §140.1.1B, a compliance threshold of 50 percent for the cost reporting period of July 1, 2004, to June 30, 2005. In addition, for the next cost reporting period that starts on July 1, 2005, the IRF must meet, as described more fully above in §140.1.1B, a compliance threshold of 60 percent for the cost reporting period of July 1, 2005, to June 30, 2006. For the cost reporting period that starts on July 1, 2005, the IRF has a compliance review period consisting of March 1, 2005, to February 28, 2006. In this example, the time period from March 1, 2005, to June 30, 2005, is part of IRF's cost reporting period that started on July 1, 2004, and ends on June 30, 2005, and the time period from July 1, 2005, to February 28, 2006, is part of the IRF's cost reporting period that starts on July 1, 2005, and ends on June 30, 2006. Therefore, for the portion of the compliance review period from March 1, 2005, to June 30, 2005, the compliance percentage threshold that must be met is 50 percent. Similarly, for the portion of the compliance review period from July 1, 2005, to February 28, 2006, the compliance percentage threshold that must be met is 60 percent. If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005, to June 30, 2005, portion of the compliance review time period, or the compliance percentage threshold of

60 percent for the July 1, 2005, to February 28, 2006, portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005, to February 28, 2006.

2. Table Of Compliance Review Periods. For a facility that has been classified as an IRF but is not a "new" IRF as defined below in §140.1.7, the following table illustrates the compliance review periods and the compliance percentage that must be met during an entire compliance review period or portion of an entire compliance review period.

Table of Compliance Review Periods

For Cost Reporting Periods Beginning On:	Review Period: (Admissions or Discharges During)	Number Of Months In Review Period	Compliance Percentage Associated With A Compliance Review Period Or Portions Of the Compliance Review Period	Compliance Determination Applies To Cost Reporting Period Beginning On:
07/01/2004	07/01/2004-02/28/2005	8	07/01/2004 to 02/28/2005: 50 %	07/01/2005
08/01/2004	07/01/2004-03/31/2005	9	07/01/2004 to 03/31/2005: 50 %	08/01/2005
09/01/2004	07/01/2004-04/30/2005	10	07/01/2004 to 04/30/2005: 50 %	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	07/01/2004 to 05/31/2005: 50 %	10/01/2005
11/01/2004	07/01/2004-06/30/2005	12	07/01/2004 to 06/30/2005: 50 %	11/01/2005
12/01/2004	08/01/2004-07/31/2005	12	08/01/2004 to 07/31/2005: 50 %	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	09/01/2004 to 08/31/2005: 50 %	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	10/01/2004 to 09/30/2005: 50 %	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	11/01/2004 to 10/31/2005: 50 %	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	12/01/2004 to 11/30/2005: 50 %	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	01/01/2005 to12/31/2005: 50 %	05/01/2006
06/01/2005	02/01/2005-01/31/2006	12	02/01/2005 to 01/31/2006: 50 %	06/01/2006
07/01/2005	03/01/2005-02/28/2006	12	03/01/2005 to 06/30/2005: 50 % 07/01/2005 to 02/28/2006: 60 %	07/01/2006
08/01/2005	04/01/2005-	12	04/01/2005 to 07/31/2005: 50 %	08/01/2006

	03/31/2006		08/01/2005 to 03/31/2006: 60 %	
09/01/2005	05/01/2005- 04/30/2006	12	05/01/2005 to 08/31/2005: 50 % 09/01/2005 to 04/30/2006: 60 %	09/01/2006
10/01/2005	06/01/2005- 05/31/2006	12	06/01/2005 to 09/30/2005: 50 % 10/01/2005 to 05/31/2006: 60 %	10/01/2006
11/01/2005	07/01/2005- 06/30/2006	12	07/01/2005 to 10/31/2005: 50 % 11/01/2005 to 06/30/2006: 60 %	11/01/2006
12/01/2005	08/01/2005- 07/31/2006	12	08/012005 to 11/30/2005: 50 % 12/01/2005 to 07/31/2006: 60 %	12/01/2006
01/01/2006	09/01/2005- 08/31/2006	12	09/01/2005 to 12/31/2005: 50 % 01/01/2006 to 08/31/2006: 60 %	01/01/2007
02/01/2006	10/01/2005- 09/30/2006	12	10/01/2005 to 01/31/2006: 50 % 02/01/2006 to 09/30/2006: 60 %	02/01/2007
03/01/2006	11/01/2005- 10/31/2006	12	11/01/2005 to 02/28/2006: 50 % 03/01/2006 to 10/31/2006: 60 %	03/01/2007
04/01/2006	12/01/2005- 11/30/2006	12	12/01/2005 to 03/31/2006: 50 % 04/01/2006 to 11/30/2006: 60 %	04/01/2007
05/01/2006	01/01/2006- 12/31/2006	12	01/01/2006 to 04/30/2006: 50 % 05/01/2006 to 12/31/2006: 60 %	05/01/2007
06/01/2006	02/01/2006- 01/31/2007	12	02/01/2006 to 05/31/2006: 50 % 06/01/2006 to 01/31/2007: 60 %	06/01/2007
07/01/2006	*03/01/2006- 02/28/2007*	*12*	03/01/2006 to 06/30/2006: 60 % *07/01/2006 to 02/28/2007: 60 %*	*07/01/2007*
08/01/2006	*04/01/2006- 03/31/2007*	*12*	04/01/2006 to 07/31/2006: 60 % *08/01/2006 to 03/31/2007: 60 %*	*08/01/2007*
09/01/2006	*05/01/2006- 04/30/2007*	*12*	05/01/2006 to 08/31/2006: 60 % *09/01/2006 to 04/30/2007: 60 %*	*09/01/2007*
10/01/2006	*06/01/2006- 05/31/2007*	*12*	06/01/2006 to 09/30/2006: 60 % *10/01/2006 to 05/31/2007: 60 %*	*10/01/2007*
11/01/2006	*07/01/2006- 06/30/2007*	*12*	07/01/2006 to 10/31/2006: 60 % *11/01/2006 to 06/30/2007: 60 %*	*11/01/2007*
12/01/2006	*08/01/2006- 07/31/2007*	*12*	08/01/2006 to 11/30/2006: 60 % *12/01/2006 to 07/31/2007: 60 %*	*12/01/2007*
01/01/2007	*09/01/2006- 08/31/2007*	*12*	09/01/2006 to 12/31/2006: 60 % *01/01/2007 to 08/31/2007: 60 %*	*01/01/2008*
02/01/2007	*10/01/2006- 09/30/2007*	*12*	10/01/2006 to 01/31/2007: 60 % *02/01/2007 to 09/30/2007: 60 %*	*02/01/2008*
03/01/2007	*11/01/2006- 10/31/2007*	*12*	11/01/2006 to 02/28/2007: 60 % *03/01/2007 to 10/31/2007: 60 %*	*03/01/2008*
04/01/2007	*12/01/2006- 11/30/2007*	*12*	12/01/2006 to 03/31/2007: 60 % *04/01/2007 to 11/30/2007: 60 %*	*04/01/2008*
05/01/2007	*01/01/2007- 12/31/2007*	*12*	01/01/2007 to 04/30/2007: 60 % *05/01/2007 to 12/31/2007: 60 %*	*05/01/2008*
06/01/2007	*02/01/2007- 01/31/2008*	*12*	02/01/2007 to 05/31/2007: 60 % *06/01/2007 to 01/31/2008: 60 %*	*06/01/2008*

