CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 478

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: FEBRUARY 18, 2005

Change Request 3704

SUBJECT:Clarification of the Verification Process to be Used to Determine if the Inpatient Rehabilitation Facility (IRF) Meets The IRF Classification Criteria

I. SUMMARY OF CHANGES: The language changes to the manual, clarify the existing policy that determines if an IRF meets the IRF classification criteria.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : June 25, 2004
IMPLEMENTATION DATE : March 21, 2005

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

II. CHANGES IN MANUAL INSTRUCTIONS:
R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / SubSection / Title
R	3/140/.1/.4 Verification Process To Be Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria
R	3/Appendix A/ Verification of Compliance Using ICD-9-CM and Impairment Group Codes

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 478	Date: February 18, 2005	Change Request 3704

SUBJECT: Clarification of the Verification Process to be Used to Determine if the Inpatient Rehabilitation Facility (IRF) Meets The IRF Classification Criteria

I. GENERAL INFORMATION

The changes that are being made are clarifying existing policies within the IRF PPS.

A. Background: 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 at the start of a facility's cost reporting period. 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. How a hospital or unit is classified takes effect only at the start of the facility's cost reporting period.

B. Policy: 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.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at 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. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3704.1	FI's shall inform providers of the clarifications regarding issues involving cost reporting periods that overlap the time spans associated with an IRF's compliance review period in the classification of IRFs.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: June 25, 2004 **Implementation Date**: March 21, 2005 **Pre-Implementation Contact(s):** August Nemec, X60612 **Post-Implementation Contact(s):** Pete Diaz, X61235	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

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

(Rev. 478, Issued: 02-18-05, Effective: 06-25-04, Implementation: 03-21-05)

A. Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period.

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

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

For cost reporting periods that start on or after July 1, 2007, the compliance percentage threshold that the IRF must meet is 75 percent. However, for cost reporting periods that start on or after July 1, 2004, and on or before June 30, 2007, the compliance percentage threshold that an IRF must meet changes in accordance with the requirements specified in §140.1.1B. Accordingly, how the compliance percentage threshold is calculated will vary.

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

When an IRF has a cost reporting period that starts on or after July 1, 2004, and the compliance review period has portions of time that are associated with only one cost reporting period (for example, but not only, a new IRF), and the IRF had a patient population in each portion of the compliance review period used to calculate the compliance threshold percentage, the weighed averages of the number of cases in each portion of the compliance review period are added together to determine if a compliance percentage as specified above in §140.1.1B was met during the entire compliance review

period. The weighed averages for each portion of the compliance review period represents the percentage of patients in that portion of the compliance review period that met one or more of the medical conditions listed above in §140.1.1C.

Below is one method for calculating the compliance percentage for each portion of the compliance review period and adding the portion percentages together:

In this example, the compliance review period is a total of 12 months and one portion of the compliance review period is 4 months, and the other portion is 8 months.

The total number of patients in the entire compliance review period is 314.

114 of the total 314 patients are associated with the 4- month portion of the compliance review period and 57 of these 114 patients met one or more of the conditions listed above in §140.1.1C.

200 of the total 314 patients are associated with the 8- month portion of the compliance review period and 140 of these 200 patients met one or more of the conditions listed above in §140.1.1C.

57/114=0.5000 140/200=0.7000

114/314=0.36305 200/314=0.63694

0.5000 X 0.36305=0.181525
0.7000 X 0.63694=0.445858

0. 181525 + 0.445858 =0.627383 which is rounded to 63 percent.

The automated report generated under the presumptive test methodology will contain the data necessary to compute the weighted averages for each portion of the compliance review period. As shown in the table entitled "Inpatient Rehabilitation Provider Eligibility (50% rule)", use the numbers shown in the columns entitled "Submitted Assmts" and "Elig. Assmts" to compute the weighted averages shown above.

