DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[HCFA–1069–P]

RIN 0938–AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. This proposed rule would implement section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33) and as amended by section 125 of the Balanced Budget Refinement Act of 1999 (Public Law 106–113), which authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units. It also authorizes the Secretary to require rehabilitation hospitals and rehabilitation units to submit such data as the Secretary deems necessary to establish and administer the prospective payment system. The prospective payment system described in this proposed rule would replace the reasonable cost-based payment system under which the rehabilitation hospitals and rehabilitation units are currently paid.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 2, 2001.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY:

Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1069–P, P.O. Box 8010, Baltimore, MD 21244–8010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201; or Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the delivery addresses may be delayed and could be considered late.

FOR FURTHER INFORMATION CONTACT:

Robert Kuhl, (410) 786–4597 (General information).

Pete Diaz, (410) 786–1235 (Requirements for completing the Minimum Data Set for Post Acute Care (MDS–PAC), and other MDS–PAC issues).

Jacqueline Gordon, (410) 786–4517 (Payment system, the case-mix classification methodology, transition payments, relative weights/case-mix index, update factors, transfer policies, payment adjustments).

Nora Hoban, (410) 786–0675 (Calculation of the payment rates, relative weights/case-mix index, wage index, payment adjustments).

SUPPLEMENTARY INFORMATION:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1069–P.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone: (202) 690–7890).

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To assist readers in referencing sections contained in this document, we are providing the following table of contents.

Table of Contents

In addition, because of the many terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ADL—Activities of Daily Living
BBA—Balanced Budget Act of 1997, Public Law 105–33
BBRA—Balanced Budget Refinement Act of 1999, Public Law 106–113
CMGs—case-mix groups
CMI—case-mix index
COS—Clinical Outcomes Systems
DRGs—diagnosis-related groups
FIM—functional independence measure
FIM—FRG-functional independence measurement-function related group
FRG—Function Related Group
FY—Federal fiscal year
HCFA—Health Care Financing Administration
HHAs—home health agencies
HMO—health maintenance organization
IRF—inpatient rehabilitation facilities
MDCN—Medicare Data Collection Network
MDS—PAC-Minimum Data Set for Post Acute Care
MedPAC—Medicare Payment Advisory Commission
MEDPAR—Medicare provider analysis and review
MPACT—MDS–PAC Tool—Minimum Data Set for Post Acute Care Tool
OASIS—Outcome and Assessment Information Set
ProPAC—Prospective Payment Assessment Commission
RICs—Rehabilitation Impairment Categories
SNF—skilled nursing facility
TEFRA—Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
UDSmr—Uniform Data Set for medical rehabilitation
Y2K—Year 2000/Millennium

I. Background

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248) to limit payment by placing a limit on allowable costs per discharge. Section 601 of the Social Security Amendments of 1983 (Public Law 98–21) added a new section 1886(d) to the Social Security Act (the Act) which replaced the reasonable cost-based payment system for most hospital inpatient services. Section 1886(d) of the Act provides for a prospective payment system for the operating costs of hospital inpatient stays effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to a prospective payment system, certain specialty hospitals were excluded from that system. As discussed in detail in section I.A.1 of this preamble, rehabilitation hospitals and distinct part rehabilitation units in hospitals were among the excluded facilities. Subsequent to the implementation of the hospital inpatient prospective payment system, both the number of excluded rehabilitation facilities, particularly distinct part units, and Medicare payments to these facilities grew rapidly. In order to control escalating costs, the Congress, through enactment of section 4421 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33) and section 125 of the Balanced Budget Refinement Act of 1999 (BBRA) (Public Law 106–113), provided for the implementation of a prospective payment system for inpatient rehabilitation facilities.

Section 4421 of the BBA amended the Act by adding section 1886(j), which authorizes the implementation of a prospective payment system for inpatient rehabilitation services. This proposed rule would implement a Medicare prospective payment system, as authorized by section 1886(j) of the Act, for inpatient rehabilitation hospitals and units. We refer to these inpatient rehabilitation hospitals and units as ''inpatient rehabilitation facilities'' or ''IRFs'' throughout this proposed rule.

The statute provides for the prospective payment system for IRFs to be implemented for cost reporting periods beginning on or after October 1, 2000. The statute also provides for a new prospective payment system for home health services for cost reporting periods beginning on or after October 1, 2000, along with modifications to the existing prospective payment systems for acute care hospitals and skilled nursing facilities.

Although we are working very hard to implement the extensive changes required by the statute, the demands of simultaneously implementing new prospective payment systems (for example, outpatient hospital and home health) and modifying existing payment systems are significant. The creation of each new payment system or modification to an existing payment system requires an extraordinary amount of lead time to develop and implement the necessary changes to our existing computerized claims processing systems. In addition, it requires additional time after implementation to ensure that these complex changes are properly administered. After an extensive analysis of the changes required to HCFA's systems, we have concluded that it is infeasible to implement the IRF prospective payment system as of October 1, 2000. Therefore, we plan to implement the IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001. We believe that this implementation date is the earliest feasible date given the scope and magnitude of the implementation requirements associated with this and other mandated provisions.

In this proposed rule, we provide a number of discussions useful in understanding the development and implementation of the IRF prospective payment system. These discussions include the following:

- An overview of the current payment system for IRFs.
- A discussion of research on IRF patient classification systems and prospective payment systems, including prior and current research performed by the RAND Corporation.
- A discussion of statutory requirements for developing and implementing an IRF prospective payment system.
- A discussion of the proposed requirement that IRFs complete the Minimum Data Set for Post Acute Care (MDS–PAC) (a patient assessment instrument) as a part of the data collection deemed necessary by the Secretary to implement and administer the IRF prospective payment system.
- A discussion of the IRF patient classification system using case-mix groups (CMGs).
- A detailed discussion of the proposed prospective payment system including the relative weights and payment rates for each CMG, adjustments to the payment system, additional payments, and budget

neutrality requirements mandated by section 1886(j).

• An analysis of the impact of the IRF prospective payment system on the Federal budget and inpatient rehabilitation facilities, including small rural facilities.

Finally, we are proposing conforming changes to existing regulations as well as new regulations that are necessary to implement the proposed IRF prospective payment system.

A. Overview of Current Payment System for Inpatient Rehabilitation Facilities

1. Exclusion of Certain Facilities From the Hospital Inpatient Prospective Payment System

Although payment for operating costs of most hospital inpatient services became subject to a prospective payment system when the hospital inpatient prospective payment system was implemented in October 1983, certain types of specialty hospitals and units were excluded from that payment system. As set forth in section 1886(d)(1)(B) of the Act, the following hospitals were originally excluded from the hospital inpatient prospective payment system: psychiatric, rehabilitation, children's, and long-term care. Effective with cost reporting periods beginning on or after October 1, 1989 cancer hospitals were added to this list by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 Public Law (101–239). In addition, psychiatric and rehabilitation distinct part units of hospitals are excluded from the hospital inpatient prospective payment system.

These specialty hospitals were excluded by the Congress from the hospital inpatient prospective payment system because they typically treat cases that involve lengths of stay that are, on average, longer or more costly than would be predicted by the diagnosis related group (DRG) system and, therefore, could be systematically underpaid if the DRG system was applied to them. These exclusions were the result of concerns that DRGs—the classification system on which payment under the hospital inpatient prospective payment system is based—might not accurately account for the resource costs for the types of patients treated in those facilities.

The concern that DRGs might not accurately account for costs in excluded hospitals arose because the hospital inpatient prospective payment system was developed from the cost and utilization experience of general hospitals, which typically provide acute care for a variety of medical conditions. The hospital inpatient prospective payment system is a system of average-based payments that assume that some patient stays will consume more resources than the typical stay, while others will demand fewer resources.

Thus, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the hospital inpatient prospective payment system. In a *Report to Congress: Hospital Prospective Payment for Medicare* (1982), the Department of Health and Human Services stated that the ''467 DRGs were not designed to account for these types of treatment'' found in the four special classes of hospitals, and noted that ''including these hospitals will result in criticism * * * (and) their application to these hospitals would be inaccurate and unfair.''

Accordingly, this report to the Congress suggested that a DRG system might not work as well for these treatment classes as they did for other medical specialties. One concern was that the resource needs of patients in these excluded hospitals were not solely correlated with diagnoses. A second concern was that the mix of service intensities provided by these specialty hospitals significantly differed from that of general medical/surgical hospitals. The legislative history of the 1983 amendments to the Act stated that the ''DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays.'' (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rep. No. 98–25, at 141 (1983)).

Following enactment in April 1983 of the Social Security Amendments of 1983, we undertook a number of initiatives to ensure implementation of the hospital inpatient prospective payment system by October 1, 1983. Important activities included the publication of the rules and regulations for the hospital inpatient prospective payment system. The interim final rule was published in the September 1, 1983 **Federal Register** (48 FR 39752). We published a final rule in the January 3, 1984, **Federal Register** (49 FR 234) following a public comment period, evaluation of comments received, and formulation of responses to and regulatory revisions to the regulations based upon the comments. Updates and modifications of the regulations are published annually in the **Federal Register**. Together, the initial statutory mandate and the published regulations addressed several important program issues. One program issue was the implementation of the criteria for hospitals that are seeking to be excluded from the hospital inpatient prospective payment system under one of the specialty classes, including IRFs. The regulations concerning exclusion from the hospital inpatient prospective payment system, in part 412, subpart B, are discussed below.

2. Requirements for Inpatient Rehabilitation Facilities To be Excluded From the Hospital Inpatient Prospective Payment System

Under section 1886(d)(1)(B) of the Act, the prospective payment system for hospital inpatient operating costs set forth in section 1886(d) of the Act does not apply to several specified types of entities, including a rehabilitation hospital ''as defined by the Secretary'' or, ''in accordance with regulations of the Secretary,'' a rehabilitation unit of a hospital which is a distinct part of the hospital ''as defined by the Secretary.'' In general, existing regulations in part 412, subpart B provide that to be excluded from the hospital inpatient prospective payment system, an IRF must—(1) Have a provider agreement or be a unit in an institution that has in effect an agreement to participate as a hospital under part 489; and (2) except for newly participating hospitals seeking to be excluded, demonstrate that they serve an inpatient population of whom at least 75 percent require intensive rehabilitative services for the treatment of 1 or more of 10 specified conditions. The specified conditions are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis including rheumatoid arthritis, neurological disorders, and burns. Patients in IRFs require frequent physician involvement, rehabilitation nursing, and care from a coordinated group of professionals. (All IRFs that meet the requirements in §§ 412.23(b), 412.25, and 412.29 would be paid under the IRF prospective payment system proposed in this rule.)

3. Payment System Requirements Prior to the Balanced Budget Act of 1997

Hospitals that are excluded from the hospital inpatient prospective payment system are paid for inpatient operating costs under the provisions of section 1886(b) of the Act. Until the IRF prospective payment system is implemented, IRFs are paid on the basis of Medicare reasonable costs limited by a facility-specific target amount per discharge. Each facility has a separate

payment limit or target amount that is calculated for that facility based on its cost per discharge in a base year, subject to caps. The target amount is adjusted annually by an update factor called the rate-of-increase percentage. Facilities whose costs are below their target amounts receive bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount. For facilities whose costs exceed their target amounts, Medicare provides relief payments equal to half of the amount by which the hospitals costs exceeded the target amount up to 10 percent of the target amount. Facilities that experience a more significant increase in patient acuity can also apply for an additional amount under the regulations for Medicare exception payments.