07/01/2007	*03/01/2007-* *02/29/2008*	*12*	*03/01/2007 to 06/30/2007: 60 %* *07/01/2007 to 02/29/2008: 65 %*	*07/01/2008*
08/01/2007	*04/01/2007-* *03/31/2008*	*12*	*04/01/2007 to 07/31/2007: 60 %* *08/01/2007 to 03/31/2008: 65 %*	*08/01/2008*
09/01/2007	*05/01/2007-* *04/30/2008*	*12*	*05/01/2007 to 08/31/2007: 60 %* *09/01/2007 to 04/30/2008: 65 %*	*09/01/2008*
10/01/2007	*06/01/2007-* *05/31/2008*	*12*	*06/01/2007 to 09/30/2007: 60 %* *10/01/2007 to 05/31/2008: 65 %*	*10/01/2008*
11/01/2007	*07/01/2007-* *06/30/2008*	*12*	*07/01/2007 to 10/31/2007: 60 %* *11/01/2007 to 06/30/2008: 65 %*	*11/01/2008*
12/01/2007	*08/01/2007-* *07/31/2008*	*12*	*08/01/2007 to 11/30/2007: 60 %* *12/01/2007 to 07/31/2008: 65 %*	*12/01/2008*
01/01/2008	*09/01/2007-* *08/31/2008*	*12*	*09/01/2007 to 12/31/2007: 60 %* *01/01/2008 to 08/31/2008: 65 %*	*01/01/2009*
02/01/2008	*10/01/2007-* *09/30/2008*	*12*	*10/01/2007 to 01/31/2008: 60 %* *02/01/2008 to 09/30/2008: 65 %*	*02/01/2009*
03/01/2008	*11/01/2007-* *10/31/2008*	*12*	*11/01/2007 to 02/29/2008: 60 %* *03/01/2008 to 10/31/2008: 65 %*	*03/01/2009*
04/01/2008	*12/01/2007-* *11/30/2008*	*12*	*12/01/2007 to 03/31/2008: 60 %* *04/01/2008 to 11/30/2008: 65 %*	*04/01/2009*
05/01/2008	*01/01/2008-* *12/31/2008*	*12*	*01/01/2008 to 04/30/2008: 60 %* *05/01/2008 to 12/31/2008: 65 %*	*05/01/2009*
06/01/2008	*02/01/2008-* *01/31/2009*	*12*	*02/01/2008 to 05/31/2008: 60 %* *06/01/2008 to 01/31/2009: 65 %*	*06/01/2009*
07/01/2008	*03/01/2008-* *02/28/2009*	*12*	*03/01/2008 to 06/30/2008: 65 %* *07/01/2008 to 02/28/2009: 75 %*	*07/01/2009*
08/01/2008	*04/01/2008-* *03/31/2009*	*12*	*04/01/2008 to 07/31/2008: 65 %* *08/01/2008 to 03/31/2009: 75 %*	*08/01/2009*
09/01/2008	*05/01/2008-* *04/30/2009*	*12*	*05/01/2008 to 08/31/2008: 65 %* *09/01/2008 to 04/30/2009: 75 %*	*09/01/2009*
10/01/2008	*06/01/2008-* 05/31/2009	*12*	*06/01/2008 to 09/30/2008: 65 %* *10/01/2008 to 05/31/2009: 75 %*	*10/01/2009*
11/01/2008	*07/01/2008-* *06/30/2009*	*12*	*07/01/2008 to 10/31/2008: 65 %* *11/01/2008 to 06/30/2009: 75 %*	*11/01/2009*
12/01/2008	*08/01/2008-* 07/31/2009	*12*	*08/01/2008 to 11/30/2008: 65 %* *12/01/2008 to 07/31/2009: 75 %*	*12/01/2009*
01/01/2009	*09/01/2008-* *08/31/2009*	*12*	*09/01/2008 to 12/31/2008: 65 %* *01/01/2009 to 08/31/2009: 75 %*	*01/01/2010*
02/01/2009	*10/01/2008-* *09/30/2009*	*12*	*10/01/2008 to 01/31/2009: 65 %* *02/01/2009 to 09/30/2009: 75 %*	*02/01/2010*
03/01/2009	*11/01/2008-* *10/31/2009*	*12*	*11/01/2008 to 02/28/2009: 65 %* *03/01/2009 to 10/31/2009: 75 %*	*03/01/2010*
04/01/2009	*12/01/2008-* *11/30/2009*	*12*	*12/01/2008 to 03/31/2009: 65 %* *04/01/2009 to 11/30/2009: 75 %*	*04/01/2010*
05/01/2009	*01/01/2009* *12/31/2009-*	*12*	*01/01/2009 to 04/30/2009: 65 %* *05/01/2009 to 12/31/2009: 75 %*	*05/01/2010*