Inpatient Rehabilitation Provider Eligibility (50% Rule)
Any Fiscal Intermediary

State	Prov. Num.	Prov. Name	Cost Report Period	Compl. Review Period	Init. 4 Mth. Rvw. Pd.	Submit. Assmts.	Elig. Assmts.	Percent	Subseq. Rvw. Pd.	Submit Assmts.	Elig. Assmts.	Percent
CA	053--	Best Rehab	7/1/05 To 6/30/06	7/1/04 To 2/28/05	7/1/04 To 10/31/04	114	57	50%	11/1/04 To 2/28/05	200	140	70%

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

When an IRF has a cost reporting period that starts on or after July 1, 2004, and on or before June 30, 2005, and the compliance review period has portions of time that are associated with two cost reporting periods, and the IRF had a

patient population in each portion of the compliance review period used to calculate the compliance threshold percentage, the weighed averages of each portion of the compliance review period are added together to determine if a compliance percentage as specified above in §140.1.1B was met during the entire compliance review period.

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

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

2. Guideline To Determine The Compliance Review Period For IRFs With Cost Reporting Periods That Start Between July 1, 2004, and October 31, 2004.

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

3. Table Of Compliance Review Periods.

For a facility that has been classified as an IRF but is not a "new" IRF as defined below in §140.1.7, the following table illustrates how both the General Guideline To Determine The Compliance Review Period, and the Guideline To Determine The Compliance Review Period For IRFs With Cost Reporting Periods That Start Between July 1, 2004, and October 31, 2004 are used to calculate the applicable compliance review time period. For cost reporting periods that start on or after July 1, 2004, the following table illustrates the compliance review periods and the compliance percentage threshold that must be met during each compliance review period:

Table Of Compliance Review Periods

For Cost Reporting Periods Beginning On:	**Review Period: (Admissions *or Discharges* During)**	**Number Of Months In Review Period**	***Compliance Percentage Threshold Associated With A Compliance Review Period Or Portions Of the Compliance Review Period***	**Compliance Determination Applies To Cost Reporting Period Beginning On:**
07/01/2004	07/01/2004-02/28/2005	8	*07/01/2004 to 02/28/2005: 50 %*	07/01/2005
08/01/2004	07/01/2004-	9	*07/01/2004 to 03/31/2005: 50*	08/01/2005

	03/31/2005		*%*	
09/01/2004	07/01/2004-04/30/2005	10	*07/01/2004 to 04/30/2005: 50 %*	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	*07/01/2004 to 05/31/2005: 50 %*	10/01/2005
11/01/2004	07/01/2004-06/30/2005	12	*07/01/2004 to 06/30/2005: 50 %*	11/01/2005
12/01/2004	08/01/2004-07/31/2005	12	*08/01/2004 to 07/31/2005: 50 %*	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	*09/01/2004 to 08/31/2005: 50 %*	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	*10/01/2004 to 09/30/2005: 50 %*	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	*11/01/2004 to 10/31/2005: 50 %*	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	*12/01/2004 to 11/30/2005: 50 %*	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	*01/01/2005 to12/31/2005: 50 %*	05/01/2006
06/01/2005	02/01/2005-01/31/2006	12	*02/01/2005 to 01/31/2006: 50 %*	06/01/2006
07/01/2005	03/01/2005-02/28/2006	12	*03/01/2005 to 06/30/2005: 50 %* *07/01/2005 to 02/28/2006: 60 %*	07/01/2006
08/01/2005	04/01/2005-03/31/2006	12	*04/01/2005 to 07/31/2005: 50 %* *08/01/2005 to 03/31/2006: 60 %*	08/01/2006
09/01/2005	05/01/2005-04/30/2006	12	*05/01/2005 to 08/31/2005: 50 %* *09/01/2005 to 04/30/2006: 60 %*	09/01/2006
10/01/2005	06/01/2005-05/31/2006	12	*06/01/2005 to 09/30/2005: 50 %* *10/01/2005 to 05/31/2006: 60 %*	10/01/2006
11/01/2005	*07/01/2005-06/30/2006*	*12*	*07/01/2005 to 10/31/2005: 50 %* *11/01/2005 to 06/30/2006: 60 %*	*11/01/2006*
12/01/2005	*08/01/2005-07/31/2006*	*12*	*08/012005 to 11/30/2005: 50 %* *12/01/2005 to 07/31/2006: 60 %*	*12/01/2006*