4. Strengths and Weaknesses of the Current Payment System

Utilization of post-acute care services has grown rapidly in recent years. Since the implementation of the hospital inpatient prospective payment system, average length of stay in acute care hospitals has decreased and patients are increasingly being discharged to post-acute care settings such as IRFs, skilled nursing facilities (SNFs), home health agencies (HHAs), and long-term care hospitals to complete their course of treatment. The increased utilization of post-acute care providers, including excluded facilities, has fueled the rapid growth in payments in recent years. With increased utilization and the incentives associated with the reasonable-cost based payment system, discussed below, the number of IRFs has also increased significantly.

In its March 1999 Report to the Congress the Medicare Payment Advisory Commission (MedPAC) (formerly the Prospective Payment Assessment Commission (ProPAC)) stated, ''Aggregate spending has increased at a fairly rapid pace, reflecting increased patient volume rather than increased payments per discharge. Aggregate Medicare operating payments to rehabilitation facilities rose 18 percent annually between 1990 and 1996, from $1.9 billion to $4.3 billion. Since 1990, payments per discharge have risen less than the rate of inflation, reaching $10,500 in 1996.'' (p. 90.) The MedPAC report explains that the—

> TEFRA system has remained in effect longer than expected partly because of difficulties in accounting for the variation in resource use across patients in exempted facilities. The unintended consequences of sustaining that system have included a steady growth in the number of prospective payment system-exempt facilities and a substantial payment inequity between older and newer facilities. In particular, the payment system encouraged new exempt facilities to maximize their costs in the base year to establish high cost limits. Once subject to its relatively high limit, a recent entrant could reduce its costs below its limit, resulting in reimbursement of its full costs. * * * By contrast, facilities that existed before they became subject to TEFRA could not influence their cost limits. Given the relatively low limits of older facilities, they are more likely to incur costs above their limits and thus receive payments less than their costs. (p. 72)

To address concerns such as the historical growth in payments and disparity in payments to existing and newly excluded hospitals and units, the BBA mandated several changes to the current payment system. These changes are outlined in section I.C.1 of this preamble. In addition, we and other organizations have conducted research since the inception of the hospital inpatient prospective payment system to determine if alternate prospective payment systems are feasible for these excluded hospitals.

B. Research for Alternate Prospective Payment Systems for Inpatient Rehabilitation Facilities Prior to the Balanced Budget Act of 1997

Below is a discussion of research projects and other analyses concerning prospective payment systems that are relevant to the development of the IRF prospective payment system that we are proposing to implement in this rule.

The methods and tasks that must be undertaken in order to develop an IRF prospective payment system include development of a patient classification system that accounts for differences in patient case mix. A patient classification system is developed by classifying patients into mutually exclusive groups based on similar clinical characteristics and similar levels of resource use. A factor to weight differences in patient case mix can be developed by measuring the relative difference in resource intensity among the different groups. We are proposing to implement a payment system that uses case-mix groups and weighting factors that account for the intensity of services delivered to IRF Medicare patients.

1. Early Studies

In October 1984, as mentioned in the 1987 Report to the Congress: Developing a Prospective Payment System for Excluded Hospitals (1987), the Medical College of Wisconsin and the RAND Corporation (RAND) began a joint effort to investigate the feasibility of a prospective payment system for excluded hospitals including IRFs. The RAND Corporation is a nonprofit institution with extensive health care background in improving policy and decision making through research and analysis. This joint effort was under a HCFA cooperative agreement with the RAND Corporation. The Medical College of Wisconsin collected data from a survey of patient records that included standard discharge data, diagnostic condition, functional status and other impairment measures, billing data, and facility information gathered from telephone interviews. RAND assisted in the design and analysis of the survey data and obtained a 20 percent sample of the HCFA patient billing file for FY 1984—the implementation year of the hospital inpatient prospective payment system.

The data were used to analyze the delivery systems of rehabilitation care. The Report to the Congress stated that care in IRFs ''emphasizes the treatment of functional limitations and disability''. Functional limitations could be measured by the patient's ability to perform activities of daily living such as locomotion, dressing, eating, bathing, etc. The patient's level of performing these activities of daily living is referred to as the patient's functional status. The results of this analysis showed that ''diagnostic condition explained little, whereas functional status measures explained substantially more, of the variance in total charges for a rehabilitation stay.'' However, at the time of this analysis, a nationally-accepted set of functional status measures had not been developed for application in a classification system for IRFs.

2. Functional Status Studies

While numerous studies involved developing and assessing functional status, several researchers (for example, Batavia 1988; Johnston 1984) suggested using functional status as the basis for a rehabilitation payment system. Functional status, as measured by a patient's ability to perform activities of daily living and by mobility, can be evaluated at admission and discharge or any time during the stay. In addition, change in functional status (the difference in functional status from admission to discharge) can be measured.

Researchers evaluated several methods of using functional status at different stages of the patient's stay to develop a payment system. For the most part, the use of these methods resulted in payment systems that appeared to be inadequate in creating the proper incentives to care for high resource use

patients and to produce quality outcomes. Basing a payment system on expected improvement in a patient's functional limitations requires a scale that is sensitive to changes in functional status. In addition, precise data describing the functional status of the patient would have to be collected on admission and at periodic intervals until discharge (Hosek et al.; 1986).

The development of a patient classification system for a case-mix adjusted prospective payment system was hindered by the lack of an appropriate and widely accepted functional status measure for inpatient rehabilitation. The functional independence measure (FIM) was developed to fill this need (Hamilton *et al.,* 1987). The functional independence measure addresses a patient's functional status covering six domains—self-care, sphincter control, mobility, locomotion, social cognition, and communication. There are two national sources of functional independence measures. The Uniform Data Set for Medical Rehabilitation (UDSmr) is operated within the Center for Functional Assessment Research, U. B. Foundation Activities, Inc. The UDSmr collects data on patient age, sex, living situation prior to hospitalization, the impairment that is the primary reason for admission to the IRF, and functional status at admission and discharge. It also includes patient admission and discharge information as well as hospital charges. The Clinical Outcomes System (COS) is operated by Caredata.com, Inc. (formerly Medirisk Inc.), located in Atlanta, Georgia. The COS contains the same type of patient information as UDSmr. However, we have been notified that the COS has been discontinued as of July 2000.

3. Studies on Patient Classification Systems

In 1991, Nancy Diane Harada presented a study in her dissertation titled ''The Development of a Resource-Based Patient Classification Scheme for Rehabilitation.'' This study developed a clinically-based, diagnosis-specific patient classification system for rehabilitation hospital services. The final classification system in this study includes 33 patient classification groups. The patient classification groups are referred to as Rehabilitation Functional Related Groups.

Harada believed that, at the facility level, the rehabilitation functional related groups could be viewed as a managerial tool to monitor the quality of care, as well as the resources expended in the treatment of rehabilitation patients. From a policy perspective, use of the rehabilitation functional related groups could minimize the adverse incentives for IRFs to underserve certain groups that may arise from the lack of case-mix index adjusted payments in the current cost limit payment system. The results of this study found that rehabilitation functional related group methodology may provide an appropriate basis for the prospective payment of rehabilitation services.

Using FIM data reported to UDSmr, a team of researchers from the University of Pennsylvania developed a patient classification system, Function Related Groups (FRGs), referred to as the FIM–FRGs (Stineman *et al.,* 1994). The American Rehabilitation Association (currently known as the American Medical Rehabilitation Providers Association) funded the development of a prototype of function related groups. Further work and revisions were funded by the Agency for Health Care Research and Quality, formerly known as the Agency for Health Care Policy and Research and the National Center for Medical Rehabilitation Research at the National Institutes of Health.

As FIM–FRGs were refined, they were reframed using the International Classification of Impairments, Disabilities and Handicaps to ensure a better measure of the consumption of rehabilitation resources, prognosis, and outcome (Stineman, 1997). These classifications were designed to be related to the major categories of the DRGs and indirectly linked to the ICD–9–CM with focus on disabilities and impairment categorization.

This original work on a FIM–FRG patient classification system identified 21 clinically defined rehabilitation impairment categories (RICs) such as stroke, traumatic brain dysfunction, non-traumatic brain dysfunction, and non-traumatic spinal cord injury. The RICs were then subdivided into FIM–FRGs using the FIM motor score, FIM cognitive score, and age. Accordingly, the FIM–FRG patient classification system first sorted patients into a RIC and then used assessments of patient functional and cognitive abilities and age to classify them into a FIM–FRG.

4. HCFA-Sponsored Analysis by RAND

In 1994, we contracted with RAND for analyses designed to: (1) examine the stability of the original FRGs; (2) extend the FRGs to take account of previously unexamined cases (re-admissions), previously unused information (interrupted stays), and newly available data (Medicare data on comorbidities and complications); and (3) evaluate the performance of FRGs when cost rather than length of stay is used to form groups and when only Medicare cases rather than all cases are used to form groups.

RAND's analyses: (1) evaluated the suitability of the FIM–FRG patient classification system; (2) evaluated a prospective payment system for inpatient rehabilitation facilities based on the FIM–FRGs; and (3) prepared final reports describing the evaluation of the UDSmr, FIM, and FIM–FRGs. This analysis used more current data to replicate and update previous work performed by RAND in 1990.

Two data systems—the UDSmr and Medicare program information—were the primary sources for these analyses. UDSmr provided RAND with functional status and demographic information for rehabilitation discharge data on 139,360 cases from 352 IRFs from calendar year 1994. The Medicare program information included Medicare bill and cost report data for 1994.

The first step of the analysis involved matching UDSmr cases with Medicare records using patient and facility identifiers. Because patient and facility identifiers on the UDSmr records were encrypted, it was necessary to use a sophisticated matching probability technique to match Medicare records to a corresponding UDSmr case. In addition, several thousand of the Medicare discharges corresponded to part of an interrupted rehabilitation stay. For the purposes of this analysis, a rehabilitation stay interrupted by a single admission to an acute care hospital is treated as two rehabilitation discharges, one interrupted by two admissions to an acute care hospital is treated as three rehabilitation discharges, and so on. Using this definition of ''interrupted stays'', RAND stated that the 139,360 cases found in the UDSmr data corresponded to 144,719 Medicare discharges. A file with the matched patient data was created.

RAND then subjected this patient data to a rigorous and complex statistical algorithm to test the predictive power of resource use to classify these patients into RICs and corresponding FIM–FRGs. As a result, RAND recommended that the number of FRGs per RIC be limited to a maximum of 5 and proposed a total of 70 FRGs. Facility level data from the hospital cost report information system file was used to test the feasibility of using the resulting FIM–FRGs to develop an IRF prospective payment system.

The results of the RAND study were released in September 1997 and are contained in two reports available through the National Technical

Information Service (NTIS). The reports are—

• Classification System for Inpatient Rehabilitation Patients—A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, NTIS order number PB98–105992INZ; and

• Prospective Payment System for Inpatient Rehabilitation, NTIS order number PB98–106024INZ. These reports can be ordered by calling the NTIS sales desk at 1–800–553–6847 or by e-mail at *orders@ntis.fedworld.gov*.

