# Fact Sheet #1
# Inpatient Rehabilitation Facility Classification Requirements

## Provider Types Affected

All hospitals or units of a hospital that are classified under subpart B of part 412 of the Medicare regulations as inpatient rehabilitation facilities (IRFs). Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412.

## Provider Action Needed

No provider action is necessary. This fact sheet is informational only and elaborates on the revised classification requirements for IRFs described in CR 3334 (Transmittal 221) and CR 3503 (Transmittal 347) issued on June 25, 2004 and October 29, 2004, respectively. The purpose of this fact sheet is to update the status of the initiatives that CMS is actively pursuing and to highlight specific aspects of the operational procedures as described regarding the classification requirements for IRFs. We are also addressing the provision of the Consolidated Appropriations Act, 2005 regarding how the application of the revised classification requirements may affect IRFs.

## General Classification Requirements – Background

Section 1886(d)(1)(B) of the Social Security Act (the Act) and Part 412 of the Medicare regulations define a Medicare certified hospital that is paid under the inpatient (acute care hospital) prospective payment system (IPPS). However, the statute and regulations also provide for the classification of special types of Medicare certified hospitals that are excluded from payment under the IPPS. These special types of hospitals must meet the criteria specified at subpart B of Part 412 of the Medicare regulations. Failure to meet any of these criteria results in the termination of the special classification, and the facility reverts to an acute care inpatient hospital or unit that is paid under the IPPS in accordance with all applicable Medicare certification and State licensing requirements. In general, however, under §§ 412.23(i) and 412.25(c), changes to the classification status of an excluded hospital or unit of a hospital are made only at the beginning of a cost reporting period.

## Special Requirements Applicable to CAH's

Critical access hospitals (CAHs) are not hospitals that are paid under the IPPS. In addition, in accordance with section 1820(c)(2)(E) of the Act, a CAH may have a distinct part rehabilitation or psychiatric unit (DPU) that is excluded from the payment system under which Medicare pays CAHs. However, in order to be excluded from the payment system under which Medicare pays CAHs, the DPU must meet the criteria specified at subpart B of Part 412

of the Medicare regulations. Failure to meet any of these criteria will result in the DPU being subject to the payment and other regulatory requirements that pertain to CAHs, including the limitation of a CAH to no more than 25 beds overall.

## IRF Classification Requirements

One of the special types of hospitals excluded from the IPPS is an inpatient rehabilitation facility (IRF). Medicare payments to IRFs are based on the IRF PPS that was implemented on January 1, 2002. The conditions for payment under the IRF PPS are specified at §412.604.

The implementation of the IRF PPS did not change the regulations and procedures applicable to entities seeking classification as an IRF. In order to receive payment under the IRF PPS, a hospital or unit of a hospital must first meet the requirements to be classified as an IRF in accordance with subpart B of Part 412. This includes meeting the requirement under §412.23(b)(2), which was commonly referred to as the "75 percent rule". In this article we refer to this requirement as the "compliance percentage threshold."

## Regulatory History of the IRF Classification Requirements

In the May 7, 2004 Federal Register (69 FR 25752), the Centers for Medicare & Medicaid Services (CMS) published a final rule that revised §412.23(b)(2). Under revised §412.23(b)(2), a specific compliance percentage threshold of an IRF's total patient population must require intensive rehabilitation services for the treatment of one or more of the specified conditions. Based on the final rule, CMS issued a Joint Signature Memorandum including instructions related to Regional Office (RO) and Medicare fiscal intermediary (FI) responsibilities regarding the performance of reviews to verify compliance with §412.23(b)(2) as detailed in CRs 3334 and 3503, which revised Medicare Claims Processing Manual Chapter 3, sections 140.1 to 140.1.8. (CR 3503 corrected some errors or clarified the instructions in CR 3334 and presented additional instructions to implement revised §412.23(b)(2).

Using the instructions in CRs 3334 and 3503, the FI determines if an IRF's patient population met the compliance percentage threshold annually, and reports that information to the appropriate CMS RO. If the IRF did not meet the compliance percentage threshold, then the RO terminates the facility's classification as an IRF and notifies the FI and the facility of this action. The facility would then be paid as an acute care hospital under the IPPS. In the case of a CAH rehabilitation DPU, the rehabilitation unit may be then paid in accordance with the payment system Medicare uses to pay CAHs, but only if such payment to the rehabilitation unit does not violate any of Medicare's CAH regulations or operational policies.

