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Information for Medicare Fee-for-Service Health Care Professionals

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Clarification of the Verification Process To Be Used to Determine if the Inpatient Rehabilitation Facility (IRF) Meets the IRF Classification Criteria

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Inpatient Rehabilitation Facilities (IRFs)

Provider Action Needed

This article includes information contained in Change Request (CR) 3704 that clarifies certain portions of the verification process used to determine if an IRF meets the classification criteria needed to be paid under the IRF Prospective Payment System (PPS), especially issues regarding the time spans associated with an IRF's compliance review period. For earlier information regarding IRF classification requirements, see related MLN Matters article MM3503, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3503.pdf> on the CMS website.

Background

The Social Security Act (Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii)) gives the Centers for Medicare & Medicaid Services (CMS) the discretion to define an IRF. In addition, the Code of Federal Regulations (CFR, Title 42, Sections 412.22, 412.23(b), 412.25, 412.29, and 412.30) specifies that the criteria for a provider 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).

When a determination has been made by the CMS RO (RO) that a facility is classified as an IRF, the classification applies to the entire cost reporting period for which the determination is made. Also, 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.

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ROs generally make these determinations on an annual basis at the start of a facility's cost reporting period, and the hospital's or unit's classification takes effect only at the start of the facility's cost reporting period.

Clarification of the General Guideline to Determine the Compliance Review Period

In general, the RO and your Medicare Fiscal Intermediary (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, titled "Table of Compliance Review Periods," illustrates the time spans associated with an IRF's compliance review period.

The compliance percentage that the IRF must meet for a specific cost reporting period will gradually increase until the compliance threshold that must always be met is 75 percent. The 75 percent threshold must be met for cost reporting periods that begin on or after July 1, 2007. (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 *Chapter 3, Section 140.1.1B* of the Medicare Claims Processing Manual.)

Depending on the specific compliance review period, a compliance review period may:

- Include a span of time from only one cost reporting period; or
- Span periods of time from two cost reporting periods.

When a compliance review period spans time periods from two cost reporting periods:

- One portion of a compliance review time period will be part of a span of time from one cost reporting period; and
- The other portion of the same compliance review time period will be part of a span of time from a different cost reporting period.

The weighed averages of each portion of the compliance review period are added together to determine if a compliance percentage as specified in §140.1.1B (Medicare Claims Processing Manual (Pub 100-04), Chapter 3) was met during the entire compliance review period when:

- An IRF has a cost reporting period that starts on or after July 1, 2004; and

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- The compliance review period has portions of time that are associated with only one cost reporting period (such as, 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 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 in §140.1.1C (Medicare Claims Processing Manual (Pub 100-04), Chapter 3).

Example

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:
 - 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 in §140.1.1C (Pub 100-04, Chapter 3);
 - 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 in §140.1.1C (Pub 100-04, Chapter 3).
- Calculations:
 - 1) $57/114=0.5000$ and $140/200=0.7000$
 - 2) $114/314=0.36305$ and $200/314=0.63694$
 - 3) $0.5000 \times 0.36305=0.181525$, and $0.7000 \times 0.63694=0.445858$
 - 4) $0.181525 + 0.445858 = 0.627383$, which is rounded to 63 percent

Note: A discussion of the actual report used by FIs to determine eligibility may be found in CR 3704.

The weighed averages of each portion of the compliance review period are added together to determine if a compliance percentage as specified in §140.1.1B (Medicare Claims Processing Manual (Pub 100-04), Chapter 3) was met during the entire compliance review period when an IRF has the following:

- A cost reporting period that starts on or after July 1, 2004, and on or before June 30, 2005;

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- 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.

For cost reporting periods starting on or after July 1, 2005 and the compliance review period spans two cost reporting periods:

It will be determined that the compliance percentage was met for the entire compliance percentage review period when an IRF has the following:

- 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; and
- Each portion of the compliance review period separately met the compliance percentage threshold of the cost reporting period that includes that portion of time of the compliance 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 titled 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 in §140.1.1B (Pub 100-04, Chapter 3), 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 in §140.1.1B (Pub 100-04, Chapter 3), a compliance threshold of 60 percent for the cost reporting period of July 1, 2005, to June 30, 2006; and
- 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
- 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.

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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:

- 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.

Table of Compliance Review Periods

For a facility that has been classified as an IRF but is not a “new” IRF as defined in §140.1.7 (Pub 100-04, Chapter 3), the following table illustrates the “General Guideline To Determine The Compliance Review Period.” (Note that CR 3704, which may be accessed at <http://www.cms.hhs.gov/transmittals/downloads/R478CP.pdf> on the CMS website.

CR3704 provides more details for facilities whose cost reporting periods begin between July 1, 2004, and October 31, 2004.): For cost reporting periods that start on or after July 1, 2004, the following are the compliance review periods.

