February 9, 2005

Laurence Wilson, Director
Chronic Care Policy Group
Mail Stop C5-01-23
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 20041

Dear Mr. Wilson:

Thank you for the recent discussion with representatives of the American Hospital Association, American Medical Rehabilitation Providers Association, and Federation of American Hospitals pertaining to the implementation of the 75% Rule. As follow-up to that discussion, I am enclosing a modified copy of our recommendations, which includes the technical coding corrections we mentioned during the meeting. Copies for Herb Kuhn, Bob Kuhl, and Pete Diaz are also enclosed. We still anticipate sharing these revised recommendations with our member inpatient rehabilitation facilities (IRF) for their use in communications with their fiscal intermediaries.

Per your request, our organizations have reconvened our inpatient rehabilitation local coverage determination (LCD) work group. This group will prepare comments on the strengths and weaknesses of the two inpatient rehabilitation LCDs that have been implemented (AdminaStar and Blue Cross/Blue Shield of Alabama) and those still in draft form.

We appreciate the clarification provided in the IRF Fact Sheet issued on January 21. However, several areas of concern remain. Following review of the pending transmittal, provider education call, and any other CMS guidance, we will resume communication on any unresolved matters. At that point, if needed, we will also revisit our request for an ad hoc forum to address 75% Rule implementation issues with CMS representatives.

Again, we thank you for the constructive meeting and for considering our 75% Rule recommendations. Please do not hesitate to call to discuss any questions concerning our recommendations.

Sincerely,

Rochelle Archuleta
Senior Associate Director – Policy
American Hospital Association

Enclosure

Cc: Herb Kuhn
Robert Kuhl
Pete Diaz

RECOMMENDATIONS FOR IRF COMPLIANCE WITH THE 75% RULE

Developed by a
Technical Expert Panel representing the
American Hospital Association,
American Medical Rehabilitation Providers Association,
and
Federation of American Hospitals

January 2005

INTRODUCTION

Following the May 7, 2004 publication of a final rule regarding the Medicare criterion known as the 75% Rule, the American Hospital Association, American Medical Rehabilitation Providers Association and the Federation of American Hospitals convened an expert panel to review the final rule. The panel included physicians, therapists, coding specialists, administrators and policy experts who developed these recommendations to help the Centers for Medicare & Medicaid Services (CMS) implement this final rule.

Our objectives are to:

- provide input to CMS on issues of concern related to implementation of the 75% Rule,
- seek CMS response on the enclosed recommendations, and
- distribute the guidelines to inpatient rehabilitation facilities to serve as a resource when assessing 75% Rule compliance, including recommended definitions that may be used during communication with fiscal intermediaries (FI) developing local standards for 75% Rule compliance assessment.

We hope these recommendations prove helpful to CMS.

Paul Echelard
Chairman, Technical Expert Panel
CEO, Pinecrest Rehabilitation Hospital

Table of Contents Page

I. Background

On May 7, 2004, the Centers for Medicare and Medicaid Services (CMS) published the rule "Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility; Final Rule" in the *Federal Register.* This Final Rule modified the qualification criterion for inpatient rehabilitation facilities (IRFs) that is known as the "75% Rule." The final rule and subsequent implementation instructions issued by CMS to its FIs and providers include certain provisions that are not clearly defined, are incomplete, and/or are inconsistent with other CMS guidelines. These recommendations address some of these issues.

On June 23 and 24, 2004, a diverse technical expert panel (TEP) comprised of medical rehabilitation experts met in Washington, D.C. to closely review the Final Rule and develop medically appropriate guidelines for implementing the terms and provisions in the rule. The panel was initiated by the American Medical Rehabilitation Providers Association, and consisted of medical rehabilitation clinicians, administrators, coders, and policy experts. It included representation from provider organizations, trade associations, and other parties who collectively represented approximately 90 percent of the inpatient rehabilitation field. The TEP participants are listed in Appendix A.

CMS issued Transmittals 221 and 347 to its FIs on June 25 and October 29, 2004, respectively, which detail the method to be used to calculate IRF compliance with the modified 75% Rule. The TEP recognizes that IRFs are governed by the standards set forth in the final rule and these transmittals. Compliance with these standards is the responsibility of each IRF. The specific parameters articulated in Transmittals 221 and 347 are inconsistent, in part, with the final rule and other CMS guidelines, as elaborated upon below. This scenario presents operational challenges for providers seeking to achieve compliance with the 75% Rule. To give providers a fair opportunity to achieve compliance, CMS must fully address these inconsistencies, as well as those in the related Medlearn Matters provider education article pertaining to the final rule.

We are concerned that the transmittals grant each FI such latitude as to implement the 75% Rule using its own interpretation and methods. As such, FIs will likely implement the 75% Rule using a variety of approaches, which will recreate the challenging scenario that was identified by CMS in 2002 – highly inconsistent application of the 75% Rule across the country by the FIs. Such inconsistency in the past led to the CMS moratorium on enforcement of the 75% Rule that was in effect from June 2002 to July 1, 2004. To discourage a reoccurrence of this scenario, the CMS Central Office should address the issues noted below, including the attachments, and encourage its FIs to utilize national guidelines, once corrected, to the greatest extent possible.

II. Objectives for TEP Recommendations

This document contains recommendations on how to determine which inpatient rehabilitation patients should be counted under the 75% Rule. The TEP developed these recommendations as a good-faith effort to communicate to CMS our consensus view on which patients are clinically appropriate. Every effort has been made to utilize existing reference documents and incorporate the prevailing practices of the medical rehabilitation community. Some of the recommended coding provisions presented below were communicated to CMS through correspondence dated September 16, 2004, Attachment B. Additional final rule implementation concerns were communicated to CMS through a July 29, 2004 letter, Attachment C.

Our objectives with the enclosed recommendations are to:

- **provide further input to CMS on issues of concern related to implementation of the 75% Rule;**
- **seek CMS response on the enclosed recommendations, especially the recommended definitions; and**
- **distribute the guidelines in upcoming months to IRFs that may use the document as a resource when assessing 75% Rule compliance and utilize the recommended definitions during communication with FIs developing local standards for 75% Rule compliance assessment.**

III. Coding Complexities in Determining 75% Rule Compliance

The diagnostic codes (ICD-9-CM) used on the Medicare bill (form UB-92) may be different from the ICD-9-CM codes used on the IRF Patient Assessment Instrument (IRF-PAI) due to distinct coding conventions. ICD-9-CM codes listed in Appendix B of the IRF-PAI manual match with a particular Impairment Group Code (IGC), but ICD-9-CM codes used on the UB-92 claim may not. The IRF-PAI manual notes that, "Commonly used ICD-9-CM codes are listed [in the manual] but the list is not exhaustive." Of particular importance when determining 75% Rule compliance is a key IRF-PAI component, etiologic diagnosis, which is the main clinical impairment requiring inpatient rehabilitation. The etiologic diagnosis is used to determine a patient's IGC, which links to the impairment category used for 75% Rule compliance. But the ICD-9-CM coding guidelines do not address the completion of the etiologic diagnosis.

Inconsistencies between these two coding protocols create problems for FIs and IRFs attempting to assess compliance with the 75% Rule. In addressing this difference, the TEP decided to tie the recommended definitions below to IRF-PAI data in the medical record, rather than solely to ICD-9-CM codes. This TEP determination was based on a statement by Coding Clinic noting that the ICD-9-CM coding guidelines do not address the completion of the etiologic diagnosis.

For the clinical conditions listed below as categories A through I and M, 75% Rule compliance should continue to be based on the IGC, since a great majority of related ICD-9-CM codes for each underlying diagnosis are already listed in the *IRF-PAI Training Manual* and link to an IGC. For these particular conditions, additional criteria (as detailed below) must be met to satisfy the temporary comorbidity eligibility criteria.

For the clinical conditions listed below as categories J, K and L, the ICD-9 CM codes used for the etiologic diagnosis will help determine a patient's eligibility for inclusion under the 75% Rule, but additional medical record information will need to be documented, as recommended below.

Since some ICD-9-CM codes match to a particular IGC (those listed in the IRF-PAI Manual), and others may not, it is necessary to seek further evidence when determining 75% Rule compliance for cases with codes that do not directly correspond to an IGC. The TEP strongly recommends that for such cases, FIs should review medical record documentation to verify and validate IGC assignment and 75% Rule compliance.

IV. Recommended Definitions for New Arthritis Categories

The arthritis categories J, K, L and M are new and include terms and medical protocols that are not familiar to the field. Compliance with these new 75% Rule requirements must be documented in the medical record in addition to the eligible diagnosis. The TEP recommendations below are a clinically appropriate and administratively reasonable means of identifying arthritis patients who should count under the 75% Rule. It is anticipated that in future months, these recommendations may be used by IRFs during communication with FIs related to local standards on 75% Rule compliance. **Provided below are a re-statement of final rule definitions of the new arthritis categories and TEP recommendations on eligible IGCs and definitions of key terms.**

A. Category J

Final Rule Language:
"(J) 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."

