

§ 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