01/01/2006	*09/01/2005-08/31/2006*	*12*	*09/01/2005 to 12/31/2005: 50 % 01/01/2006 to 08/31/2006: 60 %*	*01/01/2007*
02/01/2006	*10/01/2005-09/30/2006*	*12*	*10/01/2005 to 01/31/2006: 50 % 02/01/2006 to 09/30/2006: 60 %*	*02/01/2007*
03/01/2006	*11/01/2005-10/31/2006*	*12*	*11/01/2005 to 02/28/2006: 50 % 03/01/2006 to 10/31/2006: 60 %*	*03/01/2007*
04/01/2006	*12/01/2005-11/30/2006*	*12*	*12/01/2005 to 03/31/2006: 50 % 04/01/2006 to 11/30/2006: 60 %*	*04/01/2007*
05/01/2006	*01/01/2006-12/31/2006*	*12*	*01/01/2006 to 04/30/2006: 50 % 05/01/2006 to 12/31/2006: 60 %*	*05/01/2007*
06/01/2006	*02/01/2006-01/31/2007*	*12*	*02/01/2006 to 05/31/2006: 50 % 06/01/2006 to 01/31/2007: 60 %*	*06/01/2007*
07/01/2006	*03/01/2006-02/28/2007*	*12*	*03/01/2006 to 06/30/2006: 60 % 07/01/2006 to 02/28/2007: 65 %*	*07/01/2007*
08/01/2006	*04/01/2006-03/31/2007*	*12*	*04/01/2006 to 07/31/2006: 60 % 08/01/2006 to 03/31/2007: 65 %*	*08/01/2007*
09/01/2006	*05/01/2006-04/30/2007*	*12*	*05/01/2006 to 08/31/2006: 60 % 09/01/2006 to 04/30/2007: 65 %*	*09/01/2007*
10/01/2006	*06/01/2006-05/31/2007*	*12*	*06/01/2006 to 09/30/2006: 60 % 10/01/2006 to 05/31/2007: 65 %*	*10/01/2007*
11/01/2006	*07/01/2006-06/30/2007*	*12*	*07/01/2006 to 10/31/2006: 60 % 11/01/2006 to 06/30/2007: 65 %*	*11/01/2007*
12/01/2006	*08/01/2006-07/31/2007*	*12*	*08/01/2006 to 11/30/2006: 60 %*	*12/01/2007*

			12/01/2006 to 07/31/2007: 65 %	
01/01/2007	*09/01/2006-08/31/2007*	*12*	*09/01/2006 to 12/31/2006: 60 %* *01/01/2007 to 08/31/2007: 65 %*	*01/01/2008*
02/01/2007	*10/01/2006-09/30/2007*	*12*	*10/01/2006 to 01/31/2007: 60 %* *02/01/2007 to 09/30/2007: 65 %*	*02/01/2008*
03/01/2007	*11/01/2006-10/31/2007*	*12*	*11/01/2006 to 02/28/2007: 60 %* *03/01/2007 to 10/31/2007: 65 %*	*03/01/2008*
04/01/2007	*12/01/2006-11/30/2007*	*12*	*12/01/2006 to 03/31/2007: 60 %* *04/01/2007 to 11/30/2007: 65 %*	*04/01/2008*
05/01/2007	*01/01/2007-12/31/2007*	*12*	*01/01/2007 to 04/30/2007: 60 %* *05/01/2007 to 12/31/2007: 65 %*	*05/01/2008*
06/01/2007	*02/01/2007-01/31/2008*	*12*	*02/01/2007 to 05/31/2007: 60 %* *06/01/2007 to 01/31/2008: 65 %*	*06/01/2008*
07/01/2007	*03/01/2007-02/29/2008*	*12*	*03/01/2007 to 06/30/2007: 65 %* *07/01/2007 to 02/29/2008: 75 %*	*07/01/2008*
08/01/2007	*04/01/2007-03/31/2008*	*12*	*04/01/2007 to 07/31/2007: 65 %* *08/01/2007 to 03/31/2008: 75 %*	*08/01/2008*
09/01/2007	*05/01/2007-04/30/2008*	*12*	*05/01/2007 to 08/31/2007: 65 %* *09/01/2007 to 04/30/2008: 75 %*	*09/01/2008*
10/01/2007	*06/01/2007-05/31/2008*	*12*	*06/01/2007 to 09/30/2007: 65 %* *10/01/2007 to 05/31/2008: 75 %*	*10/01/2008*
11/01/2007	*07/01/2007-06/30/2008*	*12*	*07/01/2007 to 10/31/2007: 65 %* *11/01/2007 to 06/30/2008: 75 %*	*11/01/2008*

