Centers for Medicare & Medicaid Services, HHS  § 412.606

(e) Furnishing of inpatient hospital services directly or under arrangement. (1) Subject to the provisions of §412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this subchapter. Inpatient hospital services do not include the following:
   (i) Physicians’ services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis.
   (ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.
   (iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.
   (iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.
   (v) Qualified psychologist services, as defined in section 1861(ii) of the Act.
   (vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) The prospective payment system includes payment for inpatient operating costs of preadmission services that are—
   (1) Otherwise payable under Medicare Part B;
   (2) Furnished to a beneficiary on the date of the beneficiary’s inpatient admission, and during the calendar day immediately preceding the date of the beneficiary’s inpatient admission, to the inpatient rehabilitation facility, or to an entity wholly owned or wholly operated by the inpatient rehabilitation facility; and
   (1) An entity is wholly owned by the inpatient rehabilitation facility if the inpatient rehabilitation facility is the sole owner of the entity.

(ii) An entity is wholly operated by an inpatient rehabilitation facility if the inpatient rehabilitation facility has exclusive responsibility for conducting and overseeing the entity’s routine operations, regardless of whether the inpatient rehabilitation facility also has policymaking authority over the entity.

(3) Related to the inpatient stay. A preadmission service is related if—
   (i) It is diagnostic (including clinical diagnostic laboratory tests); or
   (ii) It is nondiagnostic when furnished on the date of the beneficiary’s inpatient admission; or
   (iii) On or after June 25, 2010, it is nondiagnostic when furnished on the calendar day preceding the date of the beneficiary’s inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary’s inpatient admission.

(4) Not one of the following—
   (i) Ambulance services.
   (ii) Maintenance renal dialysis services.

(g) Reporting and recordkeeping requirements. All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

§ 412.606 Patient assessments.

(a) Admission orders. At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient’s care during the time the patient is hospitalized.

(b) Patient assessment instrument. An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients who—
   (1) Are admitted on or after January 1, 2002; or
   (2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

§ 412.608 Comprehensive assessments.

(1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in §412.610. IRFs must also complete a patient assessment instrument in accordance with §412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient’s physician(s), family, someone personally knowledgeable about the patient’s clinical condition or capabilities, the patient’s clinical record, and other sources.


§ 412.608 Patients’ rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient—

(1) The form entitled “Privacy Act Statement—Health Care Records”; and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled “Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.”

(b) The inpatient rehabilitation facility must document in the Medicare inpatient’s clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data;

(ii) The right to have the patient assessment information collected be kept confidential and secure;

(iii) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(iv) The right to refuse to answer patient assessment questions; and

(v) The right to see, review, and request changes on his or her patient assessment.

(d) The patient rights specified in this section are in addition to the patient rights specified in §82.13 of this chapter.

[68 FR 45699, Aug. 1, 2003]

§ 412.610 Assessment schedule.

(a) General. For each Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in §412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) Starting the assessment schedule day count. The first day that the Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.