RAND found that, with limitations, the FIM–FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor scores, cognitive scores, and age remained stable over time (prediction remained consistent between the 1990 and 1994 data). Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM–FRG classifications that explains approximately 50 percent of patient costs and approximately 60 to 65 percent of costs at the facility level. Based on this analysis, RAND concluded that a rehabilitation prospective payment system using this model is feasible. RAND's design of a rehabilitation prospective payment system aimed to achieve the following three important goals:

• To provide hospitals with incentives for efficiency.

• To ensure access to high quality and appropriate care for all Medicare beneficiaries.

• To distribute Medicare payments to hospitals in an equitable way.

RAND needed to account adequately for each hospital's patient mix and for other appropriate factors that affect costs. This aspect of the analysis was based on the notion that Medicare should not pay hospitals more for inefficiency or even for a greater intensity of care than is typically received by patients with similar clinical characteristics and social support levels.

Two technical advisory panels provided advice concerning this research. The first panel reviewed the reliability of the FIM scoring process and the second panel provided guidance on the development of the patient classification system. These panels raised some major concerns about the FIM–FRG research.

First, the UDSmr data represented only 24 percent of IRFs and accounted for 40 percent of all Medicare cases in IRFs. Second, the UDSmr data over-represented free-standing rehabilitation hospitals and under-represented excluded units with a slight over-representation of teaching hospitals. Third, while the FIM–FRG system is a good predictor of length of stay, more work was needed to determine the system's ability to predict the intensity of services furnished during a stay. Fourth, hospital charges might not accurately reflect actual resource use in this context, so relative weights based on hospital charges might be distorted. This problem would be further exacerbated because there is evidence of unexplainable distorted charging patterns among facilities under the current payment limits, which have been in effect for a prolonged period of time.

5. Prospective Payment Assessment Commission Analysis for 1997 Report to Congress

In its 1997 Report to Congress, the Prospective Payment Assessment Commission (ProPAC) recommended that a prospective payment system for IRFs based on patient case mix should be implemented as soon as possible. ProPAC stated that RAND's work on the FIM–FRGs could be an adequate basis for prospective payment, and that implementation of a system in the near future is feasible. (ProPAC's March 1, 1997 report was published as Appendix F to our proposed rule ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates'' published in the June 2, 1997 **Federal Register** (62 FR 29902).)

In response to this recommendation, we cited in our final rule ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates'' published in the August 29, 1997, **Federal Register** (62 FR 45966), the concerns raised by the technical advisory panels and our review of the RAND analysis as issues that needed to be further addressed before implementing a prospective payment system using the FIM–FRG patient classification system. In addition, we stated that our preference is to focus on developing a coordinated payment system for post-acute care across all settings that relies on a core assessment tool. Accordingly, one of our goals in developing a prospective payment system would be that it is based on the characteristics of the patient and their needs rather than the characteristics or type of provider of care.

C. Requirements of the BBA and the BBRA for Inpatient Rehabilitation Facilities

1. Provisions for the Current Payment System

The following BBA provisions relating to the current payment system were explained in detail and implemented in our final rule published in the August 29, 1997 **Federal Register** (62 FR 45966).

Section 4411 describes the update of payments for specific fiscal years (FYs) using the market basket effective for cost reporting periods beginning on or after October 1, 1997.

Section 4412 describes the reduction of capital payments for FYs 1998 through 2002, effective October 1, 1997.

Section 4413 describes the provisions for rebasing a facility's target amount for cost reporting periods beginning during FY 1998.

Section 4414 describes the requirement to cap and update the rate-of-increase limits for cost reporting periods beginning on or after October 1, 1997.

Section 4415 describes the provisions regarding bonus and relief payments effective for cost reporting periods beginning on or after October 1, 1997.

Section 4419 eliminates the exemptions from the target amounts effective for cost reporting periods beginning on or after October 1, 1997.

2. Provisions for a Prospective Payment System

Section 4421(a) of the BBA amended the Act by adding a new section 1886(j) to the Act that provides for the implementation of a Medicare prospective payment system for all IRFs. For cost reporting periods beginning on or after the implementation date and before October 1, 2002, payment to IRFs will be based on a blend of—(1) the amount that would have been paid under Part A with respect to these costs if the prospective payment system were not implemented and (2) the IRF Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, IRFs will be paid under the fully implemented Federal prospective payment system.

Under the prospective payment system, rehabilitation facilities will be paid based on predetermined amounts. These prospective payments will encompass the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not for costs of approved educational activities, bad debts, and other costs not subject to the provisions of the IRF prospective

payment system. Covered rehabilitation services include services for which benefits are provided under Part A (the hospital insurance program) of the Medicare program.

Section 1886(j)(1)(A) of the Act provides that, notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of payment for inpatient rehabilitation hospital services equals an amount determined under section 1886(j) of the Act. Sections 1886(j)(1)(A)(i) and (ii) of the Act provide for a transition phase covering cost reporting periods that begin during the first two Federal fiscal years under the prospective payment system. During this transition phase, IRFs will receive a payment rate comprised of a blend of the ''TEFRA percentage'' of the amount that would have been paid under Part A with respect to those costs if the prospective payment system had not been implemented, and the ''prospective payment percentage'' of payments using the IRF prospective payment system rate.

Section 1886(j)(1)(B) of the Act sets forth a requirement applicable to all facilities for the payment rates under the fully implemented system. Notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of the payment with respect to the operating and capital costs of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, will be equal to the per unit payment rate established under this prospective payment system for the fiscal year in which the payment unit of service occurs.

Sections 1886(j)(1)(C)(i) and (ii) of the Act set forth the applicable TEFRA and prospective payment rate percentages during the transition period. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the ''TEFRA percentage'' is 66⅔ percent and ''the prospective payment percentage'' is 33⅓ percent; and on or after October 1, 2001, and before October 1, 2002, the ''TEFRA percentage'' is 33⅓ percent and ''prospective payment percentage'' is 66⅔ percent.

Section 1886(j)(1)(D) of the Act contains the definition of ''payment unit.'' Until the passage of the BBRA, ''payment unit'' was defined by the statute as ''a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary''. However, section 125(a)(1) of the BBRA amended section 1886(j)(1)(D) of the Act by striking ''day of inpatient hospital services, or other unit of payment defined by the Secretary.'' Accordingly, the payment unit utilized in the IRF prospective payment system will be a discharge.

Section 125(a)(3) of the BBRA also amended the Act by adding a new section 1886(j)(1)(E) to the Act that states: ''(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.'' We invite comments on the proposed transfer policy discussed in section V. of this preamble.

Section 1886(j)(2)(A) of the Act, as added by the BBA, directed the Secretary to establish case-mix groups based on the factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient. This section also requires the Secretary to establish a method of classifying specific patients in rehabilitation facilities within these groups. The BBRA amended section 1886(j)(2)(A)(i) of the Act to describe the classification system to read as follows: ''Classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups.''

Section 1886(j)(2)(B) of the Act provides that the Secretary will assign each case-mix group a weighting factor reflecting the facility resources used for patients within the group as compared to patients classified within other groups.

Section 1886(j)(2)(C)(i) of the Act directs the Secretary to adjust ''from time to time'' the case-mix classifications and weighting factors ''as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources.'' Such periodic adjustments shall be made in a manner so that changes in aggregate payments are a result of real changes in case-mix, not changes in coding that are unrelated to real changes in case-mix. Section 1886(j)(2)(C)(ii) of the Act provides that, if the Secretary determines that adjustments to the case-mix classifications or weighting factors resulted in (or are likely to result in) a change in aggregate payments that does not reflect real changes in case-mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of the coding or classification changes.

Section 1886(j)(2)(D) of the Act authorizes the Secretary to require rehabilitation facilities to submit such data as the Secretary deems necessary to establish and administer the IRF prospective payment system.

Section 1886(j)(3)(A) of the Act describes how the prospective payment rate will be determined. A prospective payment rate will be determined for each payment unit for which an IRF is entitled to payment under the prospective payment system. The payment rate will be based on the average payment per payment unit for inpatient operating and capital costs of IRFs, using the most recently available data, and adjusted by the following factors:

- Updating the per-payment unit amount to the fiscal year involved by the applicable percentage increase (as defined by section 1886(b)(3)(B)(ii) of the Act) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor specified by the Secretary for subsequent fiscal years;
- Reducing the rate by a factor equaling the proportion of Medicare payments under the prospective payment system as estimated by the Secretary based on prospective payment amounts which are additional payments relating to outlier and related payments;
- Accounting for area wage variations among IRFs;
- Applying the case-mix weighting factors; and
- Adjusting for such other factors as determined necessary by the Secretary to properly reflect variations in necessary costs of treatment among IRFs.

Section 1886(j)(3)(B) of the Act directs the Secretary to establish IRF prospective payment system payment rates during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, total payments under the new system will equal 98 percent of the amount that would have been made for operating and capital costs in those years if the IRF prospective payment system had not been implemented. In establishing these payment amounts, the Secretary shall consider the effects of

the prospective payment system on the total number of payment units from IRFs and other factors.

Section 1886(j)(3)(C) of the Act addresses the annual increase factor, to be applied beginning with FY 2001. This factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under section 1886(j) of the Act.

Under section 1886(j)(4)(A) of the Act, the Secretary is authorized but not required to provide for an additional payment to a rehabilitation facility for patients in a case-mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary. The amount of the additional payment must approximate the marginal cost of care above what otherwise would be paid and must be budget neutral. The total amount of the additional payments to IRFs under the prospective payment system for a fiscal year may not be projected to exceed 5 percent of the total payments based on prospective payment rates for payment units in that year.

Section 1886(j)(4)(B) of the Act establishes that the Secretary is authorized but not required to provide for adjustments to the payment amounts under the prospective payment system as the Secretary deems appropriate to take into account the unique circumstances of IRFs located in Alaska and Hawaii.

Section 1886(j)(5) of the Act provides for the Secretary to publish in the **Federal Register**, on or before August 1 of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Section 1886(j)(6) of the Act provides that the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the IRF compared to the national average wage level for such facilities. Additionally, the Secretary is required to make a budget-neutral update to the area wage adjustment factor no later than October 1, 2001, and at least once every 36 months thereafter. The budget neutral update is based on information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.

Sections 1886(j)(7)(A), (B), (C) and (D) of the Act establish that there shall be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the establishment of case-mix groups, of the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments.

Section 125(b) of the BBRA provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after the date the IRF prospective payment system is first implemented.

D. Policy Objectives in Developing a Prospective Payment System for Inpatient Rehabilitation Facilities

In developing the prospective payment system for IRFs, we identified policy objectives to evaluate the relative merits of the various policy options considered. The objectives we identified include the following:

- The creation of a beneficiary-centered payment system that promotes quality of care, access to care, and continuity of care and is administratively feasible while controlling costs.
- The provision of incentives to furnish services as efficiently as possible without diminishing the quality of the care or limiting access to care.
- The creation of a payment system that is fair and equitable to facilities, beneficiaries, and the Medicare program.
- The IRF prospective payment system must be able to recognize legitimate cost differences among various settings furnishing the same service; and any patient classification system used to group patients and services should be based on clinically coherent categories and, at the same time, reflect similar resource use. This would limit opportunities to ''upcode'' or ''game'' the system.

