

## Centers for Medicare & Medicaid Services, HHS

§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

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

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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