

## § 412.600

of CMS' decision of noncompliance no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration request by the long-term care hospital must be submitted to CMS via email and must contain the following information:

(i) The CCN for the long-term care hospital.

(ii) The business name of the long-term care hospital.

(iii) The business address of the long-term care hospital.

(iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including each individual's name, title, email address, telephone number, and physical mailing address. (The physical address may not be a post office box.)

(v) CMS's identified reason(s) for the noncompliance decision from the written notification of noncompliance.

(vi) The reason for requesting reconsideration of CMS' noncompliance decision.

(vii) Accompanying documentation that demonstrates compliance of the long-term care hospital with the LTCH QRP requirements. This documentation must be submitted electronically at the same time as the reconsideration request as an attachment to the email.

(3) *CMS decision on reconsideration request.* CMS will notify long-term care hospitals, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the MAC.

(e) *Appeals of reconsideration requests.* A long-term care hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

(f) *Data completion thresholds.* (1) Long-term care hospitals must meet or exceed the following data completeness thresholds with respect to a fiscal year:

(i)(A) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LTCH Continuity

## 42 CFR Ch. IV (10–1–23 Edition)

Assessment Record and Evaluation (CARE) Data Set (LCDS) on at least 80 percent of the assessments LTCHs submit through the CMS designated data submission system for the FY 2014 through the FY 2025 LTCH QRP.

(B) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LCDS on at least 85 percent of the assessments LTCHs submit through the CMS designated data submission system beginning with the FY 2026 LTCH QRP.

(ii) The threshold set at 100 percent for measures data collected and submitted using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for FY 2014 and all subsequent payment updates.

(2) The thresholds in paragraph (f)(1) of this section apply to all data that must be submitted under paragraph (b) of this section.

(3) A long-term care hospital must meet or exceed both thresholds in paragraph (f)(1) of this section to avoid receiving a 2 percentage point reduction to its annual payment update for a given fiscal year, beginning with the FY 2019 LTCH QRP.

[80 FR 49769, Aug. 17, 2015, as amended at 81 FR 57270, Aug. 22, 2016; 82 FR 38513, Aug. 14, 2017; 83 FR 41705, Aug. 17, 2018; 84 FR 42615, Aug. 16, 2019; 88 FR 59334, Aug. 28, 2023]

## Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

SOURCE: 66 FR 41388, Aug. 7, 2001, unless otherwise noted.

### § 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology

used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

#### § 412.602 Definitions.

As used in this subpart—

*Assessment reference date* means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

*Closure of an IRF* has the same meaning as “closure of a hospital” as defined in §413.79(h)(1)(i) as applied to an IRF meeting the requirements of §412.604(b) for the purposes of accounting for indirect teaching costs.

*Closure of an IRF’s residency training program* has the same meaning as “closure of a hospital residency training program” as defined in §413.79(h)(1)(ii) as applied to an IRF meeting the requirements of §412.604(b) for the purposes of accounting for indirect teaching costs.

*CMS* stands for the Centers for Medicare & Medicaid Services.

*Comorbidity* means a specific patient condition that is secondary to the patient’s principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

*Discharge.* A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

- (1) The patient is formally released from the inpatient rehabilitation facility; or
- (2) The patient dies in the inpatient rehabilitation facility.

*Displaced resident* has the same meaning as a “displaced resident” as defined in §413.79(h)(1)(iii) as applied to an IRF, for purposes of accounting for indirect teaching costs.

*Encode* means entering data items into the fields of the computerized patient assessment software program.

*Functional-related groups* refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

*Interrupted stay* means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

*Outlier payment* means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

*Patient assessment instrument* refers to a document that contains clinical, demographic, and other information on a patient.

*Rural area* means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in §412.62(f)(1)(iii). For discharges occurring on or after October 1, 2005, rural area means an area as defined in §412.64(b)(1)(ii)(C).

*Transfer* means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in §412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

*Urban area* means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in §412.62(f)(1)(ii). For discharges occurring on or after October 1, 2005, urban area means an area as defined in

## § 412.604

## 42 CFR Ch. IV (10–1–23 Edition)

§§ 412.64(b)(1)(ii)(A) and  
412.64(b)(1)(ii)(B).