In its March 1999 Report to the Congress, MedPAC recommended in detail the type of prospective payment system it believed should be implemented for IRFs. As will be discussed further in this proposed rule, MedPAC's recommendations share much with our approach and policy objectives for the development of an IRF prospective payment system. Both HCFA and MedPAC believe the IRF prospective payment system should include the use of a comprehensive patient assessment instrument such as the MDS-PAC. HCFA and MedPAC both seek sufficient data to devise a patient classification system that effectively predicts resource use. HCFA and MedPAC believe the prospective payment system should be based on reliable and valid payment weights using functional and other diagnostic data. We agree with MedPAC's recommendation to use a per discharge unit of payment. Also, there is a shared belief that a discharge-based system provides an inherent incentive to discharge patients prematurely, and that this impetus could be overcome by implementing sound transfer and short-stay policies as part of the prospective payment system. Accordingly, we have taken steps to initiate the appropriate research to meet our immediate needs in developing this proposed rule and in implementing an IRF prospective payment system, as well as to collect data for the future that may reflect actual facility resources used to meet the needs of Medicare beneficiaries.

E. Discussion of Evaluated Options for the Prospective Payment System for Inpatient Rehabilitation Facilities

We used the objectives identified above in section I.D. of the preamble to evaluate policy options under consideration. The IRF prospective payment system we are proposing consists of the following major components: the patient assessment instrument; the patient classification system; the unit of payment; and the data used to construct the payment rates. A brief discussion of the major issues and options considered in preparing this proposed rule follows.

1. Patient Assessment Instrument

Data from a patient assessment instrument will allow us to: (1) Group patients into a CMG for payment under the prospective payment system; and (2) monitor the effects the prospective payment system has on the access and the quality of patient care. We have reviewed the data elements of the UDSmr and COS instruments and the MDS–PAC. We are proposing to use the MDS–PAC because we believe it contains the data elements that will better enable us to implement and administer the IRF prospective payment system required by section 1886(j) of the Act. In section III of this preamble, we will discuss in detail the reasons for our proposal to use the MDS–PAC patient assessment instrument.

2. Patient Classification System

The patient classification system is another important component of the prospective payment system. We initially considered two primary patient classification systems—one similar to the hospital inpatient prospective payment system and the other similar to the one used in the skilled nursing facility prospective payment system. Ideally, we would like to maintain similar classification systems for those entities delivering comparable services. We recognize a unified classification system would have to recognize patient needs and facilitate appropriate compensation across various post-acute care settings. Section 125(a) of the BBRA mandated the use of a per discharge payment unit and established classes of patients by functional-related groups. Therefore, in implementing the IRF prospective payment system we will use CMGs, consistent with section 1886(j)(2) of the Act.

3. Unit of Payment

Under the provisions of section 1886(j)(1)(D) as added by the BBA, we considered using either a per diem or a per discharge unit of payment. The vast majority of rehabilitation episodes begin with an acute event. The goal of inpatient rehabilitation is functional improvement that will allow the patient to return to independent living in the community, and, as evidenced by ongoing research, the majority of cases are, in fact, discharged to a community setting. Further, a discharge is also the current unit of payment under the TEFRA payment system. Finally, as noted above, the BBRA amends the Act to provide that the ''payment unit'' under the IRF prospective payment system is the discharge. Therefore, we propose to use a per discharge payment unit in accordance with section 1886(j)(1)(D) of the Act.

4. Data Used to Construct Payment Rates

We gave careful consideration in deciding which data to use to create the proposed relative weights and payment rates. Two sources of data were considered: (1) Medicare bill and corresponding UDSmr/COS data; and (2) patient level staff time measurements. The methodology we are proposing to use to calculate the relative weights of each CMG attempts to account for the cost variations among rehabilitation facilities and focus on variations among patient types. Further, the payment rates we are proposing are established in a budget neutral manner in accordance with section 1886(j)(3)(B) of the Act. Section V of the preamble describes the methodology that we are proposing to use to develop relative weights and payment rates.

Under the current payment system, payment limits are based on historical costs in a base period. Accordingly, payments to a given facility for a given year might not accurately reflect the facility's actual costs in that year. Creating a new payment system based on costs that are a product of the existing payment methodology raises concerns that these costs may not adequately reflect actual resource use. In order to develop a prospective payment system that is more reflective of the actual costs of delivering care, further work is needed to identify these costs and the services and resources required by patients. The IRF data from calendar years 1996 and 1997 bills and FY 1997 cost reports contain the most recent available data we have to create the new IRF prospective payment system rates.

We will continue to explore other options, including the use of staff time measurements, later Medicare bill and UDSmr/COS data, and other data to improve the explanatory power of the CMGs and to derive payments that more directly reflect the resources used to produce services delivered in the IRFs.

F. Inpatient Rehabilitation Facility Prospective Payment System—General Overview

In accordance with the requirements of section 1886(j) of the Act, we are proposing to implement a prospective payment system for IRFs that will replace the current reasonable cost-based payment system. The new prospective payment system will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group with additional case and facility level adjustments applied, as described below.

1. Patient Assessment Provisions

We are proposing to require IRFs to complete the MDS–PAC patient assessment instrument for all Medicare patients admitted or discharged on or after April 1, 2001. In accordance with our proposed assessment schedule, the MDS–PAC would be completed on the 4th, 11th, 30th, and 60th day from the admission date of a Medicare patient and upon the discharge of a Medicare patient. In general, a 3-day observation period would be required prior to the completion of the MDS–PAC. Data from the MDS–PAC will be used to—

- Determine the appropriate classification of a Medicare patient into a CMG for payment under the prospective payment system (using data from only the MDS–PAC completed on the fourth day);
- Implement a system to monitor the quality of care furnished to Medicare patients; and
- Ensure that appropriate case-mix and other adjustments can be made to the proposed patient classification system.

A computerized MDS–PAC data collection system will be developed. Facilities will be required to input the MDS–PAC data into the data system. In general, this system consists of a computerized patient grouping software program (grouper software) and data transmission software.

Upon the discharge of the patient, the existing Medicare claim form will be completed with the appropriate CMG indicated on the claim form so that the prospective payment can be made. The operational aspects and instructions for completing and submitting Medicare claims under the IRF prospective payment system will be addressed in a Medicare Program Memorandum once the final system requirements are developed and implemented.

Further details about the MDS–PAC patient assessment instrument and data collection system are discussed in section III of this preamble.

2. Patient Classification Provisions

We are proposing a patient classification system that uses case-mix groups called CMGs. The CMGs classify patient discharges by functional-related groups based on a patient's impairment, age, comorbidities, and functional capability. We began the development of the CMGs by using the FIM–FRG classification system and, with the most recent data available, we identified clinical aspects of the FIM–FRG system that could be improved to increase the ability of the CMGs to predict resource use. Further details of the proposed CMG classification system are discussed in section IV of this preamble.

3. Payment Rate Provisions

The payment unit for the proposed IRF prospective payment system for Medicare patients will be a discharge. The payment rates will encompass inpatient operating and capital costs of furnishing covered inpatient rehabilitation hospital services, including routine, ancillary, and capital costs, but not the costs of bad debts or of approved educational activities.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and

non-covered services (for example, telephone, and television, etc.). They may not be charged for the differences between the hospital's cost of providing covered care and the proposed Medicare prospective payment amount.

The prospective payment rates that we are proposing to implement are determined using relative weights to account for the variation in resource needs among CMGs. We would adjust the payment rates to account for area differences in hospital wages. We would update the per discharge payment amounts annually. During FYs 2001 and 2002, the prospective payment system will be ''budget neutral'', in accordance with the statute. That is, total payments for IRFs during these fiscal years will be projected to equal 98 percent of the amount of payments that would have been paid for operating and capital costs of IRFs had this new payment system not been enacted. This is discussed in detail in section V of this preamble.

Based on our analysis of the data, we are proposing to adjust the payment rates for facilities located in rural areas and for costs associated with treating low income patients.

We are proposing to make additional payments to IRFs for discharges meeting specified criteria as ''outliers.'' For the purposes of this proposed rule, outliers are cases that have unusually high costs when compared to the cases classified in the same CMG. We are proposing outlier payments that are projected to equal 3 percent of total estimated payments.

In conjunction with an outlier policy, we are proposing payment policies regarding short stay cases and for cases that expire. In addition, we are proposing to implement a transfer policy, consistent with section 1886(j)(1)(E) of the Act, as added by the BBRA. (A detailed description of these policies appears in section V of the preamble.)

4. Implementation of the Prospective Payment System

The statute provides for a 2-year transition period. During that time, 2 payment percentages will be used to determine an IRF's total payment under the prospective payment system as follows. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the total prospective payment will consist of 66⅔ percent of the amount based on the current payment system and 33⅓ percent of the proposed Federal prospective payment. For a cost reporting period beginning during FY 2002, the total prospective payment will consist of 33⅓ percent of the amount based on the current payment system and 66⅔ percent of the proposed Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, Medicare payment for IRFs will be determined entirely under the proposed Federal prospective payment methodology.

G. Applicability of the Inpatient Rehabilitation Facility Prospective Payment System

This proposed rule would not change the criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, nor would it revise the survey and certification procedures applicable to entities seeking this classification. Accordingly, for cost reporting periods beginning on or after April 1, 2001, hospitals or hospital units that are classified as rehabilitation hospitals or rehabilitation units under subpart B of part 412 of the regulations will be paid under the proposed IRF prospective payment system (except for IRFs that are paid under the special payment provisions at § 412.22(c) of the regulations) as described below.

The following rehabilitation hospitals and rehabilitation units, that are currently paid under section 1886(b) of the Act, would be paid under the proposed IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001:

1. Excluded Rehabilitation Hospitals and Rehabilitation Units

We are proposing that the IRF prospective payment system apply to inpatient rehabilitation services furnished by Medicare participating entities that are classified rehabilitation hospitals or rehabilitation units under §§ 412.22, 412.23, 412.25, 412.29 and 412.30.

2. Excluded Rehabilitation Hospitals and Rehabilitation Units Outside the 50 States and the District of Columbia

Excluded rehabilitation hospitals and rehabilitation units located in Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Marianas, and the District of Columbia will be subject to the IRF prospective payment system.

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and, therefore, are *not* subject to the proposed IRF prospective payment system rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1 (note)).

II. Current Research To Support the Establishment of the Inpatient Rehabilitation Prospective Payment System—Update of the RAND Analysis

A. Overview of the Updated Work for the Proposed Rule

In July 1999, we contracted with the RAND Corporation (RAND) to update their previous research discussed in section I of this proposed rule. The update included an analysis of FIM data, the FRGs, and the model rehabilitation prospective payment system using more recent data from a greater number of IRFs. The purpose of updating the previous research is to develop the underlying data necessary to assist us in designing, developing, implementing, monitoring, and refining the proposed Medicare IRF prospective payment system based on case-mix groups. In addition, RAND expanded the scope of their previous research to include the examination of several payment elements, such as comorbidities and facility-level adjustments, as well as focus on implementation issues, including evaluation and monitoring. The update is restricted to Medicare patient data and the payment system is designed for payment of Medicare inpatient operating and capital costs only.

