Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: MM3334
Related Change Request (CR) #: 3334
Related CR Release Date: June 25, 2005
Effective Date: July 1, 2004
Related CR Transmittal #: R221CP
Implementation Date: July 1, 2004

Medicare Inpatient Rehabilitation Facility Classification Requirements

Note: This article was updated on April 5, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Rehabilitation hospitals and rehabilitation units: both are referred to as Inpatient Rehabilitation Facilities (IRFs).

Provider Action Needed

Hospitals and rehabilitation units must meet the criteria specified in regulations 42 CFR 412.23 (b), 412.25, and 412.29 to be eligible for payment under the IRF prospective payment systems. A rehabilitation hospital and rehabilitation unit are both now referred to as IRFs. The Centers for Medicare & Medicaid Services (CMS) recently issued guidance to Medicare fiscal intermediaries (FIs) regarding the criteria that a facility must meet to be classified as an IRF. This article provides that guidance.

Background

Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Social Security Act provide authority for defining which inpatient facilities may be classified as inpatient rehabilitation hospitals and as acute care hospital rehabilitation units. An inpatient rehabilitation hospital and an acute care hospital rehabilitation unit are collectively referred to as an inpatient rehabilitation facility (IRF) under the IRF prospective payment system (PPS).

On January 3, 1984, CMS published a final rule, "Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services" (49 CFR 234), which specified that for classification as an IRF, 75 percent of the IRF's total patient population during the IRF's cost reporting period must match one or more of the ten medical conditions listed in 42 CFR 405.471. This final rule provision became known as the "75-percent rule." The IRF's FI was responsible for verifying whether the IRF's total patient population met the 75 percent rule.

On March 29, 1985, CMS published a final rule, "Medicare Program; Prospective Payment System for Hospital Inpatient Services: Redesignation of Rules" (50 CFR 12740). That rule redesignated the provisions of 42 CFR 405.471 that addressed the 75-percent rule as a provision under 42 CFR 412.23(b) (2).

The regulations at 42 CFR 412.25, and 412.29 refer to 42 CFR 412.23(b) (2) as one of the criteria a provider must meet to be classified as an IRF. Hospitals and units that met the criterion specified in 42 CFR 412.23(b) (2), as well as other criteria, were eligible to be paid under the IRF PPS.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results of the verification procedure are used in determining each facility's classification status for the next cost reporting period.

IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis, an IRF must self-attest (except for the medical condition criterion specified above and certain other criteria) that it still meets all the criteria for being classified as an IRF. Your FI is always required to verify that your IRF has met the medical condition criterion.

Changes to the Classification Criteria

On May 7, 2004, CMS published a final rule entitled "Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility." In this final rule CMS changed the:

- Percentage of the IRF's total patient population that must match one or more of the medical conditions; and
- Medical conditions previously specified in the regulations.

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

Cost reporting period	Minimum percent requirements for inpatients served who required intensive rehabilitative services for treatment of one or more of the medical conditions specified in the "List of Medical Conditions" table below.	Cost reporting period
Beginning on or after July 1, 2004 and before July 1, 2005	50 percent	Beginning on or after July 1, 2004 and before July 1, 2005
Beginning on or after July 1, 2005 and before July 1, 2006	60 percent	Beginning on or after July 1, 2005 and before July 1, 2006
Beginning on or after July 1, 2006 and before July 1, 2007	65 percent	Beginning on or after July 1, 2006 and before July 1, 2007
Beginning on or after July 1, 2007	75 percent	Beginning on or after July 1, 2007

List of Medical Conditions - The list of medical conditions is shown in the table below:

	Medical Condition	Additional comments and requirements pertaining to the condition
1.	Stroke	
2.	Spinal cord injury	
3.	Congenital deformity	
4.	Amputation	
5.	Major multiple trauma	
6.	Femur fracture (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.	The noted conditions must result 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 Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

	Medical Condition	Additional comments and requirements pertaining to the condition
		The related CR3334 provides guidance regarding therapy. The medical review staff of the FI has the discretion to define: What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and When a systemic disease activation immediately before admission has occurred.
11.	Systemic vasculidities with joint inflammation	The noted condition must result 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 Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance regarding therapy. The medical review staff of the FI has the discretion to define: What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and When a systemic disease activation immediately before admission has occurred.
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	The noted condition must result 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 Result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. The related CR3334 provides guidance on therapy. The medical review staff of the FI has the discretion to define: What is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission; and When a systemic disease activation immediately before admission has occurred. Please note, a joint replaced by prosthesis is no longer 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	This condition must also meet one or more of the following specific criteria; the patient: Underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission;

	Medical Condition	Additional comments and requirements pertaining to the condition
		Is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; Is age 85 or older at the time of admission to the IRF

Written Certification

A hospital that seeks classification as an IRF for a cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the medical condition requirement specified above, instead of showing that it has treated an inpatient population that met the medical condition requirement during its most recent cost reporting period.

The written certification is also effective for a cost reporting period of not less than one month and not more than 11 months occurring between the dates the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the medical condition requirement specified above but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively.

The FI effects this payment adjustment to the hospital by calculating the difference between:

- The amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion; and
- The amount that would have been paid if the hospital, unit, or beds had not been excluded from the PPS.

The FI then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

Additional Information

If you have questions regarding this issue, you may also contact your FI on their toll free number. The toll free number for your intermediary may be found online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website..

The official instruction issued to the intermediary regarding this change can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R221CP.pdf on the CMS website.