

§ 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