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 70 FR 47952, Aug. 15, 2005; 87 FR 47090, Aug. 1, 2022]

### **§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.**

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606. 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. In addition, IRFs must complete a patient assessment instrument in accordance with § 412.606 for all other patients, regardless of payer, admitted to or discharged from an IRF on or after October 1, 2024.

(d) *Limitation on charges to beneficiaries—(1) Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under § 489.20(a) of this chapter.

(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

(i) 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.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 74 FR 39810, Aug. 7, 2009; 75 FR 50417, Aug. 16, 2010; 87 FR 47090, Aug. 1, 2022]

#### §412.606 Patient assessments.

(a) *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 are admitted on or after January 1, 2002, or were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(1) Starting on October 1, 2024, inpatient rehabilitation facilities must use the CMS inpatient rehabilitation facility patient assessment instrument to assess all inpatients, regardless of payer, who are admitted on or after October 1, 2024, or who were admitted before October 1, 2024 and are still inpatients as of October 1, 2024.

(2) [Reserved]

(b) *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. In addition, IRFs must complete a patient assessment instrument in accordance with §412.606 for all other patients, regardless of payer, admitted to or discharged from an IRF on or after October 1, 2024.

## § 412.608

## 42 CFR Ch. IV (10–1–23 Edition)

(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.

[66 FR 41388, Aug. 7, 2001, as amended at 74 FR 39810, Aug. 7, 2009; 83 FR 38573, Aug. 6, 2018; 87 FR 47090, Aug. 1, 2022]

### § 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 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 inpatient is furnished services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) *Assessment schedules and reference dates.* The inpatient rehabilitation facility must complete a patient assessment instrument upon the patient's admission and discharge as specified in paragraphs (c)(1) and (2) of this section.

(1) *Admission assessment—(i) General rule.* The admission assessment—

(A) *General.* Time period is a span of time that covers calendar days 1 through 3 of the patient's current hospitalization.

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed by the calendar day that follows the admission assessment reference day.

(ii) *Exception to the general rule.* We may specify in the patient assessment

instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) *Discharge assessment*—(i) *General rule*. The discharge assessment—

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) *Discharge assessment reference date*. The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the inpatient rehabilitation facility; or

(B) The patient stops being furnished inpatient rehabilitation services.

(iii) *Exception to the general rule*. We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) *Encoding dates*. The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) *Accuracy of the patient assessment data*. The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) *Patient assessment instrument record retention*. An inpatient rehabilitation facility must maintain all patient assessment data sets completed on all Medicare Part A fee-for-service patients within the previous 5 years, on Medicare Part C (Medicare Advantage) patients within the previous 10 years,

and all other patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 74 FR 39810, Aug. 7, 2009; 87 FR 47090, Aug. 1, 2022]

#### §412.612 Coordination of the collection of patient assessment data.

(a) *Responsibilities of the clinician*. A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under §412.610(c).

(b) *Penalty for falsification*. (1) Under Medicare, an individual who knowingly and willfully—

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$1,000 as adjusted annually under 45 CFR part 102 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$5,000 as adjusted annually under 45 CFR part 102 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

[66 FR 41388, Aug. 7, 2001, as amended at 81 FR 61562, Sept. 6, 2016]

#### §412.614 Transmission of patient assessment data.

(a) *Data format—General rule*. The inpatient rehabilitation facility must encode and transmit data for each inpatient—

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic

record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) *Transmission dates.* The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in § 412.610(d).

(d) *Failure to submit complete and timely IRF-PAI data, as required under paragraph (c) of this section—*(1) *Medicare Part-A fee-for-service.* (i) A given Medicare Part-A fee-for-service IRF claim will not be accepted and processed for payment until a corresponding IRF-PAI has been received and accepted by CMS.

(ii) [Reserved]

(2) *Medicare Part C (Medicare Advantage) data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for its Medicare Part C (Medicare Advantage) patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its Medicare Part C (Medicare Advantage) data used in the calculations for determining the facility's compliance with the regulations in § 412.29(b)(1).

