CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 221 **Date: JUNE 25, 2004**

CHANGE REQUEST 3334

I. SUMMARY OF CHANGES: Change in the criteria used to classify a hospital or hospital unit as an inpatient rehabilitation facility, and how the fiscal intermediary will verify one of the criterion.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 1, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/140.1/Medicare IRF Classification Requirements
N	3/140.1.1/Criteria That Must Be Met By Inpatient Rehabilitation Hospitals
N	3/140.1.2/Counting A Comorbidity As One Of The Listed Medical Conditions
N	3/140.1.3/Criteria That Must Be Met By Inpatient Rehabilitation Units
N	3/140.1.4/Verification Process To Be Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria
N	3/140.1.5\/ospitals That Have Not Previously Participated In Medicare
N	3/140.1.6/Changes In The Status Of An Inpatient Rehabilitation Unit
N	3/140.1.7/New And Converted Inpatient Rehabilitation Facility Units
N	3/140.1.8/Retroactive Adjustments For Provisionally Excluded Inpatient Rehabilitation Facilities Or Beds
N	3/Appendix A/Verification of Compliance Using ICD-9-CM and Impairment Group Codes

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 221	Date: June 25, 2004	Change Request 3334

SUBJECT: Medicare IRF Classification Requirements

I. GENERAL INFORMATION

A. Background: Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Social Security Act (the Act) give the Secretary the discretion to define which inpatient facilities may be classified as an inpatient rehabilitation hospital or as an acute care hospital rehabilitation unit. An inpatient rehabilitation hospital and an acute care hospital rehabilitation unit are collectively referred to as an inpatient rehabilitation facility (IRF) under the IRF prospective payment system (PPS). On January 3, 1984, we published a final rule entitled "Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services" (49 FR 234) which specified that in order to be classified as an IRF 75 percent of the IRF's total patient population during the IRF's cost reporting period must match one or more of the ten medical conditions listed in 42 CFR 405.471. The final rule provision specifying that in order to be classified as an IRF 75 percent of the IRF's total patient population must match one or more of the listed medical conditions became known as the "75 percent rule." The IRF's fiscal intermediary (FI) was responsible for verifying if the IRF's total patient population met the 75 percent rule. On March 29, 1985, we published a final rule entitled "Medicare Program; Prospective Payment System for Hospital Inpatient Services: Redesignation of Rules" (50 FR 12740). That rule redesignated the provisions of 42 CFR 405.471 that addressed the 75 percent rule as a provision under 42 CFR 412.23(b)(2). The regulations at 42 CFR 412.25, and 412.29 refer to 42 CFR 412.23(b)(2) as one of the criteria a provider must meet to be classified as an IRF. Hospitals and units meeting the criterion specified in 42 CFR 412.23(b)(2), as well as other criteria, are eligible to be paid under the IRF PPS. An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS, and the results of the verification procedure are used in determining each facility's classification status for the next cost reporting period. IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis an IRF must self-attest, except for the medical condition criterion specified above, that it still meets all the criteria for being classified as an IRF. The FI is always required to verify that an IRF has met the medical condition criterion.

B. Policy: On May 7, 2004, we published a final rule entitled "Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility." In the final rule, we changed the percent of the IRF's total patient population that must match a specific medical condition, as well as changed the medical conditions previously specified in the regulations. The final rule specified that 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, 2006, 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, 2006, and before July 1, 2007, 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, 2007, 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.

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.)

(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.

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 records

will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available for FI's who review the medical records for compliance with the requirements specified above in §140.1.1B.

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 medical condition requirement specified above, instead of showing that it has treated an inpatient population that met the medical condition requirement during its most recent 12-month cost reporting period. The written certification is also effective for a cost reporting period of not less than one 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.

If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the medical condition requirement specified above but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively. The FI adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion and the amount that would have been paid if the hospital, unit, or beds had not been excluded from the PPS. The FI then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters 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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3334.1	FIs shall ensure that currently certified IRFs, during the most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) treated an inpatient population that met or exceeded the appropriate percentages (total inpatient population that must match a	FIs

	specific medical condition) for the appropriate year to remain classified as an IRF.	
3334.2	FIs shall accept written certification from new IRFs that the inpatient population it intends to serve meets the medical condition requirements, instead of showing that it has treated an inpatient population that met the medical condition requirement during its most recent 12-month cost reporting period.	FIs
3334.2.1	The FI shall adjust payments to the new IRF retroactively, if the hospital, hospital unit, or group of beds paid under the IRF PPS for a cost reporting period, does not actually meet the requirement for that cost reporting period.	FIs
3334.2.2	The FI shall adjust payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion and the amount that would have been paid if the hospital, unit, or beds had not been excluded from the acute care hospital PPS.	FIs
3334.2.3	The FI shall take action to recover the resulting overpayment or correct the underpayment to the hospital, hospital unit, or beds provisionally excluded from the acute care hospital PPS.	FIs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