Transmittal Language:
"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."

These provisions include clinical parameters that are not medically appropriate for all patients. As such, the TEP is recommending the following definitions for key components of Category J, which accommodate more clinical variation among patients.

1. **"Active"** (acute or exacerbation)
   - increased ESR/CRP or concurrent medication for the disease (DMARDS)
   - or pain and/or warmth in joint
   - or radiographic changes
   - or inflammatory synovitis
   - and recent decline that makes it difficult to sustain independence and requiring medical management i.e., care necessitating physician involvement three or more times per week

2. **"polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies"**

IGCs 06.1 and 06.9, but not including etiological diagnosis codes 710.1, 711.0, 716. – 716.99 (CR 3334)

3. **"resulting in significant functional impairment of ambulation and other activities of daily living"**

   A significant functional impairment is a minimum of 25% loss of function in one or more areas of ambulation *and* a 25% loss of function in one or more activities of daily living skills. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment notations in the medical record.

4. **"that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy"**

   "An appropriate, aggressive, and sustained course" is provided at an intensity and duration sufficient for the physician to determine the patient is unable to meet treatment goals.

An outpatient therapy regimen may include pain management, outpatient PT, outpatient OT or alternative medicine, etc.

This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical.

5. **"or services in less intensive rehabilitation setting"**
   "less intensive rehabilitation setting" includes:
   Acute Care
   Skilled Nursing Facility
   Home Health

6. **"immediately preceding the inpatient rehabilitation admission"**
   Patient must have concluded the services in the less intensive rehabilitation setting or outpatient therapy within 60 days of the inpatient rehabilitation admission.

7. **"but have the potential to improve with more intensive rehabilitation setting"**
   Admitting physician should document the patient's potential to improve in an inpatient rehabilitation setting. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment

B. Category K

Final Rule Language:
"(K) 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."

Transmittal Language: *"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."

These provisions include clinical parameters that are not medically appropriate for all patients. As such, the TEP is recommending the following definitions for key components of Category K, which accommodate more clinical variance among patients.

1. "Systemic vasculidities with joint inflammation"
Etiologic diagnoses that qualify patients for category K include:

06.9, but not including etiological diagnosis codes 710.1, 711.0, 716. – 716.99 (CR 3334)

2. "resulting in significant functional impairment of ambulation and other activities of daily living"

A significant functional impairment is a minimum of 25% loss of function in one or more areas of ambulation *and* a 25% loss of function in one or more activities of daily living skills. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment notations in the medical record.

3. "that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy"

"An appropriate, aggressive, and sustained course**"** is provided at an intensity and duration sufficient for the physician to determine the patient is unable to meet treatment goals.

An outpatient therapy regimen may include pain management, outpatient PT, outpatient OT or alternative medicine, etc**.**

This clinical determination may be included in the pre-admission process and must be evidenced in the admission History and Physical.

4. **"or services in less intensive rehabilitation setting"**

"less intensive rehabilitation setting" includes:
Acute Care
Skilled Nursing Facility
Home Health

5. "**immediately preceding the inpatient rehabilitation admission"**

Patient must have concluded the services in the less intensive rehabilitation setting or outpatient therapy within 60 days of the inpatient rehabilitation admission.

6. "but have the potential to improve with more intensive rehabilitation setting"

Admitting physician should document the patient's potential to improve in an inpatient rehabilitation setting. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment

C. Category L

Final Rule Language:
"(L) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)"

Transmittal Language:
"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."

Note: 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.

These provisions include clinical parameters that are not medically appropriate for all patients. As such, the TEP is recommending the following definitions for key components of Category L, which accommodate more clinical variance among patients.

1. **"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)"**

Patients included in category L include Osteoarthritis and Other Arthritis ICD-9 codes include the range of etiologic diagnoses codes from 715.00-715.99 and 716-716.99, respectively. (Reference: *Appendix B IRF – PAI Training Manual)* Common coding practice is to code to the highest level of specificity which may result in the etiologic diagnosis code reflecting single joint involvement although the medical record may indicate multiple joint involvement, specifically in the hip, knee, shoulder and/or elbow. Identifying all patients who are eligible for 75% Rule compliance under category L will require review of the medical record which must contain documentation of severe or advanced involvement in two or more major weight bearing joints (including elbows, shoulders, hips, or knees, but not a joint with a prosthesis).

For guidelines on diagnosing and documenting osteoarthritis refer to *Altman, R. et al: Arthritis Rheum 29:1039; 1986* and http://www.hopkins-arthritis.som.jhmi.edu/edu/acr/acr.html.

2. "with joint deformity"

Presence of joint deformity is determined after review of radiographic evidence or physical exam. Presence of joint deformity must be documented.

3. "and substantial loss of range of motion,"

Loss of range of motion $\geq 15^{o}$ in any joint is a "substantial loss of range of motion." Range of motion must be documented.

4. "atrophy of muscles surrounding the joint"

Atrophy can be detected by manual palpation and visual findings but must be documented.

5. "resulting in significant functional impairment of ambulation and other activities of daily living"

A significant functional impairment is a minimum of 25% loss of function in one or more areas of ambulation *and* a 25% loss of function in one or more activities of daily living skills. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment notations in the medical record.

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6. "that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy"

"An appropriate, aggressive, and sustained course**"** is provided at an intensity and duration sufficient for the physician to determine the patient is unable to meet treatment goals.

An outpatient therapy regimen may include pain management, outpatient PT, outpatient OT or alternative medicine, etc**.** This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical notations in the medical record.

7. "or services in less intensive rehabilitation setting" and "less intensive rehabilitation setting" include:

Acute Care
Skilled Nursing Facility
Home Health

8. "**immediately preceding the inpatient rehabilitation admission"**
Patient must have concluded the services in the less intensive rehabilitation setting or outpatient therapy within 60 days of the inpatient rehabilitation admission.

9. "but have the potential to improve with more intensive rehabilitation setting"
Admitting physician should document the patient's potential to improve in an inpatient rehabilitation setting. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment notations in the medical record.

Patients who have had joint replacement surgery are eligible for inclusion in the 75% Rule in the category if the patient is being admitted for inpatient rehabilitation pertaining to other weight bearing joints (as detailed above) affected by osteoarthritis that have not improved through other rehabilitation efforts (as detailed above).

Patients with IGCs of:
08.51 - Status post unilateral hip replacement
08.61 - Status post unilateral knee replacement
08.9 - Other orthopedic
may be eligible for inclusion if all the category L criteria are met as detailed above. (These IGC's were not included in the transmittals.)

D. Category M

Final Rule Language:
"(M) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:
(1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
(2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
(3) The patient is age 85 or older at the time of admission to the IRF."

These provisions include clinical parameters that are not medically appropriate for all patients. As such, the TEP is recommending the following definitions for key components of Category M, which accommodate more clinical variance among patients.

1. **"(1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission."**

Patients in these IGCs are eligible for the 75% rule:
08.52 - Status post bilateral hip replacements

08.62 - Status post bilateral knee replacements
08.71 - Status post knee and hip replacements (same side)
08.72 - Status post knee and hip replacements (different sides)

2. **"(2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF."**

Patients in these IGCs:
08.51 - Status post unilateral hip replacement
08.61 - Status post unilateral knee replacement
are eligible for the 75% rule *if the patient's BMI is over 50* (Please note, "Morbid Obesity ICD-9 278.01 is not automatically eligible for the 75% rule). BMI is calculated as:

BMI = (Weight in Pounds / (Height in Inches X Height in Inches)) X 703

3. **"(3) The patient is age 85 or older at the time of admission to the IRF."**

Patients in these IGCs:
08.51 - Status post unilateral hip replacement
08.61 - Status post unilateral knee replacement
are eligible for the 75% rule if the patient's age is at 85 or over at admission.
Per CR 3334, 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 recommend that IRFs obtain copies of therapy notes from the outpatient therapy or therapy in another less intensive setting and place them in the patient's inpatient chart (in a section for prior records). We believe that these records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available for FI's who review the medical records for compliance with the requirements specified above in §140.1.1B.

V. 75% Rule Temporary Comorbidity Provision

When developing recommendations on which cases should count toward compliance with the 75% Rule under the temporary comorbidity provision in the final rule, the TEP used the following definition of "comorbidity".