(3) *All other payer data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for all other patients, regardless of payer, to our patient data system in accordance with the transmission timeline in paragraph

(c) of this section will result in a forfeiture of the facility's ability to have any of its other payer data used in the calculations for determining the facility's compliance with the regulations in § 412.29(b)(1).

(e) *Exemption to the consequences for transmitting the IRF-PAI data late for Medicare Part C (Medicare Advantage) patients and all other patients, regardless of payer.* CMS may waive the consequences of failure to submit complete and timely IRF-PAI data specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the forfeiture specified in paragraphs (d)(2) or (3) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

[66 FR 41388, Aug. 7, 2001, as amended at 68 FR 45699, Aug. 1, 2003; 74 FR 39811, Aug. 7, 2009; 82 FR 36304, Aug. 3, 2017; 87 FR 47091, Aug. 1, 2022]

**§ 412.616 Release of information collected using the patient assessment instrument.**

(a) *General.* An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an

agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

**§ 412.618 Assessment process for interrupted stays.**

For purposes of the patient assessment process, if any patient has an interrupted stay, as defined under § 412.602, the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) *Recording and encoding of data.* The clinician must record the interruption of the stay on the patient assessment instrument.

(c) If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 74 FR 39811, Aug. 7, 2009; 87 FR 47091, Aug. 1, 2022]

**§ 412.620 Patient classification system.**

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) *Weighting factors*—(1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire.* We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities.* We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors.* We may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

**§ 412.622 Basis of payment.**

(a) *Method of payment.* (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(3) *IRF coverage criteria.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a



reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Except during the emergency period described in section 1135(g)(1)(B) of the Act, generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy per week. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.

(iv) Except for care furnished to patients in a freestanding IRF hospital

solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process, except that during a Public Health Emergency, as defined in § 400.200 of this chapter, such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

(4) *Documentation.* Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in paragraph (a)(3) of this section at the time of admission, the patient's medical record at the IRF must contain the following documentation—

(i) A comprehensive preadmission screening that meets all of the following requirements—

(A) It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as

long as an update is conducted in person or by telephone to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record.

(B) It includes a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination.

(C) It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in paragraph (a)(3) of this section.

(D) It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.

(E) It is retained in the patient's medical record at the IRF.

(ii) An individualized overall plan of care for the patient that meets all of the following requirements—

(A) It is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission to the IRF.

(B) It is retained in the patient's medical record at the IRF.

(5) *Interdisciplinary team approach to care.* Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in §400.200 of this chapter, in order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by docu-

mentation in the patients' medical record of weekly interdisciplinary team meetings that meet all of the following requirements—

(i) The team meetings are led by a rehabilitation physician and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status. The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing.

(ii) The team meetings occur at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.

(iii) The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§413.75 and 413.85 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in §413.89 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(c) *Definitions.* As used in this section—

*Rehabilitation physician* means a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation.

*State (or region, as applicable) that is experiencing a surge* means a state (or region, as applicable) that is in phase 1 of the President's Guidelines for Opening Up America Again (<https://www.whitehouse.gov/openingamerica/>), specifically, a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials:

- (i) All vulnerable individuals continue to shelter in place.
- (ii) Individuals continue social distancing.
- (iii) Individuals avoid socializing in groups of more than 10.
- (iv) Non-essential travel is minimized.
- (v) Visits to senior living facilities and hospitals are prohibited.
- (vi) Schools and organized youth activities remain closed.

*Week* means a period of 7 consecutive calendar days beginning with the date of admission to the IRF.

[66 FR 41388, Aug. 7, 2001, as amended at 70 FR 47952, Aug. 15, 2005; 74 FR 39811, Aug. 7, 2009; 83 FR 38573, Aug. 6, 2018; 84 FR 39172, Aug. 8, 2019; 85 FR 19287, Apr. 6, 2020; 85 FR 27622, May 8, 2020; 85 FR 48462, Aug. 10, 2020; 85 FR 59023, Sept. 18, 2020]

**§ 412.624 Methodology for calculating the Federal prospective payment rates.**

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 of this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included

in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates—(1) General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects,

as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) Applicable increase factor for FY 2014 and for subsequent FY. Subject to the provisions of paragraphs (c)(4)(i) and (c)(4)(ii) of this section, the applicable increase factor for FY 2014 and for subsequent years for updating the standard payment conversion factor is the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(i) In the case of an IRF that is paid under the prospective payment system specified in §412.1(a)(3) that does not submit quality data to CMS in accordance with §412.634, the applicable increase factor specified in paragraph (a)(3) of this section, after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act, is reduced by 2 percentage points.

