CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 347 **Date: OCTOBER 29, 2004**

CHANGE REQUEST 3503

SUBJECT: Inpatient Rehabilitation Facility (IRF) Classification Requirements

I. SUMMARY OF CHANGES: This Change Request makes coding corrections and language clarifications for IRF classification requirements.

MANUALIZATION/CLARIFICATION - Effective Date: N/A
Implementation Date: November 29, 2004

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION.SUBSECTION-TITLE
R	3/140/.1-Medicare IRF Classification Requirements
R	3/140/.1/.1-Criteria That Must Be Met By Inpatient Rehabilitation Hospitals
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: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 347	Date: October 29, 2004	Change Request 3503

SUBJECT: Medicare Inpatient Rehabilitation Facility (IRF) Classification Requirements

I. GENERAL INFORMATION

The changes that are being made include coding corrections as well as clarifying existing policies within the IRF Prospective Payment System (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 shall 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 (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3503	FI's must inform providers of the clarifications made 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*: N/A **Implementation Date:** November 29, 2004 **Pre-Implementation Contact(s):** August Nemec (410) 786-0612 **Post-Implementation Contact(s):** Pete Diaz (410) 786-1235	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

140.1-Medicare IRF Classification Requirements

(Rev. 347, Issued: 10-29-04, Effective: N/A, Implementation: 11-29-04)

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

A determination by the Regional Office (RO) that a facility is classified as an IRF applies to the entire cost reporting period for which the determination is made. The ROs generally make these determinations on an annual basis *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.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. In addition, the results of the verification procedure are used in determining each facility's classification status for the next cost reporting period. *If a facility fails to meet the criteria necessary to be classified as an IRF, but meets the criteria to be classified as an acute care hospital or acute care hospital unit, it may be paid under the acute care hospital PPS. For the services furnished to a patient who was admitted when the facility was classified as an IRF, but who is discharged after the facility is no longer classified as an IRF, payment to the facility will be from the applicable payment system the facility is paid under when the facility is no longer classified as an IRF.* The IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis an IRF must self-attest, except for the criteria specified below in §140.1.1B, that it still meets the criteria for being classified as an IRF. The fiscal intermediary (FI) is always required to verify that an IRF has met the criteria specified below in §140.1.1B. The facility must have approval from the RO and the State Agency prior to making changes in operations. All IRFs are notified by letter by the appropriate CMS RO of the self-attestation procedures, and other procedures and requirements that apply to them. The FI is not responsible for monitoring or enforcing IRF self-attestation procedures.

140.1.1-Criteria That Must Be Met By Inpatient Rehabilitation Hospitals

(Rev. 347, Issued: 10-29-04, Effective: N/A, Implementation: 11-29-04)

A rehabilitation hospital is excluded from the acute care hospital PPS if it meets all of the following criteria.

A. The hospital has in effect an agreement to participate as a hospital.

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

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006, the hospital must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

3. For cost reporting periods beginning on or after July 1, 2006, and before July 1, 2007, the hospital must have served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at §140.1.1C.

4. For cost reporting periods beginning on or after July 1, 2007, the hospital must have served an inpatient population of whom of at least 75 percent required intensive rehabilitative services for the treatment of one or more of the medical conditions specified below at §140.1.1C.

C. List of Medical Conditions:

1. Stroke.

2. Spinal cord injury.

3. Congenital deformity.

4. Amputation.

5. Major multiple trauma.

6. Fracture of femur (hip fracture).

7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson’s disease.

9. Burns.

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in

the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

For the medical conditions specified above in subsections 10, 11, and 12, the FI has the discretion to review documentation in order to assure that an inpatient has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. We expect that the IRF will obtain copies of the therapy notes from the outpatient therapy or therapy in another less intensive setting and place it in the patient's inpatient chart (in a section for prior records). We believe that these prior records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available to FI staff who reviews the medical records for compliance with the requirements specified above in §140.1.1B.

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

D. A hospital that seeks classification as an IRF for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the requirements specified above in §140.1.1B, instead of showing that it has treated the inpatient population specified above in §140.1.1B during its most recent 12-month cost reporting period. The written certification is also effective for a cost reporting period of not less than 1 month and not more than 11 months occurring between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period. However, if the hospital does not actually meet the requirements specified above in §140.1.1B during any cost reporting period that it has certified it would meet the requirements specified above in §140.1.1B, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.8.