Comorbidity Definition: A specific patient condition that also affects a patient in addition to the principal diagnosis or impairment that is used to place a patient into a rehabilitation impairment category.
Reference: *Appendix G, IRF – PAI Training Manual, Effective 04/01/04*

A. Recommended Eligibility Requirements for Comorbidities Cases

For a case to count toward the 75% Rule due to a patient's comorbidities, the final rule requires that each of the following criteria must be met:

- The patient is admitted for inpatient rehabilitation for a condition that is not one of the CMS 13 conditions; and;

- The patient has a comorbidity that falls in one of the CMS 13 conditions as defined by the CMS CR 3334; and
- The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

It is important for IRFs to explicitly document in the medical record the primary reason for each admission *and* the comorbidity that is the basis for inclusion under the 75% Rule, when applicable. As noted in the final rule, medically necessary admissions to an IRF are determined by the medical condition *and* functional status of the patient, which are also the basis for the assignment of a patient to a case mix group.

The following are recommended definitions for the key components of 75% Rule temporary comorbidities provision:

1. A **"significant decline in functional ability"** is a minimum of 25% loss of function in one or more areas of ambulation *and* a 25% loss of function in one or more activities of daily living skills. This clinical determination may be included in the pre-admission process and must be evidenced in the admission history and physical as well as the Interdisciplinary Admission Assessment.

2. **"Even in the absence of the admitting condition"** requires documentation in the medical record to support the comorbidity in and of itself, has contributed to at least a 25% decline of functional ability.

3. **"Would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part"** is defined by current CMS policy in the *Medicare Benefit Policy Manual* (Publication 100-10 Section 110).

4. **"That cannot be appropriately performed in another care setting covered under this title"** is satisfied for patients who meet admission criteria to an IRF setting as defined by current CMS policy in the *Medicare Benefit Policy Manual.*

B. Codes for Cases to Include in the Temporary Comorbidities Provision

Each of the following comorbidities, as proposed by CMS in the May 16, 2004 proposed rule pertaining to IRFs, should be used to identify cases that count under the temporary 75% Rule comorbidities provision. This list of recommended comorbidities codes identifies certain codes that, in the view of the TEP, were inappropriately excluded from CR 3334 and should be added to the eligible codes.

(A) Stroke

The following are the ICD-9-CM Codes for stroke that are listed in Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
342.00	FLCCD HMIPLGA UNSPF SIDE
342.01	FLCCD HMIPLGA DOMNT SIDE
342.02	FLCCD HMIPLG NONDMNT SDE
342.1	SPASTIC HEMIPLEGIA
342.11	SPSTC HMIPLGA DOMNT SIDE
342.12	SPSTC HMIPLG NONDMNT SDE
342.80	OT SP HMIPLGA UNSPF SIDE
342.81	OT SP HMIPLGA DOMNT SIDE
342.82	OT SP HMIPLG NONDMNT SDE
342.90	UNSP HEMIPLGA UNSPF SIDE
342.91	UNSP HEMIPLGA DOMNT SIDE
342.92	UNSP HMIPLGA NONDMNT SDE
431.	INTRACEREBRAL HEMORRHAGE
433.01	OCCLUSION BSLR ART W INFARCTION
433.11	OCCLUSION CRTD ART W INFARCTION
433.21	OCCLUSION VRTB ART W INFARCTION
433.31	OCCLUSION MLT BI ART W INFARCTION
433.81	OCCLUSION SPCF ART W INFARCTION
433.91	OCCLUSION ART NOS W INFARCTION
434.01	CEREBRAL THRMBS W INFARCTION
434.11	CEREBRAL EMBLSM W INFARCTION
434.91	CEREBRAL ART OCL NOS W INFARCTION
437.2	HYPERTENS ENCEPHALOPATHY
437.4	CEREBRAL ARTERITIS
437.5	MOYAMOYA DISEASE
437.6	NONPYOGEN THROMBOS SINUS
438.20	LATE EF-HEMPLGA SIDE NOS
438.21	LATE EF-HEMPLGA DOM SIDE
438.22	LATE EF-HEMIPLGA NON-DOM
438.30	LATE EF-MPLGA UP LMB NOS
438.31	LATE EF-MPLGA UP LMB DOM
438.32	LT EF-MPLGA UPLMB NONDOM

438.41	LTE EF-MPLGA LOW LMB DOM
438.42	LT EF-MPLGA LOWLMB NONDM
438.50	LT EF OTH PARAL SIDE NOS
438.51	LT EF OTH PARAL DOM SIDE
438.52	LT EF OTH PARALS NON-DOM
438.53	LT EF OTH PARALS-BILAT
997.02	IATROGEN CV INFARC/HMRHG

Transmittal 347 does not include the following ICD-9-CM codes for stroke, but does include them in the brain injury category. **The TEP recommends that these codes also count toward the 75% Rule in the stroke category**, because these are non-traumatic hemorrhages of the brain.

430	SUBARACHNOID HEMORRHAGE, INCLUDING RUPTURED CEREBRAL ANEURYSM
432.0 – 432.9	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE

Transmittal 347 removed the following ICD-9-CM code for stroke. **The TEP recommends that these codes be reinstated for eligibility under the 75% Rule.**

436.	ACUTE BUT ILL DEFINED, CEREBROVASCULAR DISEASE

(B) Spinal cord injury

These are the ICD-9-CM codes listed for spinal cord injury in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	**ETIOLOGIC DIAGNOSIS**
079.51	HTLV-1 INFECTION OTH DIS
170.2	MALIGNANT NEOPLASM VERTEBRAE
192.2	MALIGNANT NEOPLASM SPINAL CORD
192.3	MALIGNANT NEOPLASM SPINAL MENINGES
225.3	BENIGN NEOPLASM SPINAL CORD
225.4	BENIGN NEOPLASM SPINAL MENINGES
323.0	ENCEPHALIT IN VIRAL DIS
324.1	INTRASPINAL ABSCESS
336.0	SYRINGOMYELIA
336.1	VASCULAR MYELOPATHIES
336.2	COMB DEG CORD IN OTH DIS

336.3	MYELOPATHY IN OTH DIS
336.8	MYELOPATHY NEC
336.9	SPINAL CORD DISEASE NOS
344.00	QUADRIPLEGIA, UNSPECIFD
344.01	QUADRPLG C1-C4, COMPLETE
344.02	QUADRPLG C1-C4, INCOMPLT
344.03	QUADRPLG C5-C7, COMPLETE
344.04	QUADRPLG C5-C7, INCOMPLT
344.09	OTHER QUADRIPLEGIA
344.1	PARAPLEGIA NOS
344.2	DIPLEGIA OF UPPER LIMBS
344.60	CAUDA EQUINA SYND NOS
344.61	NEUROGENIC BLADDER
721.1	CERV SPONDYL W MYELOPATH
721.41	SPONDYLOSIS COMPR THOR SP CORD
721.42	SPONDYLOSIS COMPR LUMB SP CORD
721.91	SPONDYLOSIS NOS W MYELOP
722.70	DISC DIS W MYELOPATH NOS
722.71	CERV DISC DIS W MYELOPAT
722.72	THOR DISC DIS W MYELOPAT
722.73	LUMB DISC DIS W MYELOPAT
806.00	C1-C4 FX-CL/CORD INJ NOS
806.01	C1-C4 FX-CL/COM CORD LES
806.02	C1-C4 FX-CL/ANT CORD SYN
806.03	C1-C4 FX-CL/CEN CORD SYN
806.05	C5-C7 FX-CL/CORD INJ NOS
806.06	C5-C7 FX-CL/COM CORD LES
806.07	C5-C7 FX-CL/ANT CORD SYN
806.08	C5-C7 FX-CL/CEN CORD SYN
806.09	C5-C7 FX-CL/CORD INJ NEC
806.10	C1-C4 FX-OP/CORD INJ NOS
806.11	C1-C4 FX-OP/COM CORD LES
806.12	C1-C4 FX-OP/ANT CORD SYN
806.13	C1-C4 FX-OP/CEN CORD SYN
806.14	C1-C4 FX-OP/CORD INJ NEC
806.15	C5-C7 FX-OP/CORD INJ NOS