## The Effect of the Consolidated Appropriations Act, 2005 on the Revised Classification Requirements for IRFs

In accordance with the Consolidated Appropriations Act, 2005 (CAA, 2005)(Pub. Law 108-447 enacted on December 8, 2004), CMS may not use the revised requirements found in §412.23(b)(2) to change the classification of facilities that were classified as IRFs as of June 30, 2004, until CMS either: (1) Determines that our current regulations at §412.23(b)(2) are not inconsistent with a soon-to-be-released Government Accountability Office (GAO) IRF study; or (2) In accordance with the provisions of a soon-to-be-released GAO IRF study, issues an interim final rule revising the criteria at §412.23(b)(2) used to classify a facility as an IRF.

In accordance with the CAA, 2005, the FIs will perform the compliance reviews on all IRFs in accordance with CRs 3334, 3503, and any subsequent CRs regarding compliance with §412.23(b)(2). However, until further notice from CMS Central Office, the ROs will not make any changes to the status of a hospital or a unit of hospital that was classified as an IRF on or before June 30, 2004, and fails to meet the requirements specified in §412.23(b)(2). For a hospital or unit of a hospital that was classified as an IRF after June 30, 2004, and fails to meet §412.23(b)(2), or any other IRF requirements specified in subpart B of Part 412, the RO will terminate the facility's classification as an IRF.

It is important to note that the CAA, 2005 provision only pertains to IRFs that fail to meet the requirements of §412.23(b)(2) of the regulations. An IRF, including facilities classified as IRFs on or before June 30, 2004, that fails to meet any of the other requirements to be classified as an IRF under subpart B of Part 412 will, in accordance with the regulations and applicable CRs, have its classification as an IRF terminated.

CMS realizes that future changes to the classification requirement under §412.23(b)(2) may occur as a result of the GAO study. However, since the CAA,2005 does not prevent CMS from performing the compliance reviews through the FIs, CMS will continue to elaborate on the current instructions in section 140*****, Chapter 3 of the Medicare Claims Processing Manual, as amended by CRs 3334 and 3503, through various means in order to educate the IRF industry. CMS will announce any changes to the revised requirements under §412.23(b)(2) based upon the GAO study.

* *This corrects a clerical error. Specifically, previously this section was referred to as "104." The correct section number is 140.*

## Payment Under IRF PPS

Section 1886(j) of the Act provides for the implementation of a Medicare PPS for IRFs. The IRF PPS was implemented for cost reporting periods beginning on or after January 1, 2002. Under the "Publications" section of the CMS website specific to IRFs, (www.cms.hhs.gov/providers/irfpps/default.asp), all Federal Register Publications and

corresponding instructions regarding the IRF PPS are available for review and/or downloading.

## Changes to the IRF Classification Requirements Under §412.23(b)(2) - Background

On June 7, 2002, CMS notified all ROs and FIs of its concerns regarding the effectiveness and consistency of the review to determine compliance with §412.23(b)(2). As a result of these concerns, CMS initiated a comprehensive assessment of the procedures used by the FIs to verify compliance with the compliance percentage threshold requirement and suspended enforcement of the compliance percentage threshold requirement for existing IRFs. The suspension of enforcement did not apply to a facility that was first seeking classification as an IRF in accordance with §412.23(b)(8) or §412.30(b)(2). In such cases, all current regulations and procedures, including §412.23(b)(2), continued to be required.

In the May 16, 2003 proposed rule (68 FR 26791) CMS described its evaluation of the existing compliance percentage threshold requirement and announced its finding of low compliance. CMS also stated that while IRFs are now paid under a PPS, the compliance percentage threshold requirement still served the relevant function of distinguishing IRFs from other types of inpatient facilities, thus facilitating compliance with sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act. Making this distinction was also critical to fulfilling the requirements of section 1886(j)(1)(A), which requires Medicare to make payments to IRFs under a PPS specifically designed for the services IRFs furnish. Accordingly, CMS stated that it would be instructing FIs to reinstitute appropriate enforcement action if a FI determines that an IRF has not met the compliance percentage threshold requirement for cost reporting periods that start on or after October 1, 2003.