N/A	

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date:** July 1, 2004 **Pre-Implementation Contact(s):** Pete Diaz 410-786-1235 **Post-Implementation Contact(s):** Pete Diaz 410-786-1235	These instructions shall be implemented within your current operating budget.

Medicare Claims Processing Manual

Chapter 3-Inpatient Hospital Billing

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(Rev. 221, 06-25-04)

140.1-Medicare IRF Classification Requirements

(Rev. 221, 06-25-04)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system (PPS) under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act give the Secretary the discretion to define an IRF. The regulations at 42 CFR 412.23(b), 412.25, 412.29, and 412.30, specify the criteria for a provider to be classified as an IRF. Hospitals and units meeting those criteria are eligible to be paid on a PPS basis as an IRF under the IRF PPS.

A determination by the Regional Office (RO) that a facility is classified as an IRF applies to the entire cost reporting period for which the determination is made. The ROs generally make these determinations on an annual basis. If a determination is made by the RO to change the classification of a facility, the IRF status classification remains in effect for the duration of that cost reporting period. The change in the hospital's or unit's classification as an IRF takes effect only at the start of the facility's next cost reporting period.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. In addition, the results of the verification procedure are used in determining each facility's classification status for the next cost reporting period. The IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis an IRF must self-attest, except for the criteria specified below in §140.1.1B, that it still meets the criteria for being classified as an IRF. The fiscal intermediary (FI) is always required to verify that an IRF has met the criteria specified below in §140.1.1B. The facility must have approval from the RO and the State Agency prior to making changes in operations. All IRFs are notified by letter by the appropriate CMS RO of the self-attestation procedures, and other procedures and requirements that apply to them. The FI is not responsible for monitoring or enforcing IRF self-attestation procedures.

140.1.1-Criteria That Must Be Met By Inpatient Rehabilitation Hospitals

(Rev. 221, 06-25-04)

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, 2006, 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, 2006, and before July 1, 2007, 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, 2007, 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.

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.)

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.

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 records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available for FI's who review the medical records for compliance with the requirements specified above in §140.1.1B.

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. 221, 06-25-04)

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 above in §140.1.1C;

B. The patient has a comorbidity that falls in one of the medical conditions specified above in §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, 2007, a patient's comorbidity is not included in the inpatient population that counts towards the 75 percent specified above in §140.1.1B.

140.1.3-Criteria That Must Be Met By Inpatient Rehabilitation Units

(Rev. 221, 06-25-04)

To be excluded from the acute care hospital PPS an inpatient rehabilitation unit must meet the criteria in paragraphs A through Q below.

A. The inpatient rehabilitation unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the acute care hospital PPS.

B. The inpatient rehabilitation unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. The inpatient rehabilitation unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. (However, the medical records of unit patients need not be physically separate from the records of patients in the acute care part of the hospital, and it is not necessary to create a second medical record when a patient is moved from the acute care part of the hospital to the excluded unit, or vice versa. The record must indicate the dates of the admission and discharge for patients of the unit.) The inpatient rehabilitation unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the inpatient rehabilitation unit.

D. If state law provides special licensing requirements for rehabilitation units, the inpatient rehabilitation unit must be licensed in accordance with the applicable requirements.

E. The hospital's utilization review plan must include separate standards for the type of care offered by the inpatient rehabilitation unit.

F. The beds assigned to the inpatient rehabilitation unit must be physically separate from (i.e., not co-mingled with) beds not included in the unit.

G. The hospital must have enough beds not excluded from the acute care hospital PPS to permit the provision of adequate cost information. The FI has discretion as to how to apply generally accepted accounting principles when making this analysis.

H. The inpatient rehabilitation unit and the hospital in which it is located must be serviced by the same FI.

I. The inpatient rehabilitation unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. The accounting system of the hospital in which the inpatient rehabilitation unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

Compliance with the criteria in items H, I, and J above may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the FI, that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion from the acute care hospital PPS, if approved, applies.