06/01/2009	*02/01/2009-01/31/2010*	*12*	*02/01/2009 to 05/31/2009:65 %* *06/01/2009 to 01/31/2010: 75 %*	*06/01/2010*
07/01/2009	*03/01/2009-02/28/2010*	*12*	*03/01/2009 to 06/30/2009: 75 %* *07/01/2009 to 02/28/2010: 75 %*	*07/01/2010*
08/01/2009	*04/01/2009-03/31/2010*	*12*	*04/01/2009 to 07/31/2009: 75 %* *08/01/2009 to 03/31/2010: 75 %*	*08/01/2010*

As illustrated in the above table, if a cost reporting period starts on or after July 1, 2004, and before November 1, 2004, data from a compliance review period that is less than 12 months in length will be used to determine if the facility met all of the criteria necessary to be classified as an IRF for the next cost reporting period. For cost reporting periods beginning on or after November 1, 2004, data from the most recent, consecutive, and appropriate 12-month period of time (as defined by CMS or the fiscal intermediary) would be used, giving the ROs and FIs a 4-month time period to administer a compliance determination.

3. Guideline To Determine The Compliance Review Period For IRFs With Cost Reporting Periods That Start Between July 1, 2004, and October 31, 2004. If an IRF has a cost reporting period beginning on or after July 1, 2004, and before November 1, 2004, the RO and FI cannot collect 12 months of the most recent, consecutive, and appropriate data from a period falling completely after, as opposed to before, July 1, 2004, and have the 4 months of time necessary to make the compliance determination. To illustrate, to determine whether a hospital with a cost reporting period beginning on July 1, 2004, should continue to be classified as an IRF for the cost reporting period beginning on July 1, 2005, the RO and FI would have to start their compliance review 4 months prior to July 1, 2005, which means that the compliance review will start on March 1, 2005. As stated above, in general the RO and FI will use 12 months of data from the most recent, consecutive, and appropriate time period that is after July 1, 2004. Starting the compliance review on March 1, 2005, means that the RO and FI must use data from the previous 12 months, which is March 1, 2004, to February 28, 2005. However, using data from March 1, 2004, to February 28, 2005, would result in the RO and FI using 4 months of data, that is, March 1, 2004, to June 30, 2004, from a time period that is before July 1, 2004. Therefore, to avoid using data from a time period that is prior to July 1, 2004, an IRF with a cost reporting period that starts between July 1, 2004, and October 31, 2004, will have a compliance review period, as generally illustrated *above* in the Table of Compliance Review Periods, that is less than 12-months.

4. Guideline for Determining the Compliance Review Period of a Facility Classified as a New IRF, and for an IRF Expanding Its Size. In order for an IRF to be classified as a new IRF, or to add new bed capacity, it must meet the criteria specified in the regulations and below in §140.1.7. A facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is similar to an IRF whose cost reporting period begins on July 1, 2004. In other words, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July

1, 2004, and is a new IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is 8 months in length, in order to allow the RO and FI a 4-month time period to make and administer a compliance determination.

The compliance threshold for a facility classified as a new IRF, or adding new bed capacity, that had a cost reporting period that started on or after June 30, 2003, and before July 1, 2004, will be 50 percent.

5. Guideline for Determining the Compliance Review Period of a Facility Undergoing Conversion to an IRF. A facility undergoing the conversion process in order to be classified as an IRF, will have a compliance review period that is similar to an IRF whose cost reporting periods begins on July 1, 2004. In other words, a facility undergoing the conversion process in order to be classified as an IRF, will have a compliance review period that starts immediately when the cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2004, and is undergoing the conversion process in order to be classified as an IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, if a facility is undergoing the conversion process in order to be classified as an IRF, it will have a compliance review period that is 8 months in length, in order to allow the RO and FI a 4-month time period to make and administer a compliance determination.

The compliance threshold for a facility undergoing the conversion process in order to be classified as an IRF, that had a cost reporting period that started on or after June 30, 2003, and before July 1, 2004, will be 50 percent.

6. Guideline for Determining the Compliance Review Period of a Facility That Changes Its Cost Reporting Period. A facility that changes its cost reporting period will have a compliance review period that, in accordance with the above table, is based on its new cost reporting period.

B. Types of Data Used to Determine Compliance with the Classification Criteria

1. Starting on July 1, 2004, the FI will use the verification procedures specified below in *subsections C or D* to verify that an IRF has complied with the requirements specified above in §140.1.1B.

2. The verification procedure specified below in *subsection C* will only be used if the FI verifies that the IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population. The IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population only if the IRF's total inpatient population is made up of 50 percent or more of Medicare Part A fee-for-service inpatients.

3. General Guideline Regarding Submission of a Listing of the IRF's Inpatients: In order to verify that the IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total patient population, the FI in writing will instruct the IRF to send to the FI, by a specific date, a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the CMS or the FI.