(ii) Any reduction of the increase factor will apply only to the fiscal year involved and will not be taken into account in computing the applicable increase factor for a subsequent fiscal year.

(iii) The 2 percentage point reduction described in paragraph (c)(4)(i) of this section may result in the applicable increase factor specified in paragraph (a)(3) of this section being less than 0.0 for a fiscal year, and may result in payment rates under the prospective payment system specified in §412.1(a)(3) for a fiscal year being less than such payment rates for the preceding fiscal year.

(5) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in §412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard

payment conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(5) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under §412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(4) *Payment adjustment for Federal fiscal year 2006 and applicable Federal fiscal years.* CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (3), (4) and (6), of this section, and to any revision specified in §412.620(c) by a factor as specified by the Secretary.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index.

(i) The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(ii) Starting on October 1, 2022, CMS applies a cap on decreases to the wage index such that the wage index applied to an IRF is not less than 95 percent of the wage index applied to that IRF in the prior FY.

(iii) Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

(2) *Adjustments for low-income patients.* We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) *Adjustments for rural areas.* We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in § 412.602.

(4) *Adjustments for teaching hospitals.* (i) *General.* For discharges on or after October 1, 2005, CMS adjusts the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions.

(A) An IRF's teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the IRF divided by the facility's average daily census.

(B) As described in § 412.105(f)(1)(iii)(A), residents with less than full-time status are counted as partial full time equivalent based on the proportion of time assigned to the inpatient rehabilitation facility compared to the total time necessary to fill a residency slot. Residents rotating to more than one hospital or non-hospital setting will be counted in proportion to

the time they are assigned to inpatient rehabilitation facility compared to the total time worked in all locations. An inpatient rehabilitation facility cannot claim time spent by the resident at another inpatient rehabilitation facility or hospital.

(C) Except as described in paragraph (e)(4)(i)(D) of this section, the actual number of current year full-time equivalent residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the IRF's final settled cost report for the most recent cost reporting period ending on or before November 15, 2004 (base year).

(D) If the inpatient rehabilitation facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (e)(4)(i)(C) of this section may be adjusted using the method described in § 413.79(e)(1)(i).

(E) The teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for the claim is made during the final settlement of the cost report.

(ii) *Closure of an IRF or IRF residency training program.* (A) *Closure of an IRF.* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of another IRF's closure if the IRF meets the following criteria:

(1) The IRF is training additional displaced residents from an IRF that closed on or after October 1, 2011.

(2) No later than 60 days after the IRF begins to train the displaced residents, the IRF submits a request to its Medicare contractor for a temporary adjustment by identifying the displaced residents who have come from the closed IRF and have caused the IRF to exceed its cap, and specifies the length of time the adjustment is needed.

(B) *Closure of an IRF's residency training program.* If an IRF that closes its residency training program on or after October 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (e)(4)(ii)(A)(2) of this section, another

IRF(s) may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of the residency training program if the criteria specified in paragraph (e)(4)(ii)(A)(1) of this section are met.

(1) *Receiving IRF(s).* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of another IRF's residency training program if the IRF is training additional displaced residents from the residency training program of an IRF that closed a program; and if no later than 60 days after the IRF begins to train the displaced residents the IRF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the displaced residents who have come from another IRF's closed program and have caused the IRF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare Contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (e)(4)(ii)(A)(2) of this section.