806.16	C5-C7 FX-OP/COM CORD LES
806.17	C5-C7 FX-OP/ANT CORD SYN
806.18	C5-C7 FX-OP/CEN CORD SYN
806.19	C5-C7 FX-OP/CORD INJ NEC
806.2	CL DORSAL FX W CORD INJ
806.20	T1-T6 FX-CL/CORD INJ NOS
806.21	T1-T6 FX-CL/COM CORD LES
806.22	T1-T6 FX-CL/ANT CORD SYN
806.23	T1-T6 FX-CL/CEN CORD SYN
806.24	T1-T6 FX-CL/CORD INJ NEC
806.25	T7-T12 FX-CL/CRD INJ NOS
806.26	T7-T12 FX-CL/COM CRD LES
806.27	T7-T12 FX-CL/ANT CRD SYN
806.28	T7-T12 FX-CL/CEN CRD SYN
806.29	T7-T12 FX-CL/CRD INJ NEC
806.30	T1-T6 FX-OP/CORD INJ NOS
806.31	T1-T6 FX-OP/COM CORD LES
806.32	T1-T6 FX-OP/ANT CORD SYN
806.33	T1-T6 FX-OP/CEN CORD SYN
806.34	T1-T6 FX-OP/CORD INJ NEC
806.35	T7-T12 FX-OP/CRD INJ NOS
806.36	T7-T12 FX-OP/COM CRD LES
806.37	T7-T12 FX-OP/ANT CRD SYN
806.38	T7-T12 FX-OP/CEN CRD SYN
806.39	T7-T12 FX-OP/CRD INJ NEC
806.4	CL LUMBAR FX W CORD INJ
806.5	OPN LUMBAR FX W CORD INJ
806.60	FX SACRUM-CL/CRD INJ NOS
806.61	FX SACR-CL/CAUDA EQU LES
806.62	FX SACR-CL/CAUDA INJ NEC
806.69	FX SACRUM-CL/CRD INJ NEC
806.70	FX SACRUM-OP/CRD INJ NOS
806.71	FX SACR-OP/CAUDA EQU LES
806.72	FX SACR-OP/CAUDA INJ NEC
806.79	FX SACRUM-OP/CRD INJ NEC
839.01	DISLOC 1ST CERV VERT-CL

839.02	DISLOC 2ND CERV VERT-CL
839.03	DISLOC 3RD CERV VERT-CL
839.04	DISLOC 4TH CERV VERT-CL
839.05	DISLOC 5TH CERV VERT-CL
839.06	DISLOC 6TH CERV VERT-CL
839.07	DISLOC 7TH CERV VERT-CL
839.08	DISLOC MULT CERV VERT-CL
839.10	DISLOC CERV VERT NOS-OPN
839.11	DISLOC LST CERV VERT-OPN
839.12	DISLOC 2ND CERV VERT-OPN
839.13	DISLOC 3RD CERV VERT-OPN
839.14	DISLOC 4TH CERV VERT-OPN
839.15	DISLOC 5TH CERV VERT-OPN
839.16	DISLOC 6TH CERV VERT-OPN
839.17	DISLOC 7TH CERV VERT-OPN
839.18	DISLOC MLT CERV VERT-OPN
839.20	DISLOCAT LUMBAR VERT-CL
839.21	DISLOC THORACIC VERT-CL
839.30	DISLOCAT LUMBAR VERT-OPN
839.31	DISLOC THORACIC VERT-OPN
907.2	LATE EFF SPINAL CORD INJ
952.01	COMPLETE LES CORD/C1-C4
952.02	ANTERIOR CORD SYND/C1-C4
952.03	CENTRAL CORD SYND/C1-C4
952.04	C1-C4 SPIN CORD INJ NEC
952.05	C5-C7 SPIN CORD INJ NOS
952.06	COMPLETE LES CORD/C5-C7
952.07	ANTERIOR CORD SYND/C5-C7
952.08	CENTRAL CORD SYND/C5-C7
952.09	C5-C7 SPIN CORD INJ NEC
952.10	T1-T6 SPIN CORD INJ NOS
952.11	COMPLETE LES CORD/T1-T6
952.12	ANTERIOR CORD SYND/T1-T6
952.13	CENTRAL CORD SYND/T1-T6
952.14	T1-T6 SPIN CORD INJ NEC
952.15	T7-T12 SPIN CORD INJ NOS

952.16	COMPLETE LES CORD/T7-T12
952.17	ANTERIOR CORD SYN/T7-T12
952.18	CENTRAL CORD SYN/T7-T12
952.19	T7-T12 SPIN CORD INJ NEC
952.2	LUMBAR SPINAL CORD INJUR
952.3	SACRAL SPINAL CORD INJUR
952.4	CAUDA EQUINA INJURY
952.8	SPIN CORD INJ-MULT SITE
952.9	SPINAL CORD INJURY NOS
013.4x	TUBRCLMA SP CORD
013.5x	TB SP CRD ABSCESS
045.1x	PARAL POLIO NEC

Transmittal 347 does not include the following ICD-9-CM codes for spinal cord injury. **The TEP recommends that these codes be established for eligibility under the 75% Rule.**

015.0	TUBERCULOSIS OF VERTEBRAL COLUMN
198.3	SECONDARY MALIGNANT NEOPLASM OF SPINAL CORD
198.4	SECONDARY MALIGNANT NEOPLASM OF SPINAL MENINGES
237.5	NEOPLASM OF SPINAL CORD, OF UNCERTAIN BEHAVIOR
237.6	NEOPLASM OF SPINAL MENINGES, OF UNCERTAIN BEHAVIOR
239.7	NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM, OF UNSPECIFIED NATURE
323.9	TRANSVERSE MYELITIS
441.00 - 441.03	DISSECTION OF AORTA
441.1, 441.3, 441.5, 441.6	AORTIC ANEURYSM, RUPTURED
723.0	SPINAL STENOSIS IN CERVICAL REGION (IF DEFICITS INCLUDE WEAKNESS)
724.00 - 724.09	SPINAL STENOSIS, OTHER THAN CERVICAL (IF DEFICITS INCLUDE WEAKNESS)
953.0 - 953.8	INJURY TO NERVE ROOTS AND SPINAL PLEXUS

(C) Congenital deformity

These are the ICD-9-CM codes listed for congenital deformity in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS

253.3	PITUITARY DWARFISM
259.4	DWARFISM NEC
333.7	SYMPTOM TORSION DYSTONIA
334.1	HERED SPASTIC PARAPLEGIA
335.10	SPINAL MUSCL ATROPHY NOS
335.11	KUGELBERG-WELANDER DIS
343.0	CONGENITAL DIPLEGIA
343.1	CONGENITAL HEMIPLEGIA
343.2	CONGENITAL QUADRIPLEGIA
343.3	CONGENITAL MONOPLEGIA
343.4	INFANTILE HEMIPLEGIA
343.8	CEREBRAL PALSY NEC
343.9	CEREBRAL PALSY NOS
356.0	HERED PERIPH NEUROPATHY
356.1	PERONEAL MUSCLE ATROPHY
356.2	HERED SENSORY NEUROPATHY
356.3	REFSUM'S DISEASE
356.4	IDIO PROG POLYNEUROPATHY
356.8	IDIO PERIPH NEURPTHY NEC
356.9	IDIO PERIPH NEURPTHY NOS
740.1	CRANIORACHISCHISIS
740.2	INIENCEPHALY
741.00	SPINA BIFIDA W HYDROCEPH NOS
741.01	SPINA BIFIDA W HYDRCEPH-CERV
741.02	SPINA BIFIDA W HYDRCEPH-DORS
741.03	SPINA BIFIDA W HYDRCEPH-LUMB
741.90	SPINA BIFIDA
741.91	SPINA BIFIDA-CERV
741.92	SPINA BIFIDA-DORSAL
741.93	SPINA BIFIDA-LUMBAR
742.0	ENCEPHALOCELE
742.1	MICROCEPHALUS
742.2	REDUCTION DEFORM, BRAIN
742.3	CONGENITAL HYDROCEPHALUS
742.4	BRAIN ANOMALY NEC
742.51	DIASTEMATOMYELIA

742.53	HYDROMYELIA
742.59	SPINAL CORD ANOMALY NEC
754.30	CONGENITAL HIP DISLOC, UNILAT
754.31	CONGENITAL HIP DISLOC, BILAT
754.32	CONGENITAL HIP SUBLUX, UNILAT
754.35	CONGENITAL HIP DISLOC W SUBLUX
755.20	REDUC DEFORM UP LIMB NOS
755.21	TRANSVERSE DEFIC ARM
755.22	LONGITUD DEFIC ARM NEC
755.23	COMBIN LONGIT DEFIC ARM
755.24	LONGITUDIN DEFIC HUMERUS
755.25	LONGITUD DEFIC RADIOULNA
755.26	LONGITUD DEFIC RADIUS
755.27	LONGITUDINAL DEFIC ULNA
755.28	LONGITUDINAL DEFIC HAND
755.30	REDUCTION DEFORM LEG NOS
755.31	TRANSVERSE DEFIC LEG
755.32	LONGITUDIN DEFIC LEG NEC
755.33	COMB LONGITUDIN DEF LEG
755.34	LONGITUDINAL DEFIC FEMUR
755.35	TIBIOFIBULA LONGIT DEFIC
755.36	LONGITUDINAL DEFIC TIBIA
755.37	LONGITUDIN DEFIC FIBULA
755.38	LONGITUDINAL DEFIC FOOT
755.4	REDUCT DEFORM LIMB NOS
755.51	CONG DEFORMITY-CLAVICLE
755.53	RADIOULNAR SYNOSTOSIS
755.61	CONGENITAL COXA VALGA
755.62	CONGENITAL COXA VARA
755.63	CONGENITAL HIP DEFORMITY NEC
756.4	CHONDRODYSTROPHY
756.5x	OSTEODYSTROPHIES