Specifically, for this proposed rule, RAND performed the following tasks:

- Constructed an updated data file, using the most recent data available from UDSmr, COS, HCFA, and other data sources.
- Determined the extent to which the UDSmr and COS data are representative of the Medicare population.
- Identified factors or variables that may be used to help us design and implement the payment system.
- Developed data on the elements of the payment system regarding the patient classification system, relative weights and payment rates for each case-mix group, facility-level adjustments, and patient-level adjustments.
- Developed data to examine the joint performance of all of the payment system elements by simulating facility payments for our analysis of the impact of implementing the payment system.

• Developed data to assist in identifying specific issues in connection with implementing the payment system.

• Presented options regarding the design and development of a system to monitor the effects of the payment system and other changes in the health care market on IRFs and on other post-acute care providers, including home health agencies and skilled nursing facilities, by measuring factors such as access, utilization, quality, and cost of care.

B. Construction of Data File for Analysis

Using the methodology in its previous research, RAND constructed a data file that was used to develop the proposed CMG patient classification system and the resulting payment weights, rates, and payment adjustments using more recent data. The analysis of this data file forms the basis of our discussion on the patient classification methodology and the structure of the payment system proposed in this rule. We expect that further analysis of the data file and review of the comments that we receive in response to this proposed rule may result in refinements to some patient CMGs and corresponding weights and rates.

C. Description of Sources of the Data File

The essential sources of the data file are Medicare program information and patient case-mix data. The Medicare program information includes patient discharge files (patient demographic, clinical, and financial information) and facility-level files (facility characteristics and financial information). Patient case-mix data is collected by IRFs using a patient assessment instrument. We are proposing to require the use of the MDS–PAC patient assessment instrument that includes patient case-mix data similar to the data collected on the UDSmr and COS, as described in section III of this preamble. However, the availability of MDS–PAC data records is limited to the sample of providers that participated in the pilot and field tests during its development. Therefore, to initially establish the IRF prospective payment system, we will be using a larger number of data records (as compared to the 1994 data used in RAND's previous study) from UDSmr and COS to represent more adequately the total number of IRFs.

1. Medicare Program Data

For this proposed rule, RAND used calendar year 1996 and 1997 Medicare Provider Analysis and Review (MEDPAR) files. The MEDPAR file contains the records for all Medicare hospital inpatient discharges (including discharges for rehabilitation facilities). The data in the MEDPAR file include patient demographics (age, gender, race, residence zip code), clinical characteristics (diagnoses and procedures), and hospitalization characteristics (admission date, discharge date, days in intensive-care wards, charges by department, and payment information).

The Medicare cost report data is contained in the Health Care Provider Cost Report Information System (HCRIS). The cost report files contain information on facility characteristics, utilization data, and cost and charge data by cost center. For this proposed rule, RAND used the HCRIS file containing the most current available cost data for cost reporting periods beginning during FYs 1996 and 1997. Supplementary information to this file includes—(1) The wage data for the area in which an IRF is located, (2) data on the number of residents assigned to rehabilitation units and the distribution of resident time across inpatient and outpatient settings, (3) data on the number of Medicare cases at each IRF that represent Supplemental Security Income (SSI) beneficiaries, and (4) information about payments under the current reasonable cost payment system.

The Online Survey, Certification and Reporting System (OSCAR) file retains a list of all IRFs that are currently Medicare certified. For this proposed rule, RAND used the OSCAR file to identify instances in which we may be missing facility-level data.

2. Patient Case-Mix Data

We entered into agreements with the University at Buffalo Foundation Activities, Inc. and Caredata.com, Inc. to retrieve UDSmr and COS data, respectively, for RAND's updated research. For this proposed rule, RAND used both UDSmr and COS data that describe rehabilitation stays in participating hospitals for calendar years 1996 and 1997. The data include demographic descriptions of the patient (birth date, gender, zip code, ethnicity, marital status, living setting), clinical descriptions of the patient (condition requiring rehabilitation, ICD–9–CM diagnoses, functional independence measures at admission and discharge) and the hospitalization data (encrypted hospital identifier, admission date, discharge date, charges, payment source, and an indicator of whether this is the first rehabilitation hospitalization for this condition, a readmission, or a short stay for evaluation).

D. Description of the Methodology Used To Construct the Data File

Under a separate contract, we contracted with RAND in September 1998 to construct a data file that linked the 1996 and 1997 UDSmr and COS patient records with patient records on the respective MEDPAR files that describe the same discharge. Under this contract, RAND determined the Medicare provider number(s) that correspond to each UDSmr/COS facility code. Next, RAND matched the UDSmr/COS and MEDPAR patients within the paired facilities.

Because of the proprietary and sensitive nature of the UDSmr and COS patient records, certain data fields that specifically identify the patient and the servicing IRF were encrypted. Therefore, as in RAND's previous study (see section I of this preamble), it was necessary to subject the UDSmr, COS, and MEDPAR records to a sophisticated and complex matching probability technique. The result produces the most statistically valid match of patient/facility records and a data file that contains the characteristics of each Medicare beneficiary and his or her servicing IRF.

Because of the complex scope and nature of the matching technique used, we have included in Appendix A of this proposed rule a technical discussion of each step taken to create the data file. The tables contained in Appendix A show the actual effects of applying the matching technique on both the patient and facility records.

E. Representativeness of the Data File

It is extremely important to examine the quality of the resulting match, including the extent to which the linked MEDPAR and UDSmr/COS records are representative of the MEDPAR universe. After constructing the data file described in Appendix A, we believe that the file contains the best available data to construct a prospective payment system for all IRFs within the parameters of the statutory requirements. Our analysis of the data file allows us to develop the proposed CMG patient classification and payment system, described below in sections IV and V of this preamble.

F. Analyses To Support Future Adjustments to the Payment System

The principal goal of the analysis described above is to determine the extent to which measurable patient characteristics permit classification of patients into identifiable groups that accurately predict the use of resources in inpatient rehabilitation facilities. The

research to date indicates that CMGs are effective predictors of resource use as measured by proxies such as length of stay and charges. The use of these proxies is necessary because data that measures actual nursing and therapy time spent on patient care, and other resource use data, are not available. The scientifically structured collection of data on patient characteristics and patient-specific resource use may enhance our ability to refine the CMGs in a manner that supports our policy objectives for implementing a IRF prospective payment system. Accordingly, we have contracted with Aspen Systems Corporation to collect actual resource use data in a sample of IRFs. The data collected by Aspen will be submitted to RAND for analysis to determine if it can be used to support future refinements to the CMGs.

III. The Minimum Data Set for Post-Acute Care (MDS–PAC) Patient Assessment Instrument

A. Implementation of the MDS–PAC

Under section 1886(j)(2)(D) of the Act, ''The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.'' The collection of patient data is indispensable for the successful development and implementation of the IRF prospective payment system. A comprehensive, reliable system for collecting standardized patient assessment data is necessary for: (1) The objective assignment of Medicare beneficiaries to appropriate IRF CMGs; (2) the development of a system to monitor the effects of an IRF prospective payment system on patient care and outcomes; (3) the determination of whether future adjustments to the IRF CMGs are warranted; and (4) the development of an integrated system for post-acute care in the future.

The MDS–PAC is the standardized patient assessment instrument we are proposing to use under the IRF prospective payment system. We acknowledge that the nature of the patient data we would collect may evolve over time. We believe that the present structure of independent Medicare post-acute benefits, which includes payment systems, coverage requirements, and quality assessment instruments based primarily on site of care, may provide incentives that result in reduced access and choice for beneficiaries and may contribute to inappropriate care. As a result of this fragmentation in the payment and delivery of post-acute care under Medicare, we are reevaluating the payment and delivery of post-acute services with the objective of developing a more integrated approach focusing on the entire post-acute episode of care and each patient's care needs regardless of setting. We believe the MDS–PAC will help to move Medicare toward our long term objective of creating a more integrated post acute care payment and delivery system that facilitates improved quality, choice and access to care for beneficiaries.

Our goal of ultimately establishing a common system to assess patient characteristics and care needs for post-acute providers was endorsed by MedPAC in its March 1999 report to the Congress. MedPAC recommended that the Secretary collect a core set of patient assessment information across all post-acute settings. (Recommendation 5A). In the narrative supporting this recommendation, MedPAC ''commends HCFA's development of the MDS–PAC and encourages its refinement and use. The instrument will facilitate greatly comparisons of patient characteristics and service use across inpatient post-acute settings. Insights gleaned from these data should inform future prospective payment system policies, as well as longer term policy considerations about post-acute care.'' We share MedPAC's opinion of the utility of a common patient data system across post-acute settings. We believe that future refinements in the design and application of the MDS–PAC will provide us with essential information to inform policy decisions related to post-acute care users and their characteristics, quality, and payment.

The implementation of the per-case prospective payment system based on the ''functional-related group'' methodology requires the use of a standardized data collection instrument that contains the elements required to classify a patient into a distinct CMG. To classify a patient into a distinct CMG the data collection instrument must first assign the patient into one of the various high level categories that are based principally on ICD–9–CM diagnoses plus some additional patient information. These high level categories are called Rehabilitation Impairment Categories. After that initial classification step a patient's comorbidity data (which is also based on the ICD–9–CM codes), the level of the patient's impairment as determined by the patient's motor and cognitive function scores, and the age of the patient are used to classify a patient into a distinct CMG within the higher level Rehabilitation Impairment Group. Additional data elements are required to identify the patient and for monitoring the quality of care furnished to patients in IRFs.

Several approaches to the collection of these data elements are available. These include—(a) the development of a new data collection instrument, the MDS–PAC (as proposed in this rule); (b) adoption of an instrument closely modeled on the Uniform Data Set for Medical Rehabilitation (UDSmr) and the Caredata.com Clinical Outcome Set (COS) that would contain the needed data elements exactly as they have been recorded in the past and as used in the development of the FIM–FRG classification of patients; and (c) the incorporation verbatim into the new instrument (MDS–PAC) of the UDSmr/COS data elements that are relevant to payment. We are proposing the first option, the MDS–PAC, for the reasons outlined in the section below.

1. Use of MDS as Foundation

The basis of the MDS–PAC system is the Minimum Data Set (MDS)/Resident Assessment Instrument (RAI). The MDS/RAI was one of the key provisions of the nursing home reform legislation enacted by the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. 100–203, and the first standardized assessment instrument that the Congress required to be used in a post-acute care setting. The MDS is a core set of screening and assessment elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment (the RAI). OBRA mandated that we develop the MDS and require its use for all residents of certified long-term care facilities as a condition of participating in Medicare or Medicaid.

We originally implemented the MDS/RAI in 1990 through 1991 in the approximately 17,000 certified long-term care facilities nationwide. The MDS/RAI has been used by long-term care facilities to assess all residents at specific points during their stay, regardless of payer source. Residents are assessed upon admission to the facility, after experiencing a significant change, and at least annually, with a review of key items required every 90 days. Regulations requiring all certified long-term care facilities to encode and transmit MDS data to the State and HCFA became effective June 22, 1998 ((62 FR 67174) ''Resident Assessment In Long Term Care Facilities''). As of March 3, 2000, there were 23,829,196 records for 4,576,748 residents submitted to our national MDS repository.