(a) Exception to the General Guideline: The Secretary of Health and Human Services can declare a Public Health Emergency under §319 of the Public Health Service Act or another appropriate statute, and the President can declare either a National Emergency under the National Emergencies Act or a Major Disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, or other appropriate law. In accordance with such declarations there may be occasions when in specific geographic areas for a definite time period the requirements stipulated in certain regulations or operational policies are waived. If applicable, in accordance with the waiver provisions, the IRF may be permitted to admit patients, referred to in this section as national emergency or disaster inpatients, who otherwise would be admitted to another inpatient setting. In order to ensure that an IRF's national emergency or disaster inpatients are not included as part of the IRF's total inpatient population when the IRF's compliance with the requirements §140.1.1B is being determined, the IRF will not submit to the FI the hospital numbers the IRF assigned to its national emergency or disaster inpatients when the IRF submits the list of hospital numbers stipulated above in section 140.1.4B3. The IRF should appropriately document in the medical record sufficient information that identifies an inpatient as a national emergency or disaster inpatient.

4. For each inpatient represented by an inpatient hospital number on the list the IRF must include the payer the IRF can bill, or has billed, for the treatment and services the IRF has furnished to the inpatient. If an inpatient represented by an inpatient hospital number on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient represented by an inpatient hospital number on the list the IRF must include the IRF admission and discharge dates.

5. The FI will use the list of hospital numbers to determine what was the IRF's total inpatient population during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by CMS or the FI. *The FI will then refer to the preceding "Table of Compliance Review Periods" and specifically the column labeled "Compliance Percentage Associated with a Compliance Review Period or Portions of the Compliance Review Period." The column illustrates that a cost reporting period may have a compliance review period which consists of one or two portions of time. After the FI has determined the IRF's total inpatient population during a 12-month period, if, as illustrated in the column, the compliance review period consists of only one portion of time then for that portion of time the FI will determine if at least 50 percent of the IRF's total inpatient population was covered under Medicare Part A fee-for-service. However, if, as illustrated in the column, the compliance review period consists of two portions of time then for each portion of time the FI will separately determine if the Medicare Part A fee-for-service inpatient population was at least 50 percent of the entire inpatient*

population which the IRF treated during the same portion of time. A determination by the FI, in accordance with the preceding methodologies, that the IRF's Medicare Part A fee-for-service inpatient population was at least 50 percent of the matching entire inpatient population allows the FI to use the procedure stipulated below in sub-section C, which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records," to presumptively determine if the IRF met the compliance percentage as specified above in §140.1.1B. However, in addition to the above process, the FI may, at the FI's discretion, sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service population is representative of the IRF's total inpatient population.

6. The FI will inform the RO if an IRF fails to send the list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI, or if the list of inpatient hospital numbers does not include the payer or payers, and the admission and discharge dates that correspond with the inpatients whose hospital numbers are shown on the list. The RO will notify the IRF that failure to send the FI the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B.

C. Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records

1. In order to determine if a facility has presumptively complied with the criteria specified above in §140.1.1B, CMS will enable the FI to access CMS' IRF-PAI data records. Specifically, each FI will be allowed to access only the IRF-PAI information submitted by the IRFs that submit claims to that FI. In order to ensure that each FI will be allowed to access only the IRF-PAI information submitted by IRFs that submit claims to that FI, CMS obtained information from the FIs in order to create software that matched each FI to the IRFs that submit claims to it. However, over time an FI may have additional IRFs that submit claims to it, or may have IRFs that no longer submit claims to it. Therefore, in order to ensure that the software that matches an IRF to the FI to which the IRF submits claims is constantly updated by the 15th calendar day of each month, starting on February 15, 2005, the FI will electronically submit to the RO a table that has at least the following title and column headings:

FI List of IRFs of The FI (Then Specify the FI's Name)

The Name of An IRF That Submits Claims To This FI	The Provider Number Of This Same IRF That Submits Claims To This FI	The Cost Reporting Period Of This Same IRF	Is This Still The FI That The IRF Has Selected to Process Its Claims?	Is This IRF Submitting Claims To This FI For The First Time?

Each row of this table will specify the name of an IRF that submits claims to that FI, and in the other columns of that row the FI will specify the appropriate information associated with that specific IRF.

The RO then, after checking the FI's table for completeness and, as necessary, communicating with the FI to assure the information in the table is accurate, will forward the FI's table to the CMS contractor that maintains the IRF-PAI database. The CMS contractor that maintains the IRF-PAI database will then, if necessary, update the IRF-PAI database software the FI uses to presumptively verify compliance with the requirements specified in §140.1.1B. The FI must coordinate with their CMS RO to obtain privileges in order to obtain access to the software system that uses the IRF-PAI information to determine presumptive compliance with the requirements specified above in §140.1.1B. The FI will provide the RO with user information from all the FI staff that *are* required to access the IRF-PAI data records.

2. When the FI accesses the IRF-PAI data records the FI will be able to generate a report using the IRF-PAI information which was previously submitted by the IRFs that submit claims to that FI. The software that the FI will use to generate the report will automatically use the specific ICD-9-CM and impairment group codes that are listed in this chapter in Appendix A to determine if a particular IRF is presumptively in compliance with the requirements specified above in §140.1.1B. Prior to generating a report that the FI will use to determine if the IRF has presumptively complied with the requirements specified above in §140.1.1B, the FI must allow the IRF to decide if the IRF prefers the data records that the FI will use to generate the report to be either the IRF-PAI data records of patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

3. An IRF whose inpatient Medicare Part A fee-for-service population reflects its total inpatient population and that, according to the report generated using the procedure specified above in *subsection C2*, is verified by the FI to have met the requirements specified above in §140.1.1B will be presumed by the FI as having a total inpatient

population that meets the requirements specified above in §140.1.1B. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B, the RO and FI still have the discretion to instruct the IRF to send to the RO or FI specific sections of the medical records of a random sample of inpatients, or specific sections of the medical records of inpatients identified by other means by CMS or the FI.

4. The CMS Central Office and RO staff have the discretion to require that each FI, on a quarterly or more frequent basis, submit a report that shows the status of the level of compliance by a FI's IRFs with the requirements specified above in §140.1.1B.

5. Appendix A to this chapter lists the ICD-9-CM and IRF-PAI impairment group codes, that will be used to determine presumptive compliance with the requirements specified above in §140.1.1B.

D. Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population

1. The FI must use the IRF's total inpatient population to verify that the IRF has met the requirements specified above in §140.1.1B if: (i) the IRF's Medicare population does not reflect its total patient population; or (ii) if the FI is unable to generate a valid report using the IRF-PAI database methodology specified previously; or (iii) if the FI generates a report which demonstrates that the IRF has not met the requirements specified above in §140.1.1B. In the case where the Medicare Part A fee-for-service inpatients comprise less than 50 percent of the IRF inpatient population, or the FI otherwise determines that the Medicare Part A fee-for-service inpatients are not representative of the overall IRF inpatient population, or the FI is unable to generate a valid report using the IRF-PAI methodology, the presumptive determination is that the IRF did not meet the requirements specified above in §140.1.1B.

2. As previously stated above, the FI will instruct the IRF to send the FI a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI. The list of inpatient hospital numbers must include the payer(s) and admission and discharge dates that correspond with the inpatients whose hospital numbers are shown on the list. The FI will then use generally accepted statistical sampling techniques to determine from the list what is a statistically appropriate random sample number of inpatients. However, prior to selecting the sample number of inpatients, the FI must allow the IRF to decide if the IRF wants the sample to contain either the patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or the patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period. If the confidence level of the statistic derived from the sample is not at least 95 percent then the FI will adjust the sample or if necessary use the entire inpatient population to determine if the IRF meets the requirements as specified above in §140.1.1B. In addition, if an IRF during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI, had a total inpatient population of

100 inpatients or less, the FI will use the total inpatient population that consists of Medicare and non-Medicare inpatients as the random sample size. The FI will instruct the IRF to send it copies of specific sections of the medical records of inpatients, using the random sample of inpatients selected from the list to identify which inpatients are selected. The FI has the discretion to decide which specific sections of the medical records of the inpatients to obtain, provided that the requested medical record sections contain enough information to allow the FI's reviewers to determine what was the inpatient's medical condition(s) that the IRF treated. In addition to submitting to the FI the sections of the medical records of the random sample inpatients specified by the FI, the IRF has the discretion to send the FI other clinical information regarding these same inpatients. The admission and discharge dates as specified in the medical record sections obtained by the FI must be for the most recent, consecutive, and appropriate 12-month period as defined by CMS or the FI.

3. The FI will examine the medical records sections obtained and determine if the IRF meets the requirements as specified above in §140.1.1B. When determining if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the FI may use the ICD-9-CM and impairment group codes specified below in Appendix A to this chapter as guidance, or make that determination based upon only the medical judgment of its reviewer(s), or use a combination of both methods. In general, when the FI is using a sample of medical records to determine compliance by the IRF with the requirements in §140.1.1B, the FI always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the presumptive test methodology described above. *In other words, the compliance percentage that is determined by the FI obtaining information from a sample of medical records will supersede the compliance percentage that was determined for the same compliance review period by the FI using the presumptive method. In order to promote a compliance percentage determination process that is similar for all IRFs, the FI must have written policies that describe the reasons for the FI using a random sample of medical records to determine the compliance percentage when the FI has already determined by the presumptive method that the IRF met the compliance threshold.*

4. The FI will inform the RO if an IRF fails to provide information in accordance with the requirements specified above in subsection D2. The RO will notify the IRF that failure to provide the FI with the information in accordance with the requirements specified above in subsection D2 will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B.

E. By the 15th day of the each month, the FI responsible for determining the compliance percentage an IRF achieved in accordance with either of the methods specified above in §§140.1.4C or 140.1.4D will submit a report via e-mail. Instructions regarding the format of the report, how to complete the report, and where to send it are specified at the following website:

http://www.cms.hhs.gov/InpatientRehabFacPPS/03_Criteria.asp

F. If a rehabilitation hospital is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the criteria specified above in §140.1.1E-H will be presumed to have been met. However, in all instances the FI must verify that the requirements specified above in §140.1.1B were met. In addition, the State Agency is required to verify that the rehabilitation hospital has a Director of Rehabilitation who meets the requirements specified above in §140.1.1I.

G. If a rehabilitation hospital is not currently accredited by CARF then the State Agency will determine whether the criteria specified above in §140.1.1E-I were met. In addition, in all instances the FI must verify that the requirements specified above in §140.1.1B were met.

H. If a rehabilitation unit is currently accredited by CARF the criteria specified above in §140.1.1E-H will be presumed to be met. However, in all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, have been met. Also, the State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

I. If a rehabilitation unit is not currently accredited by CARF then the State Agency is required to determine if the criteria specified above in §140.1.1E-H has been met. In all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, and that the criteria specified below in §140.1.6 have been met. The State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

140.1.7 - New And Converted Inpatient Rehabilitation Facility Units

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A. New Unit: A hospital unit is considered a new IRF unit if the hospital:

1. Has not previously sought exclusion from the acute care hospital PPS for any rehabilitation unit; and

2. Has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

B. A hospital that seeks to have a new unit classified as an IRF must provide a written certification that the inpatient population the hospital intends the unit to serve, meets the requirements specified above in §140.1.1B, instead of showing that the unit has treated such an inpatient population during the hospital's most recent cost reporting period. The written certification is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care. The written certification also is effective for any cost reporting period of not less than 1 month, and not more than 11 months occurring between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period.

C. A hospital that has undergone a change of ownership or leasing as defined in the regulations is not considered to have participated previously in the Medicare program.

D. Converted unit--A hospital unit is considered a converted IRF unit if it does not qualify as a new IRF unit.

1. In general, a converted unit seeking classification as an IRF unit must have treated, during the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI), an inpatient population meeting the requirements specified above in §140.1.1B, except as specified below in paragraph 2.