(2) *IRF that closed its program.* An IRF that agrees to train displaced residents who have been displaced by the closure of another IRF's program may receive a temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE of displaced residents in each program year training in the program at the time of the programs closure. This yearly reduction in the FTE cap will be determined based on the number of those displaced residents who would have been training in the program during that year had the program not closed. No later than 60 days after the displaced residents who were in the hospital that closed its program(s) begin training at another hospital must submit to its Medicare Contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IRF training the displaced residents to obtain a temporary adjustment to its

cap; identifies the displaced residents who were in the training at the time of the program's closure; identifies the IRFs to which the displaced residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at §412.84(i), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio and national averages that will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at §412.84(m), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio.

(6) *Adjustments for certain facilities geographically redesignated in FY 2006—*

(i) *General.* For a facility defined as an urban facility under §412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under §412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY 2006 and it no longer qualified for the rural adjustment under §412.624(e)(3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) *Exception.* For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e)(7)(i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under § 412.624(e)(3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e)(6)(i)(A) and (B) of this section as determined by us.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in § 412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustment described in paragraphs (e)(1), (2), (3), (4), and (6) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount and making a payment in accordance with paragraph (e)(5) of this section, if applicable.

(g) *Special payment provision for interrupted stays.* When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in § 412.602 and as indicated on the patient assessment instrument in accordance with § 412.618(b), we will make payments in the following manner:

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under § 412.602, will be—

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in § 412.1(a)(1) made to the acute care hospital.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45700, Aug. 1, 2003; 70 FR 47952, Aug. 15, 2005; 71 FR 48408, Aug. 18, 2006; 72 FR 44312, Aug. 7, 2007; 76 FR 47892, Aug. 5, 2011; 82 FR 36305, Aug. 3, 2017; 83 FR 38573, Aug. 6, 2018; 87 FR 47091, Aug. 1, 2022]

**§ 412.626 Transition period.**

(a) *Duration of transition period and proportion of the blended transition rate.*

(1) Except for a facility that makes an election under paragraph (b) of this section, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under § 412.624(e) or § 412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) *Election not to be paid under the transition period methodology.* An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient

rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received timely or is otherwise not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002]

**§ 412.628 Publication of the Federal prospective payment rates.**

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the FEDERAL REGISTER. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

**§ 412.630 Limitation on review.**

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

[78 FR 47934, Aug. 6, 2013]



**§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.**

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for

less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments—(1) General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

**§412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).**

(a) *Participation.*(1) For the FY 2018 payment determination and subsequent years, an IRF must begin reporting data under the IRF QRP requirements no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the IRF as operating in the CMS designated data submission system.

(2) [Reserved]

(b) *Submission requirements.* (1) IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, as applicable. Such data must be submitted in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the IRF QRP based on one or more of the following factors:

(i) Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;

(ii) Performance or improvement on a measure does not result in better patient outcomes;

(iii) A measure does not align with current clinical guidelines or practice;

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic;

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;

(vii) The collection or public reporting of a measure leads to negative unintended consequences other than patient harm;

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and Extension Requirements.* (1) An IRF may request and CMS may grant exceptions or extensions to the measures data or standardized patient assessment data reporting requirements, for one or more quarters, when there are certain extraordinary circumstances beyond the control of the IRF.

(2) An IRF must request an exception or extension within 90 days of the date that the extraordinary circumstances occurred.

(3) Exception and extension requests must be submitted to CMS from the IRF by sending an email to [IRFQRPreconsiderations@cms.hhs.gov](mailto:IRFQRPreconsiderations@cms.hhs.gov) containing all of the following information:

(i) IRF CMS Certification Number (CCN).

(ii) IRF Business Name.

(iii) IRF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) IRF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the IRF believes it will be able to again submit IRF QRP data and a justification for the proposed date.

(4) CMS may grant exceptions or extensions to IRFs without a request if it is determined that one or more of the following has occurred:

- (i) An extraordinary circumstance affects an entire region or locale.
- (ii) A systemic problem with one of CMS's data collection systems directly affected the ability of an IRF to submit data.

(5) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered as a valid exception or extension request.

(d) *Reconsideration.* (1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

(2) Reconsideration requests must be submitted to CMS by sending an email to [IRFQRPreconsiderations@cms.hhs.gov](mailto:IRFQRPreconsiderations@cms.hhs.gov) containing all of the following information:

- (i) IRF CCN.
- (ii) IRF Business Name.
- (iii) IRF Business Address.
- (iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)
- (v) CMS identified reason(s) for non-compliance from the non-compliance letter.
- (vi) Reason(s) for requesting reconsideration.