The May 16, 2003 proposed rule generated a large number of comments from the rehabilitation industry, calling for a review of the criteria used to classify a facility as an IRF, including an expansion of the qualifying medical conditions. Based on the interest generated from those comments and from testimony given in an IRF Town Hall meeting held on May 19, 2003, CMS published a proposed rule (68 FR 53269) on September 9, 2003 that proposed to amend §412.23(b)(2) and declared that enforcement of the existing compliance percentage threshold requirement for cost reporting periods beginning on or after October 1, 2003 as stated in the May 16, 2003 proposed rule was delayed. Based on comments received on the proposed rules, CMS published a final rule in the May 7, 2004 Federal Register (69 FR 25752) that revised §412.23(b)(2) effective for cost reporting periods beginning on or after July 1, 2004.

## Changes to the Compliance Percentage Threshold

Under revised §412.23(b)(2), a specific compliance percentage threshold of an IRF's total patient population must require intensive rehabilitation services for the treatment of one or more of the specified conditions (see List of Medical Conditions Requiring Intensive Rehabilitative Services below). The compliance percentage threshold

requirement for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, is 50 percent; for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, id 60 percent; and for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007 is 65 percent. For cost reporting periods beginning on and after July 1, 2007 the compliance percentage threshold is 75 percent.

An IRF's failure to provide the fiscal intermediary (FI) with medical records for certain patients, as specified by the FI, for services provided at the IRF could affect the IRF's ability to meet its compliance percentage threshold requirement.

## Changes to the List of Medical Conditions Requiring Intensive Rehabilitative Services

The following list includes the medical conditions that require intensive rehabilitative services under revised §412.23(b)(2):

(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.

(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.

(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. (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 meet one or more of the following specific criteria:

1. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
2. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
3. The patient is age 85 or older at the time of admission to the IRF.

In general, CMS would like to make clear that the FI always has discretion to include a patient in any of the above medical conditions based upon a review of the clinical record, irregardless of the presumptive test methodology described below.

## Patients Counted in the Category of Major Multiple Trauma

In the proposed rule dated September 9, 2003 (FR 68, 53272) CMS clarified which patients should be counted in the category of major multiple traumas to include patients in diagnosis-related groups 484, 485, 486 or 487 used under the IPPS.

## Effect of Changes in List of Medical Conditions for Cost Reporting Periods Prior to July 1, 2007 and For Cost Reporting Periods Beginning After July 1, 2007

For cost reporting periods prior to July 1, 2007, patients admitted for inpatient rehabilitation for a condition that is not one of the conditions specified above may be include in the percentage threshold requirement if the patient has a comorbidity that falls in one of the conditions specified above and the comorbidity 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 subpart P of Part 412 of the regulations, and that treatment cannot be appropriately performed in another care setting covered under the Medicare program.

For cost reporting periods beginning on or after July 1, 2007 a patient with comorbidity as described in the immediately preceding paragraph will no longer be included in the inpatient population that counts towards the compliance percentage threshold requirement.

# Additional Guidance

## How to Code the IRF-PAI

When coding patients IRF's must follow the ICD-9-CM instructions for coding the comorbidity or the IRF-PAI Instruction Manual for coding the etiologic diagnosis. IRFs that have identified an error in an assessment that has been submitted and accepted to the national database may make corrections in accordance with the instructions found in the section titled IRVEN Data Entry, found on page 30 of the Inpatient Rehabilitation Validation and Entry (IRVEN) System Reference Manual, Version 1.3.

## How the Presumptive Test Methodology is Applied

CR 3503 describes the "presumptive test" methodology and the medical record review methodology for determining compliance with the revised regulations. Unless otherwise instructed by the IRF, if the majority of an IRF's patients are Medicare Part A fee for service beneficiaries, the FI's will use the Medicare IRF-PAI data to make a presumptive judgment that an IRF's total patient population complies with the revised regulations. If an IRF fails to meet the applicable compliance percentage threshold using the presumptive test methodology, then the FI will perform a review of a sample of the medical records for the IRF's total patient population to make a final determination. IRFs that have been found to meet the "presumptive test" based solely on the percentage of Medicare Part A fee for service beneficiaries they serve are still, at the FI's discretion, subject to FI review of a sample of the medical records for the IRF's total patient population in order for the FI to make a final determination of compliance with the regulations.

The presumptive test methodology uses a computer program that produces an electronic report from the IRF PAI records retained in CMS' national repository. The report shows if an IRF's Medicare Part A fee for service patient population meets the compliance percentage threshold requirement. An IRF's FI can produce this report at any time during a given 12 month period of time. The codes contained in Appendix A of CR 3503 were used to develop the computer program only for the presumptive test methodology. We are planning on making the written specifications used in the computer program available to providers when using a sample of medical records to determine if the compliance percentage threshold requirement was met. FI's have the discretion of using

additional codes or medical information from a patient's medical record to make the determination notwithstanding the report generated by the presumptive test methodology.

