

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