K. The cost report for the hospital must include the costs of the inpatient rehabilitation unit, covering the same fiscal period as the hospital, and use the same method of cost apportionment as the hospital.

L. As of the first day of the first cost reporting period for which all other exclusion requirements are met, the inpatient rehabilitation unit must be fully equipped, staffed, and

must be capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the acute care hospital PPS.

N. Except as specified below in paragraph O, the inpatient rehabilitation unit must have treated, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) an inpatient population that meets the requirements specified above in §140.1.1B.

O. For the first cost reporting period in which a currently participating hospital seeks exclusion from the acute care hospital PPS of a new inpatient rehabilitation unit, it may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §140.1.1B above, instead of showing that it has treated such a population during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI). For the purpose of this provision, a unit is considered to be a new inpatient rehabilitation unit only if the hospital has not previously sought exclusion for any rehabilitation unit, and has obtained approval for added bed capacity under its state licensure and its approved Medicare provider agreement. A unit of a currently participating hospital that includes some beds that were previously licensed and certified, and some new beds, is recognized as a new inpatient rehabilitation unit only if more than one-half of the beds are new.

P. The unit must meet the requirements specified above in §140.1.1E-H.

Q. The unit must have a Director of Rehabilitation who has the qualifications specified above in §140.1.1I, and provides services to the unit and its inpatients for at least 20 hours per week. If a rehabilitation unit serves both inpatients and outpatients through a single integrated unit, the time spent by the director in performing administrative duties for the entire unit, counts toward the direction requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

The criteria specified in paragraphs A through Q above are used to determine whether a part of a hospital qualifies for exclusion from the acute care hospital PPS. An excluded unit must be established as a separate cost entity for cost reporting purposes.

If a hospital wishes to have a unit excluded from the acute care hospital PPS for a cost reporting period, it must notify its FI before the start of the cost reporting period of the particular areas it has designated as the unit, and of the square footage and number of beds in the unit, and the FI, or RO, will inform the IRF of the proper procedures. This notice must be sent to the FI at the same time the notice is sent to the RO regarding the request for exclusion from the acute care hospital PPS and must identify the designated space through the use of room numbers and/or bed numbers. The notice must be sent no

later than 5 months before the beginning of the hospital's cost reporting period. The RO determines, based on information obtained from the State Survey Agency and the hospital's FI, whether the unit qualifies for exclusion from the acute care hospital PPS. If the RO disapproves the exclusion, it notifies the hospital prior to the start of the hospital's next cost reporting period. If the RO approves the exclusion, it notifies the hospital prior to the start of the hospital's next cost reporting period, and notifies the FI of the unit's exclusion from the acute care hospital PPS and the provider's identification number. The hospital's self-attestation that it meets the applicable criteria, which qualifies the unit to be excluded from the acute care hospital PPS, is subject to verification by the RO, the State Agency, and the FI. An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results of the verification procedure are used in determining each facility's classification status for the next cost reporting period.

After the initial classification as an IRF, changes in the amount of the space occupied by the unit, or in the number of beds in the unit, are recognized for purposes of the exclusion from the acute care hospital PPS only at the start of a cost reporting period.

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

(Rev. 221, 06-25-04)

A. Determination of the Compliance Review Time 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.

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.

In order, when possible, to ensure that the RO and FI use the appropriate time period when obtaining data for their compliance reviews between July 1, 2004, and July 1, 2005, the RO and FI will use the following schedule to determine the compliance review period.

For Cost Reporting Periods Beginning On:	Review Period: (Admissions During)	Number of Months in Review Period	Compliance Determination Applies to Cost Reporting Period Beginning On:
07/01/2004	07/01/2004-02/28/2005	8	07/01/2005
08/01/2004	07/01/2004-03/31/2005	9	08/01/2005
09/01/2004	07/01/2004-04/30/2005	10	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	10/01/2005
11/01/2004	07/01/2004-06/30/2005	12	11/01/2005
12/01/2004	08/01/2004-07/31/2005	12	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	05/01/2006
06/01/2005	02/01/2005-01/31/2006	12	06/01/2006
07/01/2005	03/01/2005-02/28/2006	12	07/01/2006

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 qualify it 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 would be used, giving the ROs and FIs a 4-month time period to make and administer a compliance determination.