Transmittal 347 does not include the following ICD-9-CM code for congenital deformity. **The TEP recommends that this code be included for eligibility under the 75% Rule.**

728.3	ARTHROGRYPOSIS

(D) Amputation

These are the ICD-9-CM codes listed for amputation in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
887.0	AMPUTATION BELOW ELBOW, UNILAT
887.1	AMPUTATION BELOW ELBOW, UNIL-COMP
887.2	AMPUTATION ABOVE ELBOW, UNILAT
887.3	AMPUTATION ABOVE ELB, UNIL-COMP
887.4	AMPUTATION ARM, UNILAT NOS
887.5	AMPUTATION ARM, UNIL NOS-COMP
887.6	AMPUTATION ARM, BILAT
887.7	AMPUTATION ARM, BILAT-COMPL
897.0	AMPUTATION BELOW KNEE, UNILAT
897.1	AMPUTATION BELOW KNEE, UNILAT-COMPL
897.2	AMPUTATION ABOVE KNEE, UNILAT
897.3	AMPUTATION ABOVE KNEE, UNIL-COMPL
897.4	AMPUTATION LEG, UNILAT NOS
897.5	AMPUTATION LEG, UNIL NOS-COMP
897.6	AMPUTATION LEG, BILAT
897.7	AMPUTATION LEG, BILAT-COMPL
905.9	LATE EFF TRAUMAT AMPUTAT
997.60	AMPUTAT STUMP COMPL NOS
997.61	NEUROMA AMPUTATION STUMP
997.62	INFECTION AMPUTAT STUMP
997.69	AMPUTATION STUMP COMPL NEC
V49.65	UPPER LIMB AMPUTATION STATUS BELOW ELBOW
V49.66	UPPER LIMB AMPUTATION STATUS ABOVE ELBOW
V49.67	UPPER LIMB AMPUTATION STATUS SHOULDER
V49.73	LOWER LIMB AMPUTATION STATUS FOOT
V49.74	LOWER LIMB AMPUTATION STATUS ANKLE
V49.75	LOWER LIMB AMPUTATION STATUS BELOW KNEE
V49.76	LOWER LIMB AMPUTATION STATUS ABOVE KNEE
V49.77	LOWER LIMB AMPUTATION STATUS HIP

V52.0	FITTING AND ADJUSTMENT PROSTHESIS ARTIFICIAL ARM
V52.1	FITTING AND ADJUSTMENT PROSTHESIS ARTIFICIAL LEG

Transmittal 347 does not include the following ICD-9-CM codes for amputation. **The TEP recommends these codes be eligible under the 75% Rule.**

170.4, 170.5	MALIGNANT NEOPLASM OF BONES OF UPPER LIMB
170.7, 170.8	MALIGNANT NEOPLASM OF BONES OF LOWER LIMB
171.2	MALIGNANT NEOPLASM OF CARTILAGE AND OTHER SOFT TISSUE OF UPPER LIMB
171.3	MALIGNANT NEOPLASM OF CARTILAGE AND OTHER SOFT TISSUE OF LOWER LIMB
198.5	SECONDARY NEOPLASM OF BONE
356.0 – 356.9	HEREDITARY AND IDIOPATHIC PERIPHERAL NEUROPATHY
357.0 – 357.9	INFLAMMATORY AND TOXIC NEUROPATHY
440.20 – 440.29	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES
443.81	PERIPHERAL ANGIOPATHY IN DISEASES CLASSIFIED ELSEWHERE
443.9	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED
444.21, 444.22	ARTERIAL EMBOLISM AND THROMBOSIS, EXTREMITIES
447.0 - 447.2	OTHER DISORDERS OF ARTERIES AND ARTERIOLES
447.5 - 447.8	OTHER DISORDERS OF ARTERIES AND ARTERIOLES
459.0 - 459.89	OTHER DISORDERS OF CIRCULATORY SYSTEM
681.10 – 681.11	TOE CELLULITIS AND ABSCESS
707.1x	ULCER OF LOWER LIMBS, EXCEPT DECUBITUS
730.0x - 730.3x	OSTEOMYELITIS
730.05 - 730.07	OSTEOMYELITIS
730.15 - 730.17	OSTEOMYELITIS
730.25 - 730.27	OSTEOMYELITIS
733.40, 733.41,	ASEPTIC NECROSIS OF BONE
733.42 - 733.49	ASEPTIC NECROSIS OF BONE
736.89	ACQUIRED DEFORMITY OF OTHER PARTS OF LIMBS, NOT ELSEWHERE CLASSIFIED
747.63	UPPER LIMB VESSEL ANOMALY
747.64	LOWER LIMB VESSEL ANOMALY
755.21 - 755.29	REDUCTION DEFORMITIES OF UPPER LIMB
755.31 – 755.39	REDUCTION DEFORMITIES OF LOWER LIMB
785.4	GANGRENE

Transmittal 347 removed the following ICD-9-CM codes for Amputation. **The TEP recommends these codes be reinstated as eligible under the 75% Rule.**

896.0	AMPUTATION FOOT, UNILAT
896.1	AMPUTATION FOOT, UNILAT-COMPL
896.2	AMPUTATION FOOT, BILAT
896.3	AMPUTATION FOOT, BILAT-COMP

(E) Major multiple trauma

These are the ICD-9-CM codes listed for major multiple trauma in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
808.43	PELV FX-CLOS/PELV DISRUP
808.53	PELV FX-OPEN/PELV DISRUP
819.0	FX ARMS W RIB/STERNUM-CL
819.1	FX ARMS W RIB/STERN-OPEN
828.0	FX LEGS W ARM/RIB-CLOSED
828.1	FX LEGS W ARM/RIB-OPEN

Transmittal 347 does not include the following ICD-9-CM codes for major multiple trauma. **The TEP recommends these codes be designated as eligible under the 75% Rule.**

823.02 – 823.92	FRACTURES OF TIBIA AND FIBULA (5TH DIGIT SHOULD= 2)
827.0 – 827.1	FRACTURE OF MULTIPLE BONES OF SAME LOWER LIMB

(F) Fracture of femur (hip fracture)

These are the ICD-9-CM codes listed for hip fracture in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
733.14	PATHOLOGIC FRACTURE OF NECK OR FEMUR
808.0	FRACTURE ACETABULUM-CLOS
808.1	FRACTURE ACETABULUM-OPEN
820.00	FX FEMUR INTRCAPS NOS-CL
820.01	FX UP FEMUR EPIPHY-CLOS

820.02	FX FEMUR, MIDCERVIC-CLOS
820.03	FX BASE FEMORAL NCK-CLOS
820.09	FX FEMUR INTRCAPS NEC-CL
820.10	FX FEMUR INTRCAP NOS-OPN
820.11	FX UP FEMUR EPIPHY-OPEN
820.12	FX FEMUR, MIDCERVIC-OPEN
820.13	FX BASE FEMORAL NCK-OPEN
820.19	FX FEMUR INTRCAP NEC-OPN
820.20	TROCHANTERIC FX NOS-CLOS
820.21	INTERTROCHANTERIC FX-CL
820.22	SUBTROCHANTERIC FX-CLOSE
820.30	TROCHANTERIC FX NOS-OPEN
820.31	INTERTROCHANTERIC FX-OPN
820.32	SUBTROCHANTERIC FX-OPEN
820.8	FX NECK OF FEMUR NOS-CL
820.9	FX NECK OF FEMUR NOS-OPN

Transmittal 347 does not include the following ICD-9-CM codes for hip fracture. **The TEP recommends these codes be designated as eligible under the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
821.00– 821.11	FRACTURE OF SHAFT OR UNSPECIFIED PART OF FEMUR
821.20– 821.39	FRACTURE OF LOWER END OF FEMUR
808.2 – 808.9	FRACTURE OF PELVIS (ONLY 808.0 AND 808.1 ARE LISTED)

(G) Brain injury

These are the ICD-9-CM codes listed for brain injury in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9-CM	DIAGNOSIS
003.21	SALMONELLA MENINGITIS
006.5	AMEBIC BRAIN ABSCESS
013.00	TUBERCULOUS MENINGITIS UNSPECIFIED
013.01	TUBERCULOUS MENINGITIS BACTERIOL OR HISTOL NOT DONE
013.02	TUBERCULOUS MENINGITIS BACTERIOL OR HISTOL UNKNOWN