(3) The request for reconsideration must be accompanied by supporting documentation demonstrating compliance. This documentation must be submitted electronically as an attachment to the reconsideration request email. Any request for reconsideration that does not contain sufficient evidence of compliance with the IRF QRP requirements will be denied.

(4) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered

as a valid exception or extension request.

(5) CMS will notify IRFs, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

(e) *Appeals.* (1) An IRF may appeal the decision made by CMS on its reconsideration request by filing with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

(2) [Reserved]

(f) *Data Completion Thresholds.* (1) IRFs must meet or exceed two separate data completeness thresholds: One threshold set at 95 percent for completion of required quality measures data and standardized patient assessment data collected using the IRF-PAI submitted through the CMS designated data submission system; and a second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN.

(2) These thresholds (95 percent for completion of required quality measures data and standardized patient assessment data on the IRF-PAI; 100 percent for CDC NHSN data) will apply to all measures and standardized patient assessment data requirements adopted into the IRF QRP.

(3) An IRF must meet or exceed both thresholds to avoid receiving a 2 percentage point reduction to their annual payment update for a given fiscal year, beginning with FY 2016 and for all subsequent payment updates.

[80 FR 47138, Aug. 6, 2015, as amended at 81 FR 52140, Aug. 5, 2016; 82 FR 36305, Aug. 3, 2017; 83 FR 38573, Aug. 6, 2018; 84 FR 39172, Aug. 8, 2019]

**PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS**

**Subpart A—Introduction and General Rules**

Sec.

- 413.1 Introduction.
- 413.5 Cost reimbursement: General.
- 413.9 Cost related to patient care.
- 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.
- 413.17 Cost to related organizations.

**Subpart B—Accounting Records and Reports**

- 413.20 Financial data and reports.
- 413.24 Adequate cost data and cost finding.

**Subpart C—Limits on Cost Reimbursement**

- 413.30 Limitations on payable costs.
- 413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.
- 413.40 Ceiling on the rate of increase in hospital inpatient costs.

**Subpart D—Apportionment**

- 413.50 Apportionment of allowable costs.
- 413.53 Determination of cost of services to beneficiaries.
- 413.56 [Reserved]

**Subpart E—Payments to Providers**

- 413.60 Payments to providers: General.
- 413.64 Payments to providers: Specific rules.
- 413.65 Requirements for a determination that a facility or an organization has provider-based status.
- 413.70 Payment for services of a CAH.
- 413.74 Payment to a foreign hospital.

**Subpart F—Specific Categories of Costs**

- 413.75 Direct GME payments: General requirements.
- 413.76 Direct GME payments: Calculation of payments for GME costs.
- 413.77 Direct GME payments: Determination of per resident amounts.
- 413.78 Direct GME payments: Determination of the total number of FTE residents.
- 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

413.85 Cost of approved nursing and allied health education activities.

413.87 Payments for Medicare + Choice nursing and allied health education programs.

413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

413.89 Bad debts, charity, and courtesy allowances.

413.90 Research costs.

413.92 Costs of surety bonds.

413.94 Value of services of nonpaid workers.

413.98 Purchase discounts and allowances, and refunds of expenses.

413.99 Qualified and Non-Qualified Deferred Compensation Plans.

413.100 Special treatment of certain accrued costs.

413.102 Compensation of owners.

413.106 Reasonable cost of physical and other therapy services furnished under arrangements.

413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

413.123 Payment for screening mammography performed by hospitals on an outpatient basis.

413.124 Reduction to hospital outpatient operating costs.

413.125 Payment for home health agency services.

**Subpart G—Capital-Related Costs**

413.130 Introduction to capital-related costs.

413.134 Depreciation: Allowance for depreciation based on asset costs.

413.139 Depreciation: Optional allowance for depreciation based on a percentage of operating costs.

413.144 Depreciation: Allowance for depreciation on fully depreciated or partially depreciated assets.