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

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

4. Guideline For Determining The Compliance Review Period Of A Facility Classified As A New IRF, And For An IRF Expanding Its Size.

In order for an IRF to be classified as a new IRF, or to add new bed capacity, it must meet the criteria specified in the regulations and below in §140.1.7. A facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is similar to an IRF whose cost reporting period begins on July 1, 2004. In other words, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2004, and is a new IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is 8 months in length, in order to allow the RO and FI a 4-month time period to make and administer a compliance determination.

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

5. Guideline For Determining The Compliance Review Period Of A Facility Undergoing Conversion To An IRF.

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

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

6. Guideline For Determining The Compliance Review Period Of A Facility That Changes Its Cost Reporting Period.

A facility that changes its cost reporting period will have a compliance review period that, in accordance with the above table, is based on its new cost reporting period.

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

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 Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population. The IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population only if the IRF's total inpatient population is made up of 50 percent or more of Medicare Part A fee-for-service inpatients. In order to verify that the IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total patient population, the FI in writing will instruct the IRF to send to the FI, by a specific date, a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the CMS or the FI. 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 Part A fee-for-service, and using that data will determine if the IRF's Medicare Part A fee-for-service 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 Part A fee-for-service 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 *presumptively* complied with the criteria specified above in §140.1.1B, CMS will enable the FI to access CMS' IRF-PAI data

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

FI List Of IRFs Of The FI (Then Specify The FI's Name)

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

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

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

b. *When the FI accesses the IRF-PAI data records* the FI will *be able to generate a report using* the IRF-PAI information *which was previously* submitted by the IRFs that submit claims to that FI. *The software that the FI will use to generate the report will automatically use the* specific ICD-9-CM and impairment group codes *that are listed in this chapter in Appendix A* to determine if a particular IRF is *presumptively* in compliance with the requirements specified above in §140.1.1B. *Prior to generating a report that the FI will use to determine if the IRF has presumptively complied with the*

requirements specified above in §140.1.1B, the FI must allow the IRF to decide if the IRF prefers the data records that the FI will use to generate the report to be either the IRF-PAI data records of patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

c. An IRF whose inpatient Medicare Part A fee-for-service population reflects its total inpatient population and that, according to the report generated using the procedure specified above in 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 inpatient population that meets the requirements specified above in §140.1.1B. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B, the RO and FI still have the discretion to instruct the IRF to send to the RO or FI specific sections of the medical records of a random sample of inpatients, or specific sections of the medical records of inpatients identified by other means by CMS or the FI.

d. 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 *presumptive* compliance with the requirements specified above in §140.1.1B.