2. If the most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) used to verify that the converted unit seeking classification as an IRF unit includes a time period prior to July 1, 2004, then the following procedure will be used:

   a. For the part of the 12-month time period (as defined by CMS or the FI) that is after July 1, 2004, the unit's inpatient population must have met the requirements specified above in §140.1.1B.

   b. For the part of the 12-month time period (as defined by CMS or the FI) that is before July 1, 2004, the unit's inpatient population must have met 50 percent of the following medical conditions:

(1) Stroke;

(2) Spinal cord injury;

(3) Congenital deformity

(4) Amputation;

(5) Major multiple trauma;

(6) Fracture of femur (hip fracture);

(7) Brain injury;

(8) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease;

(9) Burns; and

(10) Polyarthritis.

c. For the part of the conversion compliance time period that is after July 1, 2004, the FI will use the total inpatient population verification method specified above in *§140.1.4D*, "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population," to determine what percentage of the unit's inpatient population met the requirements specified above in §140.1.1B. In other words, the post July 1, 2004, data used to verify that the requirements specified above in §140.1.1B were met, will consist of data only from July 1, 2004, and the time period afterward, until when the time period used to determine compliance as a converted unit ends.

d. For the part of the conversion compliance time period that is before July 1, 2004, the FI will use the total inpatient population verification method specified above in *§140.1.4D*, "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population," to determine what percentage of the unit's inpatient population met one, or more, of the 10 medical conditions specified above in paragraph (b) of this section. In other words, the pre July 1, 2004, data used to verify what percentage of patients matched one, or more, of the 10 medical conditions specified above in paragraph (b) of this section, would consist of data only from before July 1, 2004, and prior months as far back as the first day that started the time period used to determine compliance.

For pre July 1, 2004 data, the FI staff will use its medical expertise to evaluate if a case meets the term "polyarthritis."

e. The pre and post July 1, 2004, percentages obtained using the methodology specified above in paragraphs (c) and (d) of this section will be combined, using weighted average techniques, to determine if the converted unit's total inpatient population met a compliance threshold percentage of 50 percent or more.

E. Expansion of an IRF unit--(1) New bed capacity. The beds that a hospital seeks to add to its IRF unit are considered new beds only if:

1. The hospital's State licensed and Medicare certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its IRF unit, or at any time after the start of the preceding cost reporting period; and

2. The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the IRF unit.

3. If a hospital expands its IRF unit by adding beds, the medical conditions of the patients treated in the added beds during the most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) must be taken into account in determining whether the requirements specified above in §140.1.3N were met.

4. A hospital that has an IRF unit may obtain approval to add bed capacity under State licensure and under its approved Medicare provider agreement, and may seek to add new beds to its existing excluded unit for the first 12-month cost reporting period during which the new beds are used to provide inpatient care. The hospital must provide a written certification that the inpatient population the new beds are intended to serve, meets the requirements specified above in §140.1.1B, instead of showing that those beds were used to treat such an inpatient population during the unit's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI).

F. Conversion of Existing Bed Capacity

Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity as specified above in paragraph E(1).

A hospital may increase the size of its IRF unit through conversion of existing bed capacity only if it shows that, for the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI), the beds have been used to treat an inpatient population meeting the requirements specified above in §140.1.1B.

G. Retroactive Adjustments for Certain IRF Units

For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new IRF unit excluded from the acute care hospital PPS for a cost reporting period as specified above in paragraphs A and B of this section, or expands an existing IRF unit as specified above in paragraph E of this section, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period do not meet the requirements specified above in §140.1.1B, CMS adjusts payments to the hospital retroactively in accordance with the procedure specified below in §140.1.8.

Appendix A - Verification of Compliance Using ICD-9-CM and Impairment Group Codes

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

The following ICD-9-CM and impairment group codes from the IRF-PAI database will be used to presumptively verify compliance with the requirements specified above in §140.1.1B. The verification procedure the FI will use is specified above in *§140.1.4C* "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records." The instructions specified above in *§§140.1.4C and 140.1.4D*, and in this Appendix, are to be used by the FI when the FI is verifying compliance with the requirements specified above in §140.1.1B. The instructions in *§§140.1.4C and 140.1.4D*, and this Appendix, are not intended to be used to complete the IRF-PAI. To complete the IRF-PAI, an IRF must use the instructions in the IRF-PAI manual, and any other CMS approved instructions that specifically state how to complete the IRF-PAI. The codes in this Appendix are not intended to be used as part of the instructions when completing the IRF-PAI. This Appendix is only to be used by the FI when it is determining if a facility meets the requirements to be classified as an IRF.

An inpatient, as represented by an IRF-PAI assessment data record, is presumptively determined as being included in the count when the calculation is performed that determines if the compliance thresholds specified in §140.1.1B were met if, except as noted below, the IRF-PAI item number 21 "impairment group" code, or the IRF-PAI item number 22 "etiologic diagnosis" ICD-9-CM code, or the IRF-PAI item number 24a through 24j "comorbid conditions" ICD-9-CM code matches one of the codes listed in the table below. Specifically, in accordance with the verification procedure specified above in *§140.1.4C*, in order for the IRF-PAI assessment data record, and, thus, the inpatient, to be presumptively counted when calculating if the applicable compliance threshold specified in §140.1.1B was met, the data record must have an impairment group code that matches one of the codes specified in the table column below labeled "REHABILIATION IMPAIRMENT GROUP CODES*", or an etiologic diagnosis or comorbid condition ICD-9-CM code that matches one of the codes specified in the table column below labeled "ICD-9-CM CODES **." However, as illustrated in the table below, if a specific impairment group code is paired with a specific etiologic diagnosis (IRF-PAI item 22) ICD-9-CM code within the same IRF-PAI data record, that pairing will result in that inpatient NOT being presumptively counted in the calculation when the determination is made regarding if the compliance threshold specified in §140.1.1B was met. For example, if an IRF-PAI data record specified both the impairment group code 05.2 (amputation, unilateral upper extremity below the elbow), and an etiologic diagnosis ICD-9-CM code that was either 885.0, or 885.1, or 886.0, or 886.1, then that inpatient is not presumptively counted when the calculation is made that determines if the compliance threshold specified in §140.1.1B was met.