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

Starting on July 1, 2004, the FI will use the verification procedures specified below in subsections 1 or 2 to verify that an IRF has complied with the requirements specified above in §140.1.1B. The verification procedure specified below in subsection 1 will only be used if the FI verifies that the IRF's Medicare inpatient population reflects what is the IRF's total inpatient population. The IRF's Medicare 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 inpatients. In order to verify that the IRF's Medicare 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 Medicare 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. 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. 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 determine how many inpatients represented on the list of inpatient hospital numbers are covered under Medicare, and using that data will determine if the IRF's Medicare inpatient population is 50 percent or more of the IRF's total inpatient population for a most recent, consecutive, and appropriate 12-month period, as that time period is defined by CMS or the FI. 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 population is representative of the IRF's total inpatient population.

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.

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

    a. In order to determine if a facility has 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. The FI must coordinate with their CMS regional office to obtain privileges to obtain access to the IRF-PAI information. The FI will provide the regional office with user information from all the FI staff that is required to access the IRF-PAI data records.

    b. The FI will review the IRF-PAI information submitted by the IRFs that submit claims to that FI and generate a report that uses specific ICD-9-CM and impairment group codes from the IRF-PAI to determine if a particular IRF is in compliance with the requirements specified above in §140.1.1B.

    c. An IRF whose inpatient Medicare population reflects its total inpatient population and that, according to the report generated using the procedure specified above in paragraph (b), 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 patient 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 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.

d. 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.

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

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

a. The FI must use the IRF's total patient 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 admissions comprise less than 50 percent of the IRF inpatient population, or the FI otherwise determines that the Medicare admissions 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.

b. 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. If the confidence level of the statistic derived from the sample is not at least 90 percent then the FI will 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 freedom to decide which specific sections of the medical records of the inpatients to obtain. 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.

c. The FI will examine the medical records sections obtained according to paragraph (b) above and determine if the IRF meets the requirements as specified above in §140.1.1B based on the ICD-9-CM and impairment group codes specified below in Appendix A to this chapter as well as evidence from medical records.

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

C. 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.

D. 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.

E. 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.

F. 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.

140.1.5-Hospitals That Have Not Previously Participated In Medicare

(Rev. 221, 06-25-04)

A hospital that has not previously participated in the Medicare program, and seeks exclusion from the acute care hospital PPS for the entire hospital, may provide a written certification that the inpatient population the hospital intends to serve will meet the requirement in §140.1.1B above, instead of showing that it has treated such a population during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI). The written certification is effective for the first full 12-month cost reporting period that occurs after the hospital becomes a Medicare participating hospital, and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's first regular 12-month cost reporting period of Medicare participation.

For purposes of §140.1.5, a hospital that has undergone a change of ownership or leasing is considered to have not participated previously in the Medicare program.

140.1.6-Changes In The Status Of An Inpatient Rehabilitation Unit

(Rev. 221, 06-25-04)

The status of an inpatient rehabilitation unit may be changed from not excluded from the acute care hospital PPS, to excluded from the acute care hospital PPS, only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the acute care hospital PPS before the start of a hospital's next cost reporting period.

The status of an inpatient rehabilitation unit may be changed from excluded from the acute care hospital PPS to not excluded from the acute care hospital PPS at any time during a cost reporting period, but only if the hospital notifies the FI and the RO in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period, must remain in effect for the rest of that cost reporting period.

140.1.7-New And Converted Inpatient Rehabilitation Facility Units

(Rev. 221, 06-25-04)

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 §140.1.4B(2), "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Patient 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 §140.1.4B(2), "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Patient 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.

140.1.8-Retroactive Adjustments For Provisionally Excluded Inpatient Rehabilitation Facilities Or Beds

(Rev. 221, 06-25-04)

A. If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet one of the requirements specified above in §140.1.1B, but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively in accordance with paragraph C below.

B. In the case of a unit to which new beds have been added the requirement in §140.1.1B above is applied to the entire unit, including both new and added beds. If the entire unit is able to meet the requirement, the previously existing unit and the added beds are presumed to meet the requirement separately and no payment adjustment as specified below in paragraph C is made. If the unit as a whole does not meet the requirement specified above in §140.1.1B, the hospital must furnish the FI or the State Agency, as specified by the RO, the information needed to determine whether the requirement specified in §140.1.1B above was met by the established portion of the unit (that is, the previously existing unit) and by the newly added beds, considered separately. If the established portion of the unit did not meet the requirement, no retroactive payment adjustment is made for services in the established portion of the unit, but that portion is not classified as an IRF for the following cost reporting period. If the added beds met the requirement specified above in §140.1.1B, no retroactive payment adjustment is made for the added beds and those beds are eligible to be included as part of the unit's classification as an IRF for the following cost reporting period. If the added beds did not meet the requirement, the FI adjusts its payment to the unit retroactively in accordance with paragraph C below and the added beds are not included as part of the unit classified as an IRF for the following cost reporting period.