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

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

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. *However, prior to selecting the sample number of inpatients, the FI must allow the IRF to decide if the IRF wants the sample to contain either the patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or the patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.* If the confidence level of the statistic derived from the sample is not at least 95 percent then the FI will adjust the sample or if necessary use the entire inpatient population to determine if the IRF meets the requirements as specified above in §140.1.1B. In addition, if an IRF during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI, had a total inpatient population of 100 inpatients or less, the FI will use the total inpatient population that consists of Medicare and non-Medicare inpatients as the random sample size. The FI will instruct the IRF to send it copies of specific sections of the medical records of inpatients, using the random sample of inpatients selected from the list to identify which inpatients are selected. The FI has the discretion to decide which specific sections of the medical records of the inpatients to obtain, provided that the requested medical record sections contain enough information to allow the FI's reviewers to determine what was the inpatient's medical condition(s) that the IRF treated. In addition to submitting to the FI the sections of the medical records of the random sample inpatients specified by the FI, the IRF has the discretion to send the FI other clinical information regarding these same inpatients. The admission and discharge dates as specified in the medical record sections obtained by the FI must be for the most recent, consecutive, and appropriate 12-month period as defined by CMS or the FI.

The FI will examine the medical records sections obtained and determine if the IRF meets the requirements as specified above in §140.1.1B. When determining if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the FI may use the ICD-9-CM and impairment group codes specified below in Appendix A to this chapter as guidance, or make that determination based upon only the medical judgment of its reviewer(s), or use a combination of both methods. *In general, when the FI is using a sample of medical records to determine compliance by the IRF with the requirements in §140.1.1B, the FI always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the presumptive test methodology described above.*

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.

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.

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.

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.

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.

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

(Rev. 478, Issued: 02-18-05, Effective: 06-25-04, Implementation: 03-21-05)

The following ICD-9-CM and impairment group codes from the IRF-PAI database will be used to presumptively verify compliance with the requirements specified above in §140.1.1B. The verification procedure the FI will use is specified above in §140.1.4B(1) "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument Data Records." The instructions specified above in §§140.1.4B(1) and 140.1.4B(2), and in this Appendix, are to be used by the FI when the FI is verifying compliance with the requirements specified above in §140.1.1B. The instructions in §§140.1.4B(1) and 140.1.4B(2), and this Appendix, are not intended to be used to complete the IRF-PAI. To complete the IRF-PAI, an IRF must use the instructions in the IRF-PAI manual, and any other CMS approved instructions that specifically state how to complete the IRF-PAI. The codes in this Appendix are not intended to be used as part of the instructions when completing the IRF-PAI. This Appendix is only to be used by the FI when it is determining if a facility meets the requirements to be classified as an IRF.

An inpatient, as represented by an IRF-PAI assessment data record, is presumptively determined as being included in the count when the calculation is performed that determines if the compliance thresholds specified in §140.1.1B were met if, except as noted below, the IRF-PAI item number 21 "impairment group" code, or the IRF-PAI item number 22 "etiologic diagnosis" ICD-9-CM code, or the IRF-PAI item number 24a through 24j "comorbid conditions" ICD-9-CM code matches one of the codes listed in the table below. Specifically, in accordance with the verification procedure specified above in §140.1.4B(1), in order for the IRF-PAI assessment data record, and, thus, the inpatient, to be presumptively counted when calculating if the applicable compliance threshold specified in §140.1.1B was met, the data record must have an impairment group code that matches one of the codes specified in the table column below labeled "REHABILIATION IMPAIRMENT GROUP CODES*", or an etiologic diagnosis or comorbid condition ICD-9-CM code that matches one of the codes specified in the table column below labeled "ICD-9-CM CODES **." However, as illustrated in the table below, if a specific impairment group code is paired with a specific etiologic diagnosis (IRF-PAI item 22) ICD-9-CM code within the same IRF-PAI data record, that pairing will result in that inpatient NOT being presumptively counted in the calculation when the determination is made regarding if the compliance threshold specified in §140.1.1B was met. For example, if an IRF-PAI data record specified both the impairment group code 05.2 (amputation, unilateral upper extremity below the elbow), and an etiologic diagnosis ICD-9-CM code that was either 885.0, or 885.1, or 886.0, or 886.1, then that inpatient is not presumptively counted when the calculation is made that determines if the compliance threshold specified in §140.1.1B was met.

MEDICAL	REHABILIATION	ICD-9-CM CODES **

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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