MEDICAL	REHABILIATION	ICD-9-CM CODES **

CONDITON	IMPAIRMENT GROUP CODES*	
AMPUTATION	05.1 05.2, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 885.0, 885.1, 886.0, 886.1 05.3 05.4, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 895.0, 895.1, 896.0, 896.1, 896.2, 896.3 05.5 05.6 05.7	887.0 887.1 887.2 887.3 887.4 887.5 887.6 887.7 897.0 897.1 897.2 897.3 897.4 897.5 897.6 897.7 905.9 997.60 997.61 997.62 997.69 V49.65 V49.66 V49.67 V49.73 V49.74 V49.75 V49.76 V49.77 V52.0 V52.1
BRAIN INJURY	02.1, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 331.0, 331.2, 215.0 02.21 02.22	003.21 006.5 013.00 013.01 013.02 013.03 013.04 013.05 013.06 036.0 036.1 047.0 047.1

		047.8 047.9 048 049.0 049.1 049.8 049.9 052.0 053.0 054.3 055.0 056.01 062.0 062.1 062.2 062.3 062.4 062.5 062.8 062.9 063.0 063.1 063.2 063.8 063.9 064 066.2 066.3 066.4*** 066.41**** 072.1 072.2 090.40 090.41 090.42 091.81 094.1 094.2 094.81 100.81 112.83 114.2 115.01 115.11 115.91 130.0

		139.0 191.0 191.1 191.2 191.3 191.4 191.5 191.6 191.7 191.8 191.9 192.1 194.3 194.4 198.3 225.0 225.2 228.02 237.5 237.6 237.72 310.2 320.0 320.1 320.2 320.3 320.7 320.81 320.82 320.89 320.9 321.0 321.1 321.2 321.3 321.4 321.8 322.0 322.1 322.2 322.9 323.0 323.1 323.2 323.4 323.5

		323.6 323.7 323.8 323.9 324.0 324.9 325 326 344.81 348.0 348.1 348.4 348.5 348.8 349.82 430 432.0 432.1 432.9 800.00 800.01 800.02 800.03 800.04 800.05 800.06 800.09 850.2 850.4 850.5 851.00 851.01 851.02 851.03 851.04 851.05 851.06 851.09 907.0 997.01 013.1x 013.2x 013.3x 013.6x 045.0x 800.1x x=any last digit--see

		800.0x 800.2x x=any last digit--see 800.0x 800.3x x=any last digit--see 800.0x 800.4x x=any last digit--see 800.0x 800.5x x=any last digit--see 800.0x 800.6x x=any last digit--see 800.0x 800.7x x=any last digit--see 800.0x 800.8x x=any last digit--see 800.0x 800.9x x=any last digit--see 800.0x 801.0x x=any last digit--see 800.0x 801.1x x=any last digit--see 800.0x 801.2x x=any last digit--see 800.0x 801.3x x=any last digit--see 800.0x 801.4x x=any last digit--see 800.0x 801.5x x=any last digit--see 800.0x 801.6x x=any last digit--see 800.0x 801.7x x=any last digit--see 800.0x 801.8x x=any last digit--see 800.0x 801.9x x=any last digit--see 800.0x 803.0x x=any last digit--see 800.0x 803.1x x=any last digit--see 800.0x 803.2x x=any last digit--see 800.0x 803.3x x=any last digit--see 800.0x 803.4x x=any last digit--see

		800.0x 803.5x x=any last digit--see 800.0x 803.6x x=any last digit--see 800.0x 803.7x x=any last digit--see 800.0x 803.8x x=any last digit--see 800.0x 803.9x x=any last digit--see 800.0x 804.1x x=any last digit--see 800.0x 804.2x x=any last digit--see 800.0x 804.3x x=any last digit--see 800.0x 804.4x x=any last digit--see 800.0x 804.6x x=any last digit--see 800.0x 804.7x x=any last digit--see 800.0x 804.8x x=any last digit--see 800.0x 804.9x x=any last digit--see 800.0x 851.1x x=5th digit as in 851.0x 851.2x x=5th digit as in 851.0x 851.3x x=5th digit as in 851.0x 851.4x x=5th digit as in 851.0x 851.5x x=5th digit as in 851.0x 851.6x x=5th digit as in 851.0x 851.7x x=5th digit as in 851.0x 851.8x x=5th digit as in 851.0x 852.0x x=5th digit as in 851.0x 852.1x x=5th digit as in

		851.0x 852.2x x=5th digit as in 851.0x 852.3x x=5th digit as in 851.0x 852.4x x=5th digit as in 851.0x 852.5x x=5th digit as in 851.0x 853.0x x=5th digit as in 851.0x 853.1x x=5th digit as in 851.0x 854.0x x=5th digit as in 851.0x 854.1x x=5th digit as in 851.0x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
BURNS	11	906.5 906.7 906.8 941.00 941.02 941.09 941.30 941.32 941.39 946.2 946.3 946.4 946.5 948.1x 948.2x 948.3x 948.4x 948.5x 948.6x 948.7x 948.8x 948.9x 949.3 949.4 949.5

		941.4x 941.5x 942.0x 942.3x 942.4x 942.5x 943.0x 943.2x 943.3x 943.4x 943.5x 944.3x 944.4x 944.5x 945.0x 945.2x 945.3x 945.4x 945.5x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
CONGENITAL DEFORMITIES	12.1, 12.9	253.3 259.4 333.7 334.1 335.10 335.11 343.0 343.1 343.2 343.3 343.4 343.8 343.9 356.0 356.1 356.2 356.3 356.4 356.8 356.9 740.1 740.2 741.00 741.01