E. The hospital has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment.

F. The hospital ensures that patients receive close medical supervision and furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services.

G. The hospital has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

H. The hospital uses a coordinated multi-disciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record, to note the patient's status in relationship to goal attainment, and ensures that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.

I. The hospital has a director of rehabilitation who provides services to the hospital and its inpatients on a full time basis, is a Doctor of Medicine or Osteopathy, is licensed under state law to practice medicine or surgery, and has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

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

(Rev. 347, Issued: 10-29-04, Effective: N/A, Implementation: 11-29-04)

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.

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, and on or before October 1, 2005, the following are the compliance review periods.

Table Of Compliance Review Periods

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

As illustrated in the above table, if a cost reporting period starts on or after July 1, 2004, and before November 1, 2004, data from a compliance review period that is less than 12 months in length will be used to determine if the facility met all of the criteria necessary to qualify it to be classified as an IRF for the next cost reporting period. For cost reporting periods beginning on or after November 1, 2004, data from the most recent,

consecutive, and appropriate 12-month period of time would be used, giving the ROs and FIs a 4-month time period to make and administer a compliance determination.

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 complied with the criteria specified above in §140.1.1B, CMS will enable the FI to access CMS' IRF-PAI

data records. Specifically, each FI will be allowed to access only the IRF-PAI information submitted by the IRFs that submit claims to that FI. The FI must coordinate with their CMS *RO* to obtain privileges to obtain access to the IRF-PAI information. The FI will provide the RO with user information from all the FI staff that is required to access the IRF-PAI data records.

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

c. An IRF whose inpatient Medicare *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. The CMS Central Office and RO staff have the discretion to require that each FI, on a quarterly or more frequent basis, submit a report that shows the status of the level of compliance by a FI's IRFs with the requirements specified above in §140.1.1B.

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

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

a. The FI must use the IRF's total patient population to verify that the IRF has met the requirements specified above in §140.1.1B if: (i) the IRF's Medicare population does not reflect its total patient population; or (ii) if the FI is unable to generate a valid report using the IRF-PAI database methodology specified previously; or (iii) if the FI generates a report which demonstrates that the IRF has not met the requirements specified above in §140.1.1B. In the case where the Medicare *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. 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 according to paragraph (b) above 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.*

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

C. If a rehabilitation hospital is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the criteria specified above in §140.1.1E-H will be presumed to have been met. However, in all instances the FI must verify that the requirements specified above in §140.1.1B were met. In addition, the State Agency is

required to verify that the rehabilitation hospital has a Director of Rehabilitation who meets the requirements specified above in §140.1.1I.

D. If a rehabilitation hospital is not currently accredited by CARF then the State Agency will determine whether the criteria specified above in §140.1.1E-I were met. In addition, in all instances the FI must verify that the requirements specified above in §140.1.1B were met.

E. If a rehabilitation unit is currently accredited by CARF the criteria specified above in §140.1.1E-H will be presumed to be met. However, in all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, have been met. Also, the State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

F. If a rehabilitation unit is not currently accredited by CARF then the State Agency is required to determine if the criteria specified above in §140.1.1E-H has been met. In all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, and that the criteria specified below in §140.1.6 have been met. The State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

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

(Rev. 347, Issued: 10-29-04, Effective: N/A, Implementation: 11-29-04)

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 CONDITON	*REHABILIATION IMPAIRMENT GROUP CODES**	*ICD-9-CM 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*	*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*

	05.6 *05.7*	*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	*12.1, 12.9*	*253.3*

DEFORMITIES		*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 GROUP CODES**	*ICD-9-CM 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	*REHABILIATION*	*ICD-9-CM CODES **

CONDITON	*IMPAIRMENT GROUP 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*	*099.3* *136.1* *711.2x* *713.0*

	DIAGNOSIS CODES 710.1, 711.0x, 716.-- 716.99	*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 ***</br>
SPINAL CORD INJURY	*04.110, 04.111, 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*	*079.51* *170.2* *192.2* *192.3* *225.3* *225.4* *323.0* *324.1* *336.0* *336.1* *336.2* *336.3* *336.8* *336.9* *344.00* *344.01* *344.02* *344.03* *344.04* *344.09* *344.1* *344.2* *344.60* *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* *952.12* *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*
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* *438.41* *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.*