Long-term care facilities use the assessment system as the basis of developing an individualized plan of care. However, the design of our long-term care facility payment and quality of care systems relies on use of the resident characteristic, health status, and service use information derived from the MDS to support a number of our programs. For example, the SNF prospective payment system implemented in July 1998 relies on MDS data to classify patients into the appropriate case-mix categories. In addition, in July 1999, we began to use MDS data to generate quality indicators for use in the long-term care facility survey process. Also, long-term care facilities may request real-time MDS-based quality indicator reports, from the HCFA-sponsored State-level MDS data system, that compare the facility's performance in key care areas with the performance of other facilities within the State. These reports can be used for internal quality assurance and improvement activities. Our Peer Review Organizations (PROs) are using MDS data to conduct long-term care facility quality improvement activities in a number of areas, including pain management, pressure ulcers, and urinary incontinence.

In keeping with our commitment to the nursing home industry to refine the MDS/RAI system over time to incorporate advances in assessment technology and changes in the nursing home population, we developed a second generation instrument, known as the MDS version 2. The MDS 2 was implemented nationally in 1996. Shortly thereafter, we agreed to begin work on a post-acute version of the MDS, in response to the long-term care industry's concerns that the MDS had not been constructed to address the characteristics and needs of the increasing numbers of short stay patients admitted to SNFs for rehabilitation and medically complex care.

Before we started work on the MDS–PAC, however, we made a policy decision that our goal was to establish a common instrument to assess patients receiving services by all Medicare institutional post-acute providers. This broadened the scope of the instrument to include freestanding rehabilitation hospitals and hospital-based rehabilitation units, as well as long-term care hospitals. Our policy decision was based on a belief that there is considerable overlap among the patient populations and services rendered by post-acute care providers. The March 1999 MedPAC report to Congress indicated that prior distinctions in the types of patients and services provided across settings have become less clear for a number of reasons (p. 82), and that lack of uniform patient-level data across settings severely restricts our ability to identify where differences and overlaps occur.

This hypothesis regarding the overlap of patient populations was tested by collecting MDS 2 data for patients of rehabilitation and long-term care hospitals and comparing that data with MDS records for SNF patients. The SNF database included records for long-stay nursing home residents who had been readmitted after a hospitalization and now qualified for a period of skilled care. There were 1,535 SNF patient records collected from initial MDS assessments in 1996. Of these patient records, 517 (34 percent) of the patients were expected to be discharged within 30 days of admission. An additional 248 (16 percent) were expected to be discharged in 31 to 90 days. For the remaining patient records, discharge status was unknown, not anticipated or (in a limited number of cases) the discharge variable was missing. This activity was also conducted in order to provide us with information about the characteristics, health status, and service utilization of rehabilitation and long-term care hospital patients, as part of our initial activities to inform development of the MDS–PAC.

Staff from participating rehabilitation hospitals, rehabilitation units of acute care hospitals, and long-term care hospitals were trained in the use of the MDS 2.0, and were asked to complete it for a sample of their newly admitted patients during June through October 1998. Data were received for 614 patients in 26 rehabilitation hospitals and units, and for 479 patients in 26 long-term care hospitals. Of the 52 providers participating in the baseline data collection, 38 were recruited using a random sample of Medicare-certified providers.

We found many similarities in the characteristics, health status, medical diagnoses, and service utilization patterns of SNF and rehabilitation hospital patients. We note that our focus groups indicated to us that many rehabilitation hospitals and self-proclaimed ''subacute'' SNFs have as a criteria for admission the patient's potential ability to be discharged from the facility within a certain time period. Thus, for comparative purposes we differentiated between the MDS records of SNF patients expected to be discharged and those of SNF patients not expected to be discharged. As illustrated below by Table 1C, patients in rehabilitation hospitals and SNF patients who were expected to be discharged demonstrated similar levels of activity of daily living (ADL) overall impairment, as measured by the MDS 2, while a greater number of SNF patients who were not expected to be discharged experienced impairment in ''late loss'' ADLs or were fully dependent.

TABLE 1C.—PERCENT OF PATIENTS WITH ADL IMPAIRMENT BY FACILITY TYPE

ADL score (hierarchical)	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
0—Independent	3.1	.8	4.2	3.4
1—Supervision	4.4	9.5	6.5	5.6
2—Limited	12.8	25.4	29.3	17.9
3—Early Loss ADL—extensive or dependent	4.2	14.8	8.2	9.8
4—Mid late loss ADL—extensive assistance late loss ADL	8.0	21.1	20.9	15.9
5—Mid late-some late loss ADL dependency	34.8	22.5	27.3	33.8
6—Full dependency	32.9	5.9	3.7	13.5

In addition, fewer SNF patients were reported to have symptoms of delirium as compared to rehabilitation hospital patients. While the number of SNF patients not expected to be discharged who experienced memory problems was higher, the overall cognitive performance score (a composite measure based on several MDS items) for patients across the four populations was remarkably similar, except for the higher number of long-term care hospital patients rated as a ''6'' (that is, very severely cognitively impaired). A comparison of cognitive impairment by facility type can be seen in Table 2C.

TABLE 2C.—PERCENT OF PATIENTS WITH COGNITIVE IMPAIRMENT BY FACILITY TYPE

Condition	LTC hospital	Rehab Hospital	SNF discharge expected	SNF discharge not expected
Delirium Symptoms—New				
Easily Distracted	12.0	15.4	3.1	1.7
Altered Perceptions	9.7	5.9	2.6	2.2
Disorganized Speech	8.8	10.5	2.4	2.2
Restlessness	13.6	8.9	2.0	3.0
Lethargy	14.4	9.2	4.0	4.0
Mental Function Varies	17.2	13.5	5.2	4.0
Cognitive Performance Scale				
0=Intact	40.5	49.3	46.0	17.9
1=Borderline Intact	14.3	13.6	16.7	17.6
2=Mild	7.2	10.2	12.0	11.3
3=Moderate	9.1	13.0	16.3	26.2
4=Moderate Severe	4.0	3.3	4.1	10.5
5=Severe	3.0	5.7	3.3	6.9
6=Very Severe	21.9	4.9	1.6	9.6
Memory				
Memory Problem—short term	32.8	36.2	37.0	61.0
Memory Problem—long-term	29.9	23.0	23.1	46.2
Memory Problem—situational	37.5	12.4		

We did not find significant differences across care settings in many of the disease diagnoses recorded in section I of the MDS, although long-term care hospital patients had more cases of diabetes, cardiac dysrhythmia, post heart surgery, peripheral vascular disease, paraplegia, respiratory conditions, renal failure, and antibiotic-resistant infections (Table 3C).

TABLE 3C.—PERCENT OF PATIENTS WITH SPECIFIC CONDITIONS BY FACILITY TYPE

Condition	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
Diseases				
Diabetes	37.0	25.0	27.0	24.2
Hyperthyroidism	0.4	0.7	0.7	0.3
Hypothyroidism	9.0	8.2	8.0	6.8
Arteriosclerotic heart disease	17.3	14.7	15.7	18.3
Cardiac dysrhythmia	21.1	11.3	14.7	17.2
Post heart surgery	24.0	13.0	6.9	6.2
CHF	23.0	8.5	21.6	22.9
Deep vein thrombosis	4.8	3.1	11.4	1.8
Hypertension	37.6	45.8	47.9	46.5
Hypotension	2.8	1.3	1.5	1.0
Peripheral vascular disease	15.0	9.0	8.6	6.0
Other cardiovascular disease	14.8	10.3	19.5	20.8
Arthritis	11.3	20.1	25.4	21.9
Hip fracture	6.7	11.6	14.1	7.4
Missing limb	5.4	4.9	3.0	3.5
Osteoporosis	7.1	3.6	8.0	10.5
Pathological bone fracture	1.3	1.8	1.0	1.5
Alzheimer's	1.5	0.5	4.1	12.3
Aphasia	2.3	6.5	3.8	7.2
CP	0.2	0.7	.....	.....
CVA	23.8	34.6	22.2	27.7
Other dementia	7.9	2.1	13.9	31.5
Hemiplegia/hemiparesis	12.9	27.8	8.8	10.1
MS	2.1	1.1	0.1	0.7
Paraplegia	3.0	2.1	0.3	0.3
Parkinson's	2.5	1.6	3.3	4.0
Quadriplegia	3.3	2.6	0.1	0.2
Seizure disorder	6.5	5.2	4.5	4.5
TIA	1.0	23	4.0	4.0
Traumatic brain injury	4.2	7.0	0.3	0.3
Anxiety disorder	4.6	5.2	7.8	6.8
Depression	10.2	14.4	14.6	13.6
Manic depression	0.8	1.1	0.9	0.7

TABLE 3C.—PERCENT OF PATIENTS WITH SPECIFIC CONDITIONS BY FACILITY TYPE—Continued

Condition	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
Schizophrenia	0.8	0.5	1.0	1.5
Asthma	3.5	3.1	2.0	1.5
Emphysema/COPD	29.0	10.1	19.3	17.2
Pulmonary failure	24.0	4.3	.....	.....
Cataracts	2.9	3.3	6.5	5.5
Diabetic retinopathy	1.9	1.8	0.7	0.5
Glaucoma	3.8	2.9	5.9	4.0
Macular degeneration	1.5	0.7	1.2	0.8
Allergies	9.4	15.2	28.2	28.9
Anemia	15.7	11.9	18.2	19.5
Cancer	12.1	7.5	14.4	15.3
Renal failure	14.0	4.7	4.9	5.3
Amputated limb	5.4	5.0	N/A	N/A
Post surgery—elective hip	4.0	13.0	.....	.....
Antibiotic resistant infection	16.7	2.8	1.0	0.5
Pneumonia	19.2	3.1	8.5	6.5
UTI	21.9	19.9	21.1	23.1
Bladder Continence				
Continent, no catheter	28.0	60.9	63.4	45.6
Continent, catheter	52.1	15.2	N/A	N/A
Some incontinence	50.8	31.6	36.6	54.4
Bowel Continence	48.0	75.0	71.3	47.9
Complications				
Inability to lie flat—loss of breath	44.0	6.5	6.9	6.2
Shortness of breath—exertion	52.0	21.7	.....	.....
Shortness of breath—at rest	32.0	0.0	.....	.....
Difficulty coughing/clearing airways	40.0	2.2	N/A	N/A
Recurrent respiratory infection	28.0	2.2	.....	.....
Surgical wound	48.0	56.5	.....	.....
Pain				
None	45.4	25.6	36.0	58.8
Less than daily	17.3	19.5	31.0	22.3
Daily	37.3	55.0	33.0	18.9
Health Complications				
Syncope	2.3	1.0	.07	0
Unsteady Gait	26.2	52.5	48.0	40.1
Limited ROM—Arm	20.7	9.3	6.3	12.5
Limited ROM—Hand	18.0	7.2	3.5	8.8
Limited ROM—Foot	26.4	10.5	5.7	14.7
Pressure Ulcers—Any (stage 1–4)	36.0	17.9	17.7	21.6
Expectations (Rehabilitation Potential)				
Patient believes self could be more independent	53.7	74.5	45.1	16.2
Staff believes patient could be more independent	59.1	76.4	50.9	31.3
Patient able to perform tasks slowly	26.1	33.9	12.7	12.4
Major difference in ADLs AM and PM	8.1	16.7	1.9	3.2
Behavior				
Wander	3.6	4.1	2.8	9.1
Verbally abusive	3.4	3.8	3.0	5.4
Physically abusive	1.8	2.1	1.4	5.9
Socially inappropriate	3.2	4.8	4.2	8.6
Resists care	12.2	8.6	9.8	16.3

The diagnostic profiles of patients in rehabilitation hospitals and SNFs were similar, although rehabilitation hospitals treated a higher percentage of patients with strokes, hemiplegia/hemiparesis, and traumatic brain injury and fewer patients with congestive heart failure and emphysema or chronic obstructive pulmonary disease. Both bladder and bowel continence levels were similar for rehabilitation hospital and SNF patients who were expected to be discharged. Pain levels for rehabilitation hospital and SNF patients were also similar overall, although more

SNF patients were reported to experience pain less frequently than daily and more rehabilitation hospital patients were assessed as having daily pain. Pressure ulcer rates for rehabilitation hospital and SNF patients were comparable, as were the number of patients with unsteady gait and limitations in range of motion. Rehabilitation hospitals reported a higher use of restraints. Rehabilitation hospital and SNF patients who were expected to be discharged had a similar number of behavioral symptoms, which were less overall as compared to the number of behavioral symptoms experienced by SNF patients not expected to be discharged.

