

§ 412.604

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§§ 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.