If the hospital does not have the records needed to discriminate between the performance of the previously existing unit, and that of the added beds or for other reasons does not furnish the information requested by the FI or State Agency, neither the previously existing unit nor the added beds are classified as an IRF for the following cost reporting period. In that case, the FI adjusts its payment to the entire unit retroactively in accordance with paragraph C below.

C. The FI adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion, and the amount that would have been

paid if the hospital, unit, or beds had not been excluded from the PPS. The FI then takes action to recover the resulting overpayment, or corrects the underpayment to the hospital.

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

(Rev. 221, 06-25-04)

The following ICD-9-CM and impairment group codes from the IRF-PAI database will be used to verify compliance with the requirements specified above in §140.1.1B. The rehabilitation impairment category codes specified below are for informational purposes, and will not be used as part of the verification process. The verification procedure the FI will use is specified above in §140.1.4B(1) "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument Data Records."

MEDICAL CONDITON	**REHABILITATION IMPAIRMENT CATEGORY CODES**	**REHABILIATION IMPAIRMENT GROUP CODES***	**ICD-9-CM CODES ****
AMPUTATION	10 AND 11	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 896.0-3, 895 05.6 05.7	887.0 887.1 887.2 887.3 887.4 887.5 887.6 887.7 896.0 896.1 896.2 896.3 897.0 897.1 897.2 897.3 897.4 897.5 897.6 897.7 905.9 997.6 997.60 997.61 997.62 997.69

			V49.65 V49.66 V49.67 V49.73 V49.74 V49.75 V49.76 V49.77 V52.0 V52.1
BRAIN INJURY	02 AND 03	02.1, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 331.0, 331.2, 215.0 02.21 02.22	003.21 006.5 013.0 036.0 036.1 047.0 047.1 047.8 047.9 048. 049.0 049.1 049.8 049.9 052.0 053.0 054.3 055.0 056.01 062.0 062.1 062.2 062.3 062.5 062.8 062.9 063.0 063.1 063.2 063.8 063.9 064. 066.2 066.3 066.4 072.1

			072.2 090.40 090.41 090.42 091.81 094.1 094.2 094.81 100.81 112.83 114.2 115.01 115.11 115.91 130.0 139.0 191.0 191.1 191.2 191.3 191.4 191.5 191.6 191.7 191.8 191.9 192.1 194.3 194.4 198.3 225.0 225.2 228.02 237.5 237.6 237.7 237.72 310.2 320.0 320.1 320.2 320.3 320.7 320.81 320.82 320.89

			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	**REHABILITATION IMPAIRMENT CATEGORY CODES**	**REHABILIATION IMPAIRMENT GROUP CODES***	**ICD-9-CM CODES ****
BURNS	21	11	906.5 906.7 906.8 941.00 941.02 941.09 941.30 941.32 941.39 946.2 946.3 946.4 946.5 948.1 948.2 948.3 948.4 948.5 948.6 948.7 948.8 948.9 949.3 949.4 949.5 941.4x 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	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
CONGENITAL DEFORMITIES	20	12.1, 12.9	253.3 259.4 333.7 334.1 335.10 335.11 343.0 343.1 343.2 343.3 343.4 343.8 343.9 356.0 356.1 356.2 356.3 356.4 356.8 356.9 740.1 740.2 741.00 741.01 741.02 741.03 741.90 741.91 741.92 741.93 742.0 742.1 742.2 742.3 742.4 742.5 742.51 742.53 742.59 754.3 754.30

			754.31 754.32 754.35 755.20 755.21 755.22 755.23 755.24 755.25 755.26 755.27 755.28 755.30 755.31 755.32 755.33 755.34 755.35 755.36 755.37 755.38 755.4 755.51 755.53 755.61 755.62 755.63 756.4 756.5

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
HIP FRACTURE	07	8.11, 8.12	808.0 808.1 820.00 820.01 820.02 820.03 820.09 820.1 820.10 820.11 820.12 820.13 820.19 820.20 820.21 820.22 820.30 820.31 820.32 820.8 820.9