013.03	TUBERCULOUS MENINGITIIS TUBERCLE BACILLI FOUND BY MICRO
013.04	TUBERCULOUS MENINGITIIS TUBERCLE BACILLI FOUND BY MICRO, BUT CONFIRNED HISTO
013.05	TUBERCULOUS MENINGITIIS TUBERCLE BACILLI NOT FOUND BY BACTERIAL EXAM BUT CONFIRMED BY HISTO
013.06	TUBERCULOUS MENINGITIIS TUBERCLE BACILLI NOT FOUND BY BACT OR HISTO BUT TB CONFIRMED BY OTHER METHODS
036.0	MENINGOCOCCAL MENINGITIS
036.1	MENINGOCOCC ENCEPHALITIS
047.0	COXSACKIE VIRUS MENINGITIS
047.1	ECHO VIRUS MENINGITIS
047.8	VIRAL MENINGITIS NEC
047.9	VIRAL MENINGITIS NOS
048.	OTH ENTEROVIRAL CNS DIS
049.0	LYMPHOCYTIC CHORIOMENING
049.1	ADENOVIRAL MENINGITIS
049.8	VIRAL ENCEPHALITIS NEC
049.9	VIRAL ENCEPHALITIS NOS
052.0	POSTVARICELLA ENCEPHALIT
053.0	HERPES ZOSTER MENINGITIS
054.3	HERPETIC ENCEPHALITIS
055.0	POSTMEASLES ENCEPHALITIS
056.01	RUBELLA ENCEPHALITIS
062.0	JAPANESE ENCEPHALITIS
062.1	WEST EQUINE ENCEPHALITIS
062.2	EAST EQUINE ENCEPHALITIS
062.3	ST LOUIS ENCEPHALITIS
062.4	AUTRALIAN ENCEPHALITIS
062.5	CALIFORNIA ENCEPHALITIS
062.8	MOSQUIT-BORNE ENCEPH NEC
062.9	MOSQUIT-BORNE ENCEPH NOS
063.0	RUSSIA SPR-SUMMER ENCEPH
063.1	LOUPING ILL
063.2	CENT EUROPE ENCEPHALITIS
063.8	TICK-BORNE ENCEPH NEC
063.9	TICK-BORNE ENCEPH NOS
064.	VIR ENCEPH ARTHROPOD NEC
066.2	VENEZUELAN EQUINE FEVER

066.3	MOSQUITO-BORNE FEVER NEC
072.1	MUMPS MENINGITIS
072.2	MUMPS ENCEPHALITIS
090.4	JUVENILE NEUROSYPHILIS*
090.41	CONGEN SYPH ENCEPHALITIS
090.42	CONGEN SYPH MENINGITIS
091.81	ACUTE SYPHIL MENINGITIS
094.1	GENERAL PARESIS
094.2	SYPHILITIC MENINGITIS
094.81	SYPHILITIC ENCEPHALITIS
100.81	LEPTOSPIRAL MENINGITIS
112.83	CANDIDAL MENINGITIS
114.2	COCCIDIOIDAL MENINGITIS
115.01	HISTOPLASM CAPSUL MENING
115.11	HISTOPLASM DUBOIS MENING
115.91	HISTOPLASMOSIS MENINGIT
130.0	TOXOPLASM MENINGOENCEPH
139.0	LATE EFF VIRAL ENCEPHAL
191.0	MALIGN NEOPL CEREBRUM
191.1	MALIG NEO FRONTAL LOBE
191.2	MAL NEO TEMPORAL LOBE
191.3	MAL NEO PARIETAL LOBE
191.4	MAL NEO OCCIPITAL LOBE
191.5	MAL NEO CEREB VENTRICLE
191.6	MAL NEO CEREBELLUM NOS
191.7	MAL NEO BRAIN STEM
191.8	MALIG NEO BRAIN NEC
191.9	MALIG NEO BRAIN NOS
192.1	MAL NEO CEREBRAL MENING
194.3	MALIG NEO PITUITARY
194.4	MALIGN NEO PINEAL GLAND
198.3	SEC MAL NEO BRAIN/SPINE
225.0	BENIGN NEOPLASM BRAIN
225.2	BEN NEO CEREBR MENINGES
228.02	HEMANGIOMA INTRACRANIAL
237.5	UNC BEH NEO BRAIN/SPINAL

237.6	UNC BEHAV NEO MENINGES
237.72	NEUROFIBROMATOSIS TYP II
310.2	POSTCONCUSSION SYNDROME
320.0	HEMOPHILUS MENINGITIS
320.1	PNEUMOCOCCAL MENINGITIS
320.2	STREPTOCOCCAL MENINGITIS
320.3	STAPHYLOCOCC MENINGITIS
320.7	MENING IN OTH BACT DIS
320.81	ANAEROBIC MENINGITIS
320.82	MNINGTS GRAM-NEG BCT NEC
320.89	MENINGITIS OTH SPCF BACT
320.9	BACTERIAL MENINGITIS NOS
321.0	CRYPTOCOCCAL MENINGITIS
321.1	MENING IN OTH FUNGAL DIS
321.2	MENING IN OTH VIRAL DIS
321.3	TRYPANOSOMIASIS MENINGIT
321.4	MENINGIT D/T SARCOIDOSIS
321.8	MENING IN OTH NONBAC DIS
322.0	NONPYOGENIC MENINGITIS
322.1	EOSINOPHILIC MENINGITIS
322.2	CHRONIC MENINGITIS
322.9	MENINGITIS NOS
323.0	ENCEPHALIT IN VIRAL DIS
323.1	RICKETTSIAL ENCEPHALITIS
323.2	PROTOZOAL ENCEPHALITIS
323.4	OTH ENCEPHALIT D/T INFEC
323.5	POSTIMMUNIZAT ENCEPHALIT
323.6	POSTINFECT ENCEPHALITIS
323.7	TOXIC ENCEPHALITIS
323.8	ENCEPHALITIS NEC
323.9	ENCEPHALITIS NOS
324.0	INTRACRANIAL ABSCESS
324.9	CNS ABSCESS NOS
325.	PHLEBITIS INTRCRAN SINUS
326.	LATE EFF CNS ABSCESS
344.81	LOCKED-IN STATE

348.0	CEREBRAL CYSTS
348.1	ANOXIC BRAIN DAMAGE
348.4	COMPRESSION OF BRAIN
348.5	CEREBRAL EDEMA
348.8	BRAIN CONDITIONS NEC
349.82	TOXIC ENCEPHALOPATHY
430.	SUBARACHNOID HEMORRHAGE
432.0	NONTRAUM EXTRADURAL HEM
432.1	SUBDURAL HEMORRHAGE
432.9	INTRACRANIAL HEMORR NOS
800.00	CLOSED SKULL VAULT FX
800.01	CL SKULL VLT FX W/O COMA
800.02	CL SKULL VLT FX-BRF COMA
800.03	CL SKULL VLT FX-MOD COMA
800.04	CL SKL VLT FX-PROLN COMA
800.05	CL SKUL VLT FX-DEEP COMA
800.06	CL SKULL VLT FX-COMA NOS
800.09	CL SKL VLT FX-CONCUS NOS
850.2	CONCUSSION-MODERATE COMA
850.4	CONCUSSION-DEEP COMA
850.5	CONCUSSION W COMA NOS
851.00	CEREBRAL CORTX CONTUSION
851.01	CORTEX CONTUSION-NO COMA
851.02	CORTEX CONTUS-BRIEF COMA
851.03	CORTEX CONTUS-MOD COMA
851.04	CORTX CONTUS-PROLNG COMA
851.05	CORTEX CONTUS-DEEP COMA
851.06	CORTEX CONTUS-COMA NOS
851.09	CORTEX CONTUS-CONCUS NOS
907.0	LT EFF INTRACRANIAL INJ
997.01	SURG COMPLICATION - CNS
013.1X	TUBRCLMA MENINGES
013.2X	TUBERCULOMA BRAIN
013.3X	TB BRAIN ABSCESS
013.6X	TB ENCEPHALITIS
045.0X	AC BULBAR POLIO