Table of Compliance Review Periods

For Cost Reporting Periods Beginning On:	Review Period: (Admissions or Discharges During)	# 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	07/01/2004-03/31/2005	9	07/01/2004 to 03/31/2005: 50%	08/01/2005
09/01/2004	07/01/2004-04/30/2005	10	07/01/2004 to 04/30/2005: 50%	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	07/01/2004 to 05/31/2005: 50%	10/01/2005
11/01/2004	07/01/2004-06/30/2005	12	07/01/2004 to 06/30/2005: 50%	11/01/2005
12/01/2004	08/01/2004-07/31/2005	12	08/01/2004 to 07/31/2005: 50%	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	09/01/2004 to 08/31/2005: 50%	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	10/01/2004 to 09/30/2005: 50%	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	11/01/2004 to 10/31/2005: 50%	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	12/01/2004 to 11/30/2005: 50%	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	01/01/2005 to 12/31/2005: 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 06/30/2006: 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

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For Cost Reporting Periods Beginning On:	Review Period: (Admissions or Discharges During)	# 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:
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	08/01/2005 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% 12/01/2006 to 07/31/2007: 65%	12/01/2007
01/01/2007	09/01/2006-08/31/2007	12	09/01/2006 to 12/31/2006: 60% 01/01/2007 to 08/31/2007: 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

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For Cost Reporting Periods Beginning On:	Review Period: (Admissions or Discharges During)	# 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:
07/01/2007	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; then 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, thereby giving the ROs and FIs a 4-month time period to make and administer a compliance determination.

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Clarification of the Data Used to Determine Compliance with the Classification Criteria

Starting on July 1, 2004, the FI will use certain data in the verification process as specified in §140.1.4 (Pub 100-04, Chapter 3). The verification procedure specified in section 140.1.4B1 will be used only if the FI verifies that the IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of the IRF's total inpatient population. The IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of 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.

To verify that the IRF's Medicare Part A fee-for-service inpatient population reflects the makeup of 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;
- 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); then
- 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.

Note: 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 CMS 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
- 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

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- 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 (Pub 100-04, Chapter 3).

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

To determine if a facility has presumptively complied with the criteria specified in §140.1.1B (Pub 100-04, Chapter 3), 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.

When the FI accesses the IRF-PAI data records the FI will be able to generate a report using the IRF-PAI information that 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 Appendix A (Pub 100-04, Chapter 3) to determine if a particular IRF is presumptively in compliance with the requirements specified in §140.1.1B (Pub 100-04, Chapter 3). Note: Appendix A is attached to CR 3704, which may be accessed at

<http://www.cms.hhs.gov/transmittals/downloads/R478CP.pdf> on the CMS website.

Prior to generating a report that the FI will use to determine if the IRF has presumptively complied with the requirements specified in §140.1.1B (Pub 100-04, Chapter 3), 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.

An IRF will be presumed by the FI as having a total inpatient population that meets the requirements specified in §140.1.1B (Pub 100-04, Chapter 3) if

- Their inpatient Medicare Part A fee-for-service population reflects its total inpatient population and
- It is determined (according to the report described in CR3704 and used by FIs to determine eligibility) by the FI that the requirements specified in §140.1.1B (Pub 100-04, Chapter 3) were presumably met.

However, even when an IRF is presumed to have met the requirements specified in §140.1.1B (Pub 100-04, Chapter 3), 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 Inpatients identified by other means by CMS or the FI.

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

The FI must use the IRF's total patient population to verify that the IRF has met the requirements specified in §140.1.1B (Pub 100-04, Chapter 3) if:

- The IRF's Medicare Part A fee-for-service population does not reflect its total patient population;

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- The FI is unable to generate a valid report using the IRF-PAI database methodology specified previously; or
- The FI generates a report which demonstrates that the IRF has not met the requirements specified in §140.1.1B (Pub 100-04, Chapter 3).

The presumptive determination that the IRF did not meet the requirements specified in §140.1.1B (Pub 100-04, Chapter 3) will occur in the case in which:

- The Medicare Part A fee-for-service inpatients make up less than 50 percent of the IRF inpatient population;
- 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 FI will use generally accepted statistical sampling techniques to determine the makeup of 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:

- 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 in §140.1.1B (Pub 100-04, Chapter 3).

Implementation

The implementation date for this instruction is March 21, 2005.

Additional Information

The official instruction (CR 3704) issued to your Medicare intermediary regarding this change may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R478CP.pdf> on the CMS website.

This instruction includes Appendix A, the list of ICD-9-CM and Impairment Group Codes. It also includes key provisions of Chapter 3, Section 140 of the Medicare Claims Processing Manual, including a discussion of the report FIs use to determine a facility's eligibility. This article deals mainly with the clarifications attached to CR 3704 as the basic policies are unchanged.

Also, for earlier information regarding IRF classification requirements, see related MLN Matters article MM3503, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3503.pdf> on the CMS website.

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If you have any questions, please contact your intermediary at their toll-free number found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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