		741.02 741.03 741.90 741.91 741.92 741.93 742.0 742.1 742.2 742.3 742.4 742.51 742.53 742.59 754.30 754.31 754.32 754.35 755.20 755.21 755.22 755.23 755.24 755.25 755.26 755.27 755.28 755.30 755.31 755.32 755.33 755.34 755.35 755.36 755.37 755.38 755.4 755.51 755.53 755.61 755.62 755.63 756.4 756.5x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT	ICD-9-CM CODES **

	GROUP CODES*	
HIP FRACTURE	8.11, 8.12	733.14 808.0 808.1 820.00 820.01 820.02 820.03 820.09 820.10 820.11 820.12 820.13 820.19 820.20 820.21 820.22 820.30 820.31 820.32 820.8 820.9
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
BILATERAL KNEE OR BILATERAL HIP JOINT REPLACEMENTS	08.52 08.62 08.72	None
JOINT REPLACEMENTS AND PATIENT AGE 85 OR MORE	08.51 plus age 85 or older 08.61 plus age 85 or older 08.71 plus age 85 or older	None
JOINT REPLACEMENTS AND PATIENT BODY MASS INDEX 50 OR MORE	Codes not applicable. Determination of matching this medical condition based on medical record review.	Codes not applicable. Determination of matching this medical condition based on medical record review.
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **

MAJOR MULTIPLE TRAUMA	14.1 14.2 14.3 14.9, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 808.2. 808.3, 808.59, 808.8, 808.9	808.43 808.53 819.0 819.1 828.0 828.1
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
NEUROLOGICAL DISORDERS	03.1 03.2 03.5 03.8	053.13 094.0 094.82 138 332.0 332.1 333.0 334.0 335.19 335.20 335.21 335.22 335.23 335.24 335.29 335.8 335.9 340 341.0 341.1 341.8 341.9 344.31 344.32 344.5 344.89 353.0 353.1 353.2 353.3 353.4 353.5 353.8

		354.5 356.0 356.1 356.2 356.3 356.4 356.8 357.0 357.1 357.3 357.4 357.5 357.6 357.7 357.81 357.82 358.00 358.01 358.1 358.2 358.8 359.0 359.1 359.2 359.3 359.4 359.5 359.6 359.81 359.89 710.3 710.4
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
OSTEOARTHRITIS Involving two or more major joints (hips, knees, shoulders, and elbows), not counting any joints with a prosthesis		715.11 715.12 715.15 715.16 715.21 715.22 715.25 715.26 715.31 715.32 715.35

		715.36 716.01 716.02 716.05 716.06 716.11 716.12 716.15 716.16 716.21 716.22 716.25 716.26 716.51 716.52 716.55 716.56
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
RHEUMATOID ARTHRITIS	06.1 06.9, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0x, 716.--716.99	099.3 136.1 711.2x 713.0 713.1 713.2 713.3 713.4 713.6 713.7 714.0 714.1 714.2 714.31 714.32 714.81 714.89 714.9 719.3x 720.0 720.81 720.89
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
SPINAL CORD	04.110, 04.111,	079.51

INJURY	04.112, 04.120, 04.1211, 04.1212, 04.1221, 04.1222, 04.130, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 723.0, 724.00-724.09 04.210, 04.211, 04.212, 04.220, 04.2211, 04.2212, 04.2221, 04.2222, 04.230 -- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 953.0-953.8	170.2 192.2 192.3 225.3 225.4 323.0 324.1 336.0 336.1 336.2 336.3 336.8 336.9 344.00 344.01 344.02 344.03 344.04 344.09 344.1 344.2 344.60 344.61 721.1 721.41 721.42 721.91 722.70 722.71 722.72 722.73 806.00 806.01 806.02 806.03 806.05 806.06 806.07 806.08 806.09 806.10 806.11 806.12 806.13 806.14 806.15

		806.16 806.17 806.18 806.19 806.20 806.21 806.22 806.23 806.24 806.25 806.26 806.27 806.28 806.29 806.30 806.31 806.32 806.33 806.34 806.35 806.36 806.37 806.38 806.39 806.4 806.5 806.60 806.61 806.62 806.69 806.70 806.71 806.72 806.79 839.01 839.02 839.03 839.04 839.05 839.06 839.07 839.08 839.10 839.11 839.12 839.13

		839.14 839.15 839.16 839.17 839.18 839.20 839.21 839.30 839.31 907.2 952.01 952.02 952.03 952.04 952.05 952.06 952.07 952.08 952.09 952.10 952.11 952.13 952.14 952.15 952.16 952.17 952.18 952.19 952.2 952.3 952.4 952.8 952.9 013.4x 013.5x 045.1x 952.1x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
STROKE	01.1, 01.2, 01.3, 01.4, 01.9	342.00 342.01 342.02 342.10 342.11 342.12

		342.80 342.81 342.82 342.90 342.91 342.92 431 433.01 433.11 433.21 433.31 433.81 433.91 434.01 434.11 434.91 437.2 437.4 437.5 437.6 438.20 438.21 438.22 438.30 438.31 438.32 438.40 438.41 438.42 438.50 438.51 438.52 438.53 997.02
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
SYSTEMIC VASCULIDITIES	06.9-- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0x, 716.xx	446.0 710.0

* The Rehabilitation Impairment Group codes are from IRF-PAI item number 21. Either the admission or discharge impairment group code may be used.

** The ICD-9-CM codes are from IRF-PAI item number 22 "Etiologic Diagnosis" and item number 24 “Comorbid Conditions."

***Starting on October 1, 2004, this ICD-9-CM code will no longer be one of the ICD-9-CM codes used to determine if an IRF-PAI data record matches one of the medical conditions.

****Starting on October 1, 2004, this ICD-9-CM code will be one of the ICD-9-CM codes used to determine if an IRF-PAI data record matches one of the medical conditions.