These results confirmed anecdotal information reported by rehabilitation hospital and SNF clinicians during our focus groups. While Medicare coverage policies allow payment to SNFs for a wider range of patients than rehabilitation hospitals, both groups reported that their patient populations had changed over the past few years, leading to some convergence in the types of patients treated by rehabilitation hospitals and SNFs. Both reported a large increase in the number of comorbidities and clinical complexities for patients admitted primarily for rehabilitative services, saying that ''uncomplicated'' patients were no longer admitted for inpatient rehabilitation, (instead, for example, ''uncomplicated'' patients requiring rehabilitation after a hip fracture now generally receive therapy in their homes).

It is our view that any system used to classify rehabilitation patients should be based on the same measures of a patient's health status and care needs as are used in other segments of the post-acute care industry. However, for purposes of this proposed rule, we are most concerned that the classification instrument work well with IRF patients. Given our use of the MDS in SNFs, it is logical to extend an MDS-based system to IRFs.

We are developing version 3 of the MDS/RAI, which we envision as containing sections for specific populations (for example, traditional, long stay resident; short-stay patient; those receiving palliative or end of life care; and pediatrics).

2. Other Options

We recognized that many rehabilitation hospitals already use a patient assessment instrument that contains the functional independence measures (FIM). The FIM were developed by researchers who were funded by a consortium of rehabilitation professional associations and the Department of Education, at the State University of New York (SUNY) at Buffalo in the 1980s. The FIM are contained in a patient assessment instrument that is marketed by the Uniform Data System for Medical Rehabilitation (UDSmr) maintained by SUNY/Buffalo. Caredata.com Clinical Outcome System (COS) used to market a patient assessment instrument that contained the FIM, but we have been notified that Caredata.com has discontinued its business related to FIM reporting as of July 2000. The patient assessment instrument marketed by UDSmr is proprietary.

Many rehabilitation providers are clients of UDSmr. Our 1997 data shows that approximately 68 percent of Medicare patients had a UDSmr or COS data file, indicating that these patients were assessed with the FIM. There is extensive experience with the FIM contained in the UDSmr and COS patient assessment instruments and the uses of the FIM data. This is documented by a substantial list of publications produced both in the United States and overseas (for example, Sweden and Japan), by the developers of the system, and by independent investigators.

The developers of the FIM offer a certification course to train assessors in the use of the instruments. This results in very high rates of intra and inter rater reliability, with Cronbach alpha coefficients of more than 0.9 for both the motor and cognitive subscores. The Cronbach alpha coefficient is a statistical measure of inter-rater reliability with perfect reliability equal to 1.0. Therefore, a score of 0.9 indicates a very high level of inter-rater reliability.

The MDS-PAC is a modification of the MDS, the patient assessment instrument developed for use in nursing facilities. The principal objective of the MDS is to facilitate care planning through a description of the needs of the patient for services. In contrast, the principal objective of the FIM is to assess person level disability in the inpatient medical rehabilitation setting.

The strength of the FIM assessment instrument is that it is a well-evolved and extensively tested approach to the assessment of the critical components of care provided by IRFs, the impact on the patient improvement in functional capacity, and the purpose of the care provided by the IRFs. The variations among facilities in the difference between the observed and expected improvement in function are used as indicators of the quality and the effectiveness of the facilities. The organization that analyzes FIM data for providers generates benchmark data that allows IRFs to compare the outcome of their performance on the functional independence measures relative to other providers participating in the system.

One drawback of the FIM assessment instrument is that it is specifically focused on functional performance. Information is collected only on the matters directly related to functional performance and only at admission and discharge, and, when possible, 6 months after discharge. There is, therefore, a lack of detail on the needs of the patient or on the evolution of the condition of the patient during the course of the admission. However, given that the mean length of stay in an IRF is 15.81 days (median length of stay is 14 days), we are specifically soliciting comments on the benefits of mid-stay assessments.

We are not proposing to use the FIM assessment instruments marketed by either the UDSmr or COS as the basis for an IRF prospective payment, because of our desire to have a common measurement instrument across different post-acute provider settings. Our proposal to use an MDS-based approach comes from our conviction that the use of common item labels and definitions across different provider settings would be essential to monitoring patient care across different provider settings. While we recognize that there are differences between the MDS and the MDS–PAC, our intention is, at some point in the future, to reconcile these differences. Structuring the IRF assessment instrument consistent with the MDS would allow for comparison of patients across different institutional settings. The MDS–PAC collects information on many of the same activities or functional measures as the FIM but defines these activities more specifically in some cases. It would also help facilitate continuity of care in that comparable baseline data would accompany the patient's transfer from one setting to the other. Standardized information across provider types would also be extremely useful in comparing patient characteristics and potentially the appropriateness of care in different settings that serve the same populations. This is especially important since analysis by RAND (1997) shows that costs for the same services vary significantly by provider.

When we began to develop the MDS in the 1980s, the possibility of using the FIM ADL scoring schema was considered. However, field experience demonstrated that nursing home staff did not feel comfortable making the level of distinctions required in the FIM.

The FIM serve as a functional-based system designed to capture specific aspects of ADL performance. Therefore, the FIM's ability to measure items that are not functionally related, such as cognition, may be problematic. For example, in order to score communication on the FIM, compromises must be made to blend cognitive and performance ideas into a single construct. The scoring schema used in the MDS–PAC allows the instrument to describe a concept like communication from a functional performance perspective as well as from the cognitive perspective based on how much caregivers have to intervene to help compensate for the patient's communication deficits.

UDSmr requires that users of the FIM (for example, therapists) be trained. An evaluation of the FIM scoring will be performed by RAND before a final rule is published. FIM scoring rules assign the lowest (most dependent) value to missing data which is likely to bias scores downward, especially upon admission when data are more likely to be missing. The payment implications may generally be to place patients in a more service intensive CMG. The MDS–PAC addresses this by having a separate coding entry (8) for activities that do not occur rather than instructing users to code with the most dependent level.

An independent team of technical experts highlighted areas of concern regarding the FIM's accuracy in predicting costs for patient care. Panelists were concerned that the scoring of some items, such as cognitive functioning, gave raters a great deal of discretion in determining what evidence was used in the assessment and how often the behavior had occurred. These technical experts also agreed that a functional status assessment for payment purposes should be based on clinical observation of performance rather than on the rater's assessment of the patient's capacity to perform the task.

The MDS–PAC uses the same FIM constructs as were originally designed by the UDSmr team but rewords them in such a way so that these items better fit into the context of the MDS instrument. In addition, the item language and definitions and instructions are integrated into the instrument. The administration of the MDS–PAC at more than one point in a patient's stay will permit assessment of patient changes during that episode of treatment and may lead to possible refinements to the patient classification system.

We seek public comment on our proposal to use the MDS–PAC as the assessment instrument for the IRF prospective payment system, including: comments and supporting data regarding the additional burden and cost, if any, associated with this instrument; the suitability of the instrument for the rehabilitation setting and as a model for other post-acute care settings; views on whether the instrument has been properly tested and validated for industry-wide use; and the utility and reliability of the quality data items contained in the instrument.

3. Combining the MDS–PAC and the FIM

The MDS–PAC covers several topics, for example, nutrition, swallowing, and pain, that are either not included in the FIM or not covered in sufficient detail in the FIM for clinical assessment purposes, and that are not currently used in classifying patients for payment. An alternative to using the MDS–PAC would be to retain the non-payment items from the MDS–PAC and incorporate the FIM items for patient classification into CMGs. Because of our concerns, as outlined above (for example, compatibility with assessments in other settings), we have rejected this option for purposes of this proposed rule and propose to use payment-related questions that are compatible with the FIM.

However, the FIM assessment system has been under development since the mid 1980s and is currently recognized as a valid and reliable instrument to measure impairments in IRFs. The FIM are in current and increasing use in rehabilitation facilities, the data analysis being performed by UDSmr and by COS, with the data analysis organization depending on which of these two organizations the IRF has selected. Thus, there has been extensive training in and experience with the data elements, particularly the functional components, that enter into the construction of the CMGs. We will be testing whether the MDS–PAC results in patient classifications that are equivalent to the classifications that occurred with the FIMs (that is, the assessment instruments that were used to design the payment system).

If the tests show that patients are classified differently using the MDS–PAC, HCFA will, in the final rule, incorporate the phrasing, definitions, and order of the items required by the payment system, based on the FIM, replacing the proposed equivalent sections of the MDS–PAC. This would meet our objective to field the more extensive instrument to provide a more complete picture of the evolution of condition of the patient and of the care provided in the IRF, but also to retain confidence in the validity of the classification of the patient. Using the phrasing, definitions, and order of the items would minimize the effect on reliability and validity inherent in the design of new data collection instruments.

4. The MDS-PAC Development Process

Under contract, a team led by John N. Morris, Ph.D., at the Hebrew Rehabilitation Center for the Aged, began to develop the MDS-PAC in 1997. This team played a key role in designing the original MDS/RAI system and MDS 2.

The MDS–PAC development process relied on broad-based input from a large and diverse constituency, representing rehabilitation facilities, SNFs, long-term care hospitals, and the viewpoints of individual and corporate providers, clinical disciplines, consumers, States, other Federal agencies, and researchers. Examples of organizations representing rehabilitation providers and clinicians include the American Medical Rehabilitation Providers Association, the American Hospital Association (representing hospital-based rehabilitation units), the Federation of American Health Systems, the Commission on Accreditation of Rehabilitation Facilities, the National Head Injury Foundation, the Uniform Data System for Medical Rehabilitation, the Association of Academic Physiatrists, and the American Academy of Physical Medicine and Rehabilitation.