## Use of The Codes in "Appendix A" when Calculating the Percentage Threshold Compliance Requirement under the Presumptive Methodology

In accordance with the verification procedure specified in 140.1.4.B(1) of Chapter 3 of the Medicare Claims Processing Manual, in order for the IRF-PAI assessment data record, and thus, the patient, to be presumptively counted when calculating if the applicable compliance percentage threshold requirement was met, the data record must have an impairment group code that exactly matches one of the codes specified in the table column labeled "REHABILITATION IMPAIRMENT GROUP CODES*", or an etiologic diagnosis or comorbid condition ICD-9CM code that exactly matches one of the codes specified in the table column labeled "ICD-9-CM-Codes**."

Header codes in Appendix A with an "x," include all codes subsumed within that specific code for purposes of determining if the inpatient may be counted when calculating if the applicable percentage threshold requirement was met. However, if a specific impairment group code is paired with a excluded 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 applicable compliance percentage threshold requirement was met. Specific impairment group, comorbidity, and etiologic diagnosis ICD-9CM codes were excluded from Appendix A in certain cases or medical conditions because it was determined that review of the medical record was more appropriate than the use of codes, under the presumptive test methodology.

An IRF should maintain direct contact with the appropriate FI staff to ensure that proper methodology is used to determine compliance with the revised requirements for a given compliance review period.

If an IRF is dissatisfied with the calculation of its compliance percentage that results in a change of its classification, the IRF may file an appeal of its Notice of Program Reimbursement for the affected cost reporting period in accordance with 405 Subpart R of Part 42 of the regulations.

## Determining an "appropriate, aggressive, and sustained course of outpatient therapy services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission"

In subsections 140.1C10, 11 and 12 of Chapter 3 of the Medicare Claims Processing Manual, we list three of the 13 medical conditions that count as meeting the revised compliance regulations. In these subsections, we further state that, to qualify as meeting

one of these specific three medical conditions, a patient with 1 of these conditions must have had, "an appropriate, aggressive, and sustained course of outpatient therapy services in other less intensive rehabilitation settings."

In addition, in these subsections, we further state that the therapy services "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."

Also, for these three medical conditions we state in the CR 3503 that the FI has the discretion to use local practices and more current clinical information, instead of the criteria we specified in CR 3503, to interpret or define an appropriate, aggressive sustained course of outpatient therapy services or services in other less intensive rehabilitation settings.

## "Within 20 Calendar Days" Defined

The "within 20 calendar days" provision means that in order for a patient to be counted as meeting the medical conditions specified in subsections 140.1.1C10, 11, and 12, the patient must have failed a trial of an appropriate course of outpatient therapy, or therapy services in other less intensive rehabilitation settings 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 functional improvement within 20 calendar days of an acute hospitalization preceding immediately an IRF stay. Due to the dynamic nature of medical illness, a patient who completed a course of outpatient therapy, or received therapy services in other less intensive rehabilitation settings, in the remote past might potentially benefit from a renewed effort at rehabilitation in the outpatient setting, or in other less intensive rehabilitation settings, with therapy focused on the specific clinical deficits accounting for the patient's current functional impairments.

## Clarification of Joint Replacement Instructions

Based on CR 3334, we are aware of the inadvertent placement of the paragraph that appears after the knee or hip joint replacement medical condition specified at subsection 140.1.1C13c. Furthermore, we understand the inadvertent placement of this paragraph, might be incorrectly interpreted to mean, that in order to be counted as part of the compliance threshold the knee or hip joint replacement cases must also meet the therapy requirements, in addition to the separate parameters specified for knee or hip joint replacements. We corrected the placement of the paragraph when we issued CR 3503, so as to avoid any suggestion that the therapy condition "appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive

rehabilitation settings," pertains to the knee or hip joint replacement conditions specified in subsection 140.1.1C13.

## How to Determine the Compliance Review Period

Section 140, Chapter 3, of the Medicare Claims Processing Manual, as amended by CRs 3334, and 3503 describes the process for determining a compliance review period. The FI in conjunction with the RO will make a final determination of an IRF's compliance review period. The compliance review period must allow adequate time for the FI and RO to determine if the classification of an IRF must be made prior to the beginning of the next cost reporting period affected by such change. IRFs should contact the appropriate FI and RO staff to determine its specific compliance review period.