800.1X	FRACTURE OF VAULT OF SKULL CLOSED WITH CEREBRAL LACERATION AND CONTUSION
800.2X	FRACTURE OF VAULT OF SKULL CLOSED WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
800.3X	FRACTURE OF VAULT OF SKULL CLOSED WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
800.4X	FRACTURE OF VAULT OF SKULL CLOSED WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
800.5X	FRACTURE OF VAULT OF SKULL OPEN WITHOUT MENTION OF INTRACRANIAL INJURY
800.6X	SKULL FRACTURE (VAULT) OPEN WITH CEEREBRAL LACERATION AND CONTUSION
800.7X	SKULL FRACTURE (VAULT) OPEN WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
800.8X	SKULL FRACTURE (VAULT) OPEN WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
800.9X	SKULL FRACTURE (VAULT) OPEN WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
801.0X	FRACTURE OF BASE OF SKULL CLOSED WITHOUT MENTION OF INTRACRANIAL INJURY
801.1X	FRACTURE OF BASE OF SKULL CLOSED WITH CEREBRAL LACERATION AND CONTUSION
801.2X	FRACTURE OF BASE OF SKULL CLOSED WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
801.3X	FRACTURE OF BASE OF SKULL CLOSED WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
801.4X	FRACTURE OF BASE OF SKULL CLOSED WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
801.5X	FRACTURE OF BASE OF SKULL OPEN WITHOUT MENTION OF INTRACRANIAL INJURY
801.6X	SKULL FRACTURE (BASE) OPEN WITH CEREBRAL LACERATION AND CONTUSION
801.7X	SKULL FRACTURE (BASE) OPEN WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
801.8X	SKULL FRACTURE (BASE) OPEN WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
801.9X	SKULL FRACTURE (BASE) OPEN WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
803.0X	OTHER AND UNQUALIFIED SKULL FRACTURES, CLOSED WITHOUT MENTION OF INTRACRANIAL INJURY
803.1X	OTHER AND UNQUALIFIED SKULL FRACTURES CLOSED WITH CEREBRAL LACERATION AND CONTUSION
803.2X	OTHER AND UNQUALIFIED SKULL FRACTURES CLOSED WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
803.3X	OTHER AND UNQUALIFIED SKULL FRACTURES CLOSED WITH OTHER AND UNSPECIFIED HEMORRHAGE
803.4X	OTHER AND UNQUALIFIED SKULL FRACTURES CLOSED WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
803.5X	OTHER AND UNQUALIFIED SKULL FRACTURES OPEN WITHOUT MENTION OF INTRACRANIAL INJURY

803.6X	OTHER AND UNQUALIFIED SKULL FRACTURES OPEN WITH CEREBRAL LACERATION AND CONTUSION
803.7X	OTHER AND UNQUALIFIED SKULL FRACTURES OPEN WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
803.8X	OTHER AND UNQUALIFIED SKULL FRACTURES OPEN WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
803.9X	OTHER AND UNQUALIFIED SKULL FRACTURES OPEN WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
804.1X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES CLOSED WITH CEREBRAL LACERATION AND CONTUSION
804.2X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES CLOSED WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
804.3X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES CLOSED WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
804.4X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES CLOSED WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
804.6X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES OPEN WITH CEREBRAL LACERATION AND CONTUSION
804.7X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES OPEN WITH SUBARACHNOID, SUBDURAL AND EXTRADURAL HEMORRHAGE
804.8X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES OPEN WITH OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE
804.9X	MULTIPLE FRACTURES INVOLVING SKULL OR FACE WITH OTHER BONES OPEN WITH INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE
851.1X	CEREBRAL CONTUSION, W OPEN INTRACRANIAL WOUND
851.2X	CEREBRAL LACERATION WITHOUT OPEN INTRACRANIAL WOUND
851.3X	CEREBRAL LACERATION WITH OPEN INTRACRANIAL WOUND
851.4X	CEREBELLAR CONTUSION, WITHOUT OPEN INTRACRANIAL WOUND
851.5X	CEREBELLAR CONTUSION, WITH OPEN INTRACRANIAL WOUND
851.6X	CEREBELLAR LACERATION WITHOUT OPEN INTRACRANIAL WOUND
851.7X	CEREBELLAR LACERATION WITH OPEN INTRACRANIAL WOUND
851.8X	OTHER AND UNSPECIFIED CEREBRAL LACERATION AND CONTUSION WITHOUT OPEN INTRACRANIAL WOUND
852.0X	SUBARACHNOID, HEMORRHAGE, FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND
852.1X	SUBARACHNOID HEMORRHAGE FOLLOWING INJURY, WITH OPEN INTRACRANIAL WOUND

852.2X	SUBDURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND
852.3X	SUBDURAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND
852.4X	EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND
852.5X	EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND
853.0X	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND
853.1X	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND
854.0X	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE WITHOUT OPEN INTRACRANIAL WOUND
854.1X	INTRACRANIAL INJURY WITH OPEN INTRACRANIAL WOUND

Transmittal 347 does not include the following ICD-9-CM codes for brain injury. **The TEP recommends these codes be designated as eligible under the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
225.1	BENIGN NEOPLASM OF CRANIAL NERVES
239.6	BRAIN TUMOR OF UNSPECIFIED NATURE
331.0	ALZHEIMER'S DISEASE
331.2	SENILE DEGENERATION OF BRAIN
331.3	COMMUNICATING HYDROCEPHALUS
905.0	LATE EFFECT OF FRACTURE OF SKULL AND FACE BONES

Transmittal 347 removed the following ICD-9-CM codes for brain injury. **The TEP recommends these codes be reinstated as eligible under the 75% Rule.**

066.41	WEST NILE FEVER WITH ENCEPHALITIS
066.42	WEST NILE FEVER WITH OTHER NEUROLOGIC MANIFESTATION
066.49	WEST NILE FEVER WITH OTHER COMPLICATIONS
237.70	NEUROFIBROMATOSIS, UNSPECIFIED
237.71	NEUROFIBROMATOSIS, TYPE 1

(H) Neurological disorders, including multiple sclerosis, motor neuron diseases polpolymeuropathy, muscular dystrophy, and Parkinson's disease

These are the ICD-9-CM codes listed for neurological disorders in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
053.13	POSTHERPES POLYNEUROPATH
094.0	TABES DORSALIS
094.82	SYPHILITIC PARKINSONISM
138.	LATE EFFECT ACUTE POLIO
332.0	PARALYSIS AGITANS
332.1	SECONDARY PARKINSONISM
333.0	DEGEN BASAL GANGLIA NEC
334.0	FRIEDREICH'S ATAXIA
335.19	SPINAL MUSCL ATROPHY NEC
335.2	MOTOR NEURON DISEASE*
335.21	PROGRESSIVE MUSCULAR ATROPHY
335.22	PROGRESSIVE BULBAR PALSY
335.23	PSEUDOBULBAR PALSY
335.24	PRIMARY LATERAL SCLEROSIS
335.29	MOTOR NEURON DISEASE NEC
335.8	ANT HORN CELL DIS NEC
335.9	ANT HORN CELL DIS NOS
340.	MULTIPLE SCLEROSIS
341.0	NEUROMYELITIS OPTICA
341.1	SCHILDER'S DISEASE
341.8	CNS DEMYELINATION NEC
341.9	CNS DEMYELINATION NOS
344.31	MONPLGA LWR LMB DMNT SDE
344.32	MNPLG LWR LMB NONDMNT SD
344.5	MONOPLEGIA NOS
344.89	OTH SPCF PARALYTIC SYND
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEX LESION
353.2	CERVICAL ROOT LESION NEC
353.3	THORACIC ROOT LESION NEC
353.4	LUMBSACRAL ROOT LES NEC
353.5	NEURALGIC AMYOTROPHY
353.5	NEURALGIC AMYOTROPHY
353.8	NERV ROOT/PLEXUS DIS NEC
354.5	MONONEURITIS MULTIPLEX

356.	HERED PERIPH NEUROPATHY*
356.0	HERED PERIPH NEUROPATHY
356.1	PERONEAL MUSCLE ATROPHY
356.2	HERED SENSORY NEUROPATHY
356.3	REFSUM'S DISEASE
356.4	IDIO PROG POLYNEUROPATHY
356.8	IDIO PERIPH NEURPTHY NEC
357.0	AC INFECT POLYNEURITIS
357.1	NEURPTHY IN COL VASC DIS
357.3	NEUROPATHY IN MALIG DIS
357.4	NEUROPATHY IN OTHER DIS
357.5	ALCOHOLIC POLYNEUROPATHY
357.6	NEUROPATHY DUE TO DRUGS
357.7	NEURPTHY TOXIC AGENT NEC
357.81	CHRONIC INFAMMATORY DEMYELINATING POLYNEURITIS
357.82	CRITICAL ILLNESS POLYNEURITIS
358.00	MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION
358.01	MYASTHENIA GRAVIS WITH (ACUTE) EXACERBATION
358.1	MYASTHENIA IN OTH DIS
358.2	TOXIC MYONEURAL DISORDER
358.8	MYONEURAL DISORDERS NEC
359.0	CONG HERED MUSC DYSTRPHY
359.1	HERED PROG MUSC DYSTRPHY
359.2	MYOTONIC DISORDERS
359.3	FAMIL PERIODIC PARALYSIS
359.4	TOXIC MYOPATHY
359.5	MYOPATHY IN ENDOCRIN DIS
359.6	INFL MYOPATHY IN OTH DIS
359.81	CRITICAL ILLNESS MYOPATHY
359.89	OTHER MYOPATHIES
710.3	DERMATOMYOSITIS
710.4	POLYMYOSITIS