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
BILATERAL KNEE OR BILATERAL HIP JOINT REPLACEMENTS	08	08.52 08.62 08.72	
JOINT REPLACEMENTS AND PATIENT AGE 85 OR MORE	08	08.51 plus age 85 or older 08.61 plus age 85 or older 08.71 plus age 85 or older	
JOINT REPLACEMENTS AND PATIENT BODY MASS INDEX 50 OR MORE	08	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	**REHABILITATION IMPAIRMENT CATEGORY CODES**	**REHABILIATION IMPAIRMENT GROUP CODES***	**ICD-9-CM CODES ****
MAJOR MULTIPLE TRAUMA	17 AND 18	14.1 14.2 14.3 14.9, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 808.2. 808.3, 808.59, 808.8, 808.9	808.43 808.53 819.0 819.1 828 828.0 828.1

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
NEUROLOGICAL DISORDERS	06	03.1 03.2 03.5 03.8 For others, use diagnoses	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. 341.0 341.1 341.8 341.9 344.31 344.32 344.5 344.89 353.0 353.1 353.2 353.3 353.4 353.5 353.5 353.8 354.5 356.0 356.0 356.1 356.2 356.3 356.4

			356.8 357. 357.0 357.1 357.3 357.4 357.5 357.6 357.7 357.8 358.0 358.1 358.2 358.8 359.0 359.1 359.2 359.3 359.4 359.5 359.6 359.8 710.3 710.4

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	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	12		715.01 715.02 715.05 715.06 715.81 715.82 715.85 715.86 715.11 715.12 715.15 715.16 715.21 715.22 715.25 715.26 715.31 715.32 715.35 715.36 716.01 716.02 716.05 716.06 716.11 716.12 716.15 716.16 716.21 716.22 716.25 716.26 716.51 716.52 716.55 716.56

MEDICAL CONDITON	**REHABILITATION IMPAIRMENT CATEGORY CODES**	**REHABILIATION IMPAIRMENT GROUP CODES***	**ICD-9-CM CODES ****
RHEUMATOID ARTHRITIS	13	06.1 06.9, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0, 716.---716.99	099.3 136.1 711.2 713.0 713.1 713.2 713.3 713.4 713.6 713.7 714.0 714.1 714.1 714.2 714.3 714.31 714.32 714.8 714.9 719.3 720.0 720.8

MEDICAL CONDITON	**REHABILITATION IMPAIRMENT CATEGORY CODES**	**REHABILIATION IMPAIRMENT GROUP CODES***	**ICD-9-CM CODES ****
SPINAL CORD INJURY	04 AND 05	04.110-04.130, -- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 723.0, 724.00-724.09 04.210-04.230, -- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 953.0-953.8	079.51 170.2 192.2 192.3 225.3 225.4 323.0 324.1 336.0 336.1 336.2 336.3 336.8 336.9 344.00 344.01 344.02 344.03 344.04 344.09 344.1 344.2 344.6 344.60 344.61 721.1 721.4 721.41 721.42 721.91 722.70 722.71 722.72 722.73 806.0 806.00 806.01 806.02 806.03 806.05 806.06

			806.07 806.08 806.09 806.1 806.10 806.11 806.12 806.13 806.14 806.15 806.16 806.17 806.18 806.19 806.2 806.20 806.21 806.22 806.23 806.24 806.25 806.26 806.27 806.28 806.29 806.3 806.30 806.31 806.32 806.33 806.34 806.35 806.36 806.37 806.38 806.39 806.4 806.5 806.6 806.60 806.61 806.62 806.69 806.7 806.70 806.71

			806.72 806.79 839.0 839.01 839.02 839.03 839.04 839.05 839.06 839.07 839.08 839.1 839.10 839.11 839.12 839.13 839.14 839.15 839.16 839.17 839.18 839.2 839.20 839.21 839.3 839.30 839.31 907.2 952.01 952.02 952.03 952.04 952.05 952.06 952.07 952.08 952.09 952.10 952.11 952.13 952.14 952.15 952.16 952.17 952.18 952.19

			952.2 952.3 952.4 952.8 952.9 013.4x 013.5x 045.1x 952.1x

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
STROKE	01	01.1-01.9	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. 433.01 433.11 433.21 433.31 433.81 433.91 434.01 434.11 434.91 436 437.2 437.4 437.5 437.6 438.2 438.20 438.21 438.22 438.3 438.30 438.31 438.32 438.4 438.41 438.42 438.5 438.50 438.51

			438.52 438.53 997.02

MEDICAL CONDITON	REHABILITATION IMPAIRMENT CATEGORY CODES	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
SYSTEMIC VASCULIDITIES		06.9,-- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0, 716.---716.99	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."