Section 140, Chapter 3, of the Medicare Claims Processing Manual, as amended by CRs 3334 and, 3503 also describe how to determine the compliance review period for the initial cost reporting periods following the implementation of the revised regulations effective July 1, 2004. This special determination of a compliance review period was necessary to account for a period that was less than 12 months long since the new requirements were not effective until July 1, 2004. Affected IRFs should contact the appropriate FI and RO staff to determine its specific compliance review period.

## How the FI Will Use Generally Accepted Statistical Sampling Techniques to Determine an IRF's Compliance With the Compliance Percentage Threshold Requirement

The FI will use generally accepted statistical sampling techniques to determine what is a statistically appropriate random sample number of inpatients for purposes of determining compliance with the compliance percentage threshold requirement, based upon the instructions found in § 140.1.4(B)(2)(b) of Chapter 3 of the Medicare Claims Processing Manual. IRFs are responsible for reporting to the FI that they fail to meet the compliance percentage threshold requirement, where the IRF has made such a determination.

If an IRF is dissatisfied with a finding of non-compliance that results in a change to its classification, the IRF may file an appeal of its Notice of Program Reimbursement for the affected cost reporting period in accordance with 405 Subpart R of Part 42 of the regulations.

## How To Determine If an IRF is New, Converted, or an Expansion

The ROs are responsible for determining if a hospital or unit of a hospital seeking to be classified as an IRF is considered new, converted, or is an expansion of an already classified IRF. A facility should contact the appropriate RO staff to make this determination.

A newly participating hospital or a new unit of a hospital that seeks classification as an IRF for the first full 12-month cost reporting period that occurs after its becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the compliance percentage threshold requirements described above, instead of showing that is has treated that population during its most recent 12-month cost reporting period. If an IRF is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the percentage threshold compliance requirement but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively under §412.130. There is no specific form or content requirements for completing the written certification. The FI adjusts payment to the hospital calculating the difference between the amount actually paid for services to Medicare Part A fee for service patients in the facility during the period of provisional exclusion and the amount that would have been paid if the hospital or unit not been excluded from the IPPS. The FI then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

A facility that is not new is considered to be a converted facility. A converted facility and an expansion of an existing facility must show that during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), it meets the revised compliance percentage threshold requirements of §412.23(b)(2).

***For further information IRFs should contact the appropriate FI and RO staff if they have any questions regarding the IRF PPS or its classification as an IRF.***

## Intermediary Provider Training

No mandatory training will be provided by the Intermediary on the IRF classification requirements. However, the Intermediary's may at their discretion provide training regarding the IRF classification requirements. Therefore, interested providers should contact the appropriate FI to determine if the FI will be offering training on the IRF classification requirements.

***For further information IRFs should contact the appropriate FI and RO staff if they have any questions regarding the IRF PPS or its classification as an IRF.***

## Future Research Into Rehabilitation Services in Various Settings

In the May 7, 2004 final rule, CMS described the process necessary to develop a future research agenda to assist in determining the data needed to assess the efficacy of rehabilitation services in various settings. In particular, the two questions most in need of objective, outcomes-oriented answers with respect to IRFs are: (1) How better to identify those patients who are most appropriate for intensive medical rehabilitation resources provided in the IRF setting as opposed to alternative care settings (such as acute hospital, skilled nursing facilities, home health rehabilitation or outpatient rehabilitation)? and (2)

What conditions, in addition to those in §412.23(b) typically require the intensive rehabilitation treatment available in IRFs but not in alternative care settings?

The IRF study required by the CAA, 2005 by the GAO is nearing completion and an exit conference between GAO and CMS's Central Office was held. The National Center for Medical Rehabilitation Research at the National Institutes of Health (NIH) is convening a workgroup of experts in the field of rehabilitation for CMS that will utilize the most current clinical information to develop a future research agenda and that research will be used to inform CMS if changes to our revised policies are warranted.

CMS will also be determining the feasibility of periodically holding these types of meetings to identify the latest research findings in this area and potential for future studies to inform CMS in this area. CMS anticipates that it will solicit comments from the public for data and studies through its annual rulemaking process associated with the IRF PPS.

***For further information IRFs should contact the appropriate FI and RO staff if they have any questions regarding the IRF PPS or its classification as an IRF.***