Transmittal 347 does not include the following ICD-9-CM codes for neurological disorders. **The TEP recommends these codes be designated as eligible under the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
343.0 – 343.8	INFANTILE CEREBRAL PALSY
333.1 - 333.7, 333.80– 333.99	OTHER EXTRAPYRAMIDAL DISEASE AND ABNORMAL MOVEMENT DISORDERS
334.1 - 334.3, 334.8	SPINOCEREBELLAR DISEASE
337.0, 337.20 – 337.29, 337.3, 337.9	DISORDERS OF THE AUTONOMIC NERVOUS SYSTEM

(I) Burns

These are the ICD-9-CM codes listed for burns in the Transmittal 347. **The TEP agrees that these codes should count toward the 75% Rule.**

ICD-9 CODE	ETIOLOGIC DIAGNOSIS
906.5	LATE EFF HEAD/NECK BURN
906.7	LATE EFF BURN EXTREM NEC
906.8	LATE EFFECT OF BURNS NEC
941.00	BURN NOS HEAD-UNSPEC
941.02	BURN NOS EYE
941.09	BURN NOS HEAD-MULT
941.30	3RD DEG BURN HEAD NOS
941.32	3RD DEG BURN EYE
941.39	3RD DEG BURN HEAD-MULT
946.2	2ND DEG BURN MULT SITE
946.3	3RD DEG BURN MULT SITE
946.4	DEEP 3 DEG BRN MULT SITE
946.5	3RD BRN W LOSS-MULT SITE
948.1x	10-19% BODY SURFACE BURN
948.2x	20-29% BODY SURFACE BURN
948.3x	30-39% BODY SURFACE BURN
948.4x	40-49% BODY SURFACE BURN
948.5x	50-59% BODY SURFACE BURN
948.6x	60-69% BODY SURFACE BURN
948.7x	70-79% BODY SURFACE BURN
948.8x	80-89% BODY SURFACE BURN
948.9x	90% OR MORE BDY SURF BRN
949.3	3RD DEGREE BURN NOS

949.4	DEEP 3RD DEG BURN NOS
949.5	3RD BURN W LOSS-SITE NOS
941.4x	DEEP 3RD DEG BURN
941.5x	3RD DEG BURN W LOSS
942.0x	BURN NOS TRUNK
942.3x	3RD DEG BURN TRUNK
942.4x	DEEP 3RD BURN TRUNK
942.5x	3RD DEG BURN W LOSS TRUNK
943.0x	BURN NOS ARM
943.2x	2ND DEG BURN ARM
943.3x	3RD DEG BURN ARM
943.4x	DEEP 3 DEG BURN ARM
943.5x	3RD BURN W LOSS-ARM
944.3x	3RD DEG BURN HAND
944.4x	DEEP 3 DEG BRN HAND
944.5x	3RD BRN W LOSS-HAND
945.0x	BURN NOS LEG
945.2x	2ND DEG BURN LEG
945.3x	3RD DEG BURN LEG
945.4x	DEEP 3RD DEG BRN LEG
945.5x	3 DEG BRN W LOSS-LEG

VI. Qualifying IGCs For "CMS 13" Categories:

Listed below is a restatement of the currently qualifying IGCs for the conditions that are eligible for the 75% Rule, per the IRF-PAI Manual and Transmittal 347. As noted in Attachment C, coding concerns related to the following conditions were already communicated to CMS.

(A) Stroke
Patients are classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
01.1 - Stroke: Left body involvement (right brain)
01.2 - Stroke: Right body involvement (left brain)
01.3 - Stroke: Bilateral Involvement
01.4 - Stroke: No Paresis
01.9 - Stroke: Other Stroke

(B) Spinal Cord Injury

Patients are classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
04.110 - Paraplegia, unspecified
04.111 - Paraplegia, incomplete
04.112 - Paraplegia, complete
04.120 - Quadriplegia, unspecified
04.1211 - Quadriplegia, Incomplete C1-4
04.1212 - Quadriplegia, Incomplete C5-8
04.1221 - Quadriplegia, Complete C1-4
04.1222 - Quadriplegia, Complete C5-8
04.130 - Other non-traumatic spinal cord dysfunction
04.210 - Paraplegia, Unspecified
04.211 - Paraplegia, Incomplete
04.212 - Paraplegia, Complete
04.220 - Quadriplegia, Unspecified
04.2211 - Quadriplegia, Incomplete C1-4
04.2212 - Quadriplegia, Incomplete C5-8
04.2221 - Quadriplegia, Complete C1-4
04.2222 - Quadriplegia, Complete C5-8
04.230 - Other traumatic spinal cord dysfunction

The following ICD-9-CM codes are not included: 723.0, 724.00-724.09, 953.0 – 953.8.

(C) Congenital Deformity
Patients are classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
12.1 - Spina Bifida
12.9 - Other congenital

(D) Amputation
Patients are classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
05.1 - Unilateral upper extremity above the elbow (AE)
05.2 - Unilateral upper extremity below the elbow (BE), but not including etiological diagnosis codes 885.0 – 885.1, 886.0, 886.1 (CR 3334)
05.3 - Unilateral lower extremity above the knee (AK)
05.4 - Unilateral lower extremity below the knee (BK), but not including etiological diagnosis codes 896.0 – 3, 895 (CR 3334)
05.6 - Bilateral lower extremity above/below the knee (AK/BK)
05.5 - Bilateral lower extremity above the knee (AK/AK)
05.7 - Bilateral lower extremity below the knee (BK/BK)

This IGC is not included: 05.9 - Other Amputation.

(E) Major Multiple Trauma
Patients should be classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
14.1 - Brain and spinal cord injury
14.2 - Brain and multiple fractures/amputation
14.3 - Spinal cord and multiple fractures/amputation
14.9 - Other multiple trauma, but not including etiological diagnosis codes 808.2, 808.3, 808.59, 808.8, 808.9 (CR 3334)

This IGC is not included: 08.4 – Status post major multiple fractures

(F) Fracture of Femur (Hip Fracture)
Patients should be classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
08.11 - Status post unilateral hip fracture
08.12 - Status post bilateral hip fractures

These IGCs are not included:
08.2 - Status post femur (shaft) fracture
08.3 - Status post pelvic fracture

(G) Brain Injury
Patients should be classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
02.1 - Non-traumatic Brain Injury, but not including etiological diagnosis codes 331.0, 331.2, 215.0
02.21 - Open Traumatic Brain Injury
02.22 - Closed Traumatic Brain Injury

This IGC is not included: 02.9 - Other Brain Injury

(H) Neurological Disorders, Including Multiple Sclerosis, Motor Neuron Diseases, Polyneuropathy, Muscular Dystrophy, and Parkinson's Disease.
Patients should be classified as being compliant with the 75% Rule if the patient's IGC is one of the following:
03.1 - Multiple Sclerosis
03.2 – Parkinsonism
03.5 - Cerebral Palsy
03.8 - Neuromuscular disorders

These IGCs are not included:
03.3 – Polyneuropathy
03.4 - Guillian Barre
03.9 - Other neurologic

(I) Burns

Patients should be classified as being compliant with the 75% Rule if the patient's IGC is:

11 - Burns

Attachment A

75% Rule Recommended Guidelines
Technical Expert Panel
Hosted by the American Medical Rehabilitation Providers Association
Washington, DC
June 2004

Organizations Present:
American Hospital Association
American Medical Rehabilitation Providers Association
Federation Of American Hospitals
eRehabData

Individuals Present:

Ken Adams, MD
Medical Director, Rehab Unit
RHD Memorial Medical Center
Tenet Health System

Joan Alverzo, PhD, CRRN
Kessler Institute
Vice President Clinical Support Services
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Rochelle Archuleta
Senior Associate Director, Policy
American Hospital Association

Bob Bianchi
Senior Vice President
Product Development
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Renee Costenbader, RN, MSN, CRRN
Administrator/Dir. of Nursing
Good Shepherd Hospital

Jean Davis
Vice Pres, Operations
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Health South

Pam Dunn, CRRN
Director, Business Operations
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Paul Echelard, CEO
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Sam Fleming
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Melanie Frazey, RHIA
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