Representatives and staff of over 40 national organizations and agencies with a stake in the MDS–PAC were brought together in a technical expert panel, which met at the outset of the MDS–PAC development process, and at key intervals thereafter. The purpose of the technical expert panel was to provide us with advice on technical and operational issues associated with assessment of post-acute patients. We requested that technical expert panel representatives disseminate project information to their constituents, coordinate input from their members back to our project team, and assist with identifying facilities to participate in field testing of the instrument. We solicited comments from technical expert members on several drafts of the MDS–PAC, and also conducted a mailing that solicited comments from over 1100 facilities and individuals, identified in part by technical expert panel members. We also posted a project summary and various drafts of the MDS–PAC on our MDS web site. In addition, the project team reviewed the

comments we received on the assessment instrument.

We began development of the MDS–PAC by gathering baseline information through focus groups, a provider survey, and collection of MDS data within rehabilitation hospitals/hospital-based units and long-term care hospitals. We held two focus groups, consisting of physicians, nurses, and therapists who were involved in patient assessment and care planning on a daily basis within rehabilitation hospitals and units, SNFs, and long-term care hospitals. The clinicians who participated in the focus groups were all nominated by the national associations representing rehabilitation hospitals, SNFs, and long-term care hospitals. The purpose of the focus groups was to solicit real-world input regarding current assessment and care planning practices for post-acute patients.

We also conducted a survey of SNF, rehabilitation hospital, and long-term care hospital providers to gather information about their patient populations, assessment and care planning practices, care processes, care delivery models, and the availability of various types of specialized staff. Facility staff were asked to comment on the perceived clinical utility of MDS items and each of the RAPs for their own patient populations. Providers participating in our focus groups were asked to pilot the questionnaire, which was subsequently refined. The questionnaire was then distributed to over 900 SNFs, rehabilitation hospitals and units, and long-term care hospitals that had requested information on the project or whose names we had received from associations participating on the technical expert panel. A total of 416 providers (224 SNFs, 131 rehabilitation hospitals or units, and 61 long-term care hospitals) responded to the survey during January through March 1998. A summary of these responses was presented during our March 1998 meeting with the technical expert panel.

Using the input gathered from our initial activities, we developed an initial draft of the MDS–PAC in September 1997. In developing the initial MDS–PAC draft, it is important to note that we did not start with the current MDS 2. Rather, we used a ''bottom-up'' approach to build the MDS–PAC. This means that we started by listing the various domains and issues that had been identified through our initial focus groups and provider survey as relevant for the post-acute patient. We then selected items to measure those specific issues from the MDS 2 or other HCFA assessment instruments, such as the Outcome and Assessment Information Set (OASIS) or the Uniform Needs Assessment Instrument. New items were developed for those areas in which no item currently existed within our group of assessment tools. In building and refining the MDS–PAC items we relied extensively on the input of clinical experts serving on, or identified by, our technical expert panel. Appendix B contains a summary of the survey items and the responses of the clinical experts.

The original MDS–PAC draft was refined through the production of 10 major draft revisions over a 2-year period. We solicited comments on various drafts through mailings to our technical expert panel, and to over 1100 providers that had been identified by the technical expert panel or otherwise indicated an interest in the project, as well as through posting of various drafts on our web site.

One of the guiding principles of our MDS–PAC development has been that the instrument had to include items that were compatible with the FIM and would result in the same patient classifications generated using the FIM. In nearly all instances, we did not simply insert the functional independence measures items into the MDS–PAC. Generally, the goal was to develop blended items that were consistent with the general MDS model and scales, but were also capable of generating the type and level of detail contained in a specific functional independence measure item. This work was conducted through extensive collaboration with Dr. Carl Granger, who was a member of our MDS–PAC technical expert panel, and his UDSmr team. Prior to our final rule, we will be conducting further research to determine whether the MDS–PAC will classify patients into the same CMGs as they would have been classified into using FIM.

5. Developmental Testing of the MDS–PAC

Drafts of the MDS–PAC were subjected to substantial field testing, to ensure it is both reliable and feasible for use as the patient data collection system needed to implement the IRF prospective payment system. Formal testing consisted of an initial pilot test, as well as two larger rounds of field testing, in rehabilitation hospitals and units, SNFs, and long-term care hospitals. In conducting research, a pilot test allows a preliminary trial of an instrument to discover and rectify any major problems before the main study begins. A pilot test uses a small study sample of facilities, whose results enable researchers to make last minute corrections and adjustments. A field test uses a larger sample and more formally delineated procedures and protocols.

In conducting our tests we worked with a number of providers that volunteered to participate either directly or through their provider associations. However, most of the participants in each of the testing rounds were recruited randomly from our listing of Medicare-certified providers maintained in the Online Survey and Certification Reporting System; we designed our sample to ensure that participating facilities varied in geographic location, size, etc.

Pilot testing of the MDS–PAC was conducted in September through October 1998, with a total of 20 providers (7 rehabilitation hospitals or units, 4 long-term care hospitals, 9 SNFs; 15 sites recruited randomly). A total of 161 assessments were completed as part of the pilot test, with 69 completed by rehabilitation hospitals, 68 by SNFs, and 24 by long-term care hospitals.

MDS–PAC testing consisted of a pilot test and two field tests. A total of 16 assessors participated in the pilot test conducted in IRFs and 96 and 75 assessors participated in the first and second field tests, respectively. The MDS–PAC was used to assess a total of 885 admissions and 345 discharges in these IRFs during this pilot and field testing. The average length of stay for these admissions was 18.9 days with a median of 16 days.

The initial field test occurred in January through April 1999, in 85 providers total (40 rehabilitation hospitals or units, 21 long-term care hospitals, 22 SNFs, and 2 facilities for which the above category was not properly recorded; 51 sites recruited randomly). A total of 1164 patients were assessed using draft 8 of the MDS–PAC, with 599 cases assessed in rehabilitation hospitals or units, 284 in SNFs and 281 in long-term care hospitals.

The second field test was conducted in June through September 1999, in a total of 57 providers (33 rehabilitation hospitals and units, 11 long-term care hospitals, 13 SNFs; 39 sites recruited randomly). A total of 462 cases were completed in the second field test, with 285 patients assessed by rehabilitation hospitals, 80 by SNFs, and 97 by long-term care hospitals.

Testing focused on the inter-rater reliability and clinical validity of MDS–PAC items, as well as the administrative feasibility and burden associated with completion of the assessment tool. Paired assessments were completed for a sample of cases during each of the field trials (N=171 assessments

conducted using the June 30, 1999 version of the MDS–PAC used in field test 2) and reliability coefficients were calculated using a weighted Kappa statistic. Reliability measures whether the instrument would result in the same findings if it were administered at a later date or by a different person. The average reliability for the 315 items on the version of the MDS–PAC tested in the second field test (draft 9) was 0.78. A frequently cited standard in the research community, Fleiss (1975), establishes item reliability of 0.5 as acceptable, with levels of 0.75 or better considered as superior for tools of this nature. Reliability coefficients ranged from 0.51 for ''repetitive health complaints'' to 1.0 for several items.

Facility staff were asked to log the amount of time spent on each MDS–PAC assessment, and also categorize how that time was spent. There was general comparability across provider types in how time was spent. Review of the clinical record consumed the most time and interaction with the patient's physician or family was conducted by only a minority of assessors. Recognizing the learning curve associated with any new process, burden estimates were calculated for both the initial few cases completed by staff and subsequent cases after staff had become more familiar with the process (that is, after completing approximately 10 MDS–PAC assessments).

Rehabilitation hospital staff initially required a median of 105 minutes to complete the intake assessment and 85 minutes after they became familiar with the Version 9 MDS–PAC, as compared to the 85 and 77 minutes respectively, required by SNF staff. The time required to complete follow-up or discharge MDS–PAC assessments was also calculated, as these assessments involve fewer items than the initial MDS–PAC assessment. Rehabilitation hospital staff required a median of 75 minutes to complete the first few cases using this shorter assessment and 48 minutes after they completed approximately 10 cases. SNF staff spent a median of 50 minutes on the first few follow-up assessments they completed, and 45 minutes subsequently.

B. Overview of the MDS–PAC Assessment Process

1. Description of the MDS–PAC

We include, in Appendix BB of this proposed rule, the MDS–PAC Version 1, which we refer to throughout this preamble as the MDS–PAC. Appendix BBB contains the Item-by-Item Guide to the MDS–PAC, which consists of instructions for completing the MDS–PAC. The MDS–PAC that is included in Appendix BB is a modified version of the MDS–PAC that was the product of the previously described pilot and field testing. This modified version MDS–PAC reflects changes we made in order to ensure that the MDS–PAC items used to classify a patient into a CMG cover all of the same subjects as the functional independence measures items that were used to develop the classification system.

Before the final rule, we will conduct field testing of the modified MDS–PAC, Version 1, to establish its validity, reliability, and equivalence for payment. In addition, we will study a sample of facilities that are currently using UDSmr's FIM patient assessment instrument and the COS. These facilities will complete their instruments (either UDSmr's or COS) and the MDS–PAC on the same patient at the same time. Results of this paired assessment will be compared to determine the capability of the MDS–PAC instrument to accurately and consistently assign CMGs and whether the MDS–PAC assigns the same CMGs as the UDSmr/COS instrument would. If the results of this study do not indicate that the MDS–PAC accurately and consistently assigns CMGs as the UDSmr/COS instrument would, then the MDS–PAC will be redesigned to incorporate the phrasing, content, and coding conventions of the UDSmr/COS instruments. This study will be completed this fall by researchers from RAND, and the results will be incorporated into the final rule. The study and any modifications to the assessment instrument will be completed prior to the publication of the IRF prospective payment system final rule.

The MDS–PAC is a patient-centered assessment tool that emphasizes a patient's care needs, rather than the characteristics of the provider. The assessment instrument consists of 15 sections, each collecting different categories of patient information. These categories include identification and demographic information about the patient, as well as the following categories of information: cognition; communication; behavior and mood; functional status; bowel and bladder continence; diagnoses; medical complexities and other health conditions; oral and nutritional information; pain status information; information on procedures and services; functional prognosis; and resources for discharge.

2. Use of the MDS–PAC

We propose to require that IRFs use a standardized patient data collection assessment instrument for Medicare patients in IRFs, the MDS–PAC. We propose to require that IRFs must computerize and electronically report the MDS–PAC data.

Each year tens of thousands of Medicare patients are treated in IRFs. As discussed in more detail in section III.F. of this preamble, we propose that each of these patients would be assessed on the average at least of three times, with the MDS–PAC being used as the patient assessment instrument. Therefore, there will be a very large quantity of data collected and submitted to us each year. As a result, it would be unrealistic for us to perform a meaningful analysis of this large amount of data for payment, medical review, and quality monitoring purposes in the absence of the capability to use automated data collection. An analysis of MDS–PAC data would allow us to use MDS–PAC data in a manner similar to how we use SNF MDS data.

One use of SNF MDS data is to support quality of care monitoring. The SNF MDS data is reliable and effective in supporting early identification of potential quality of care problems. Early identification, in turn, helps to focus the survey process upon these identified problem areas.

Using MDS data we have developed indicators of the quality of care in SNFs. The quality of care indicators are used to support analytical evaluations of the quality of services that SNFs furnish. For example, we use MDS data to provide us with objective and detailed measures of the clinical status and care outcomes of residents in a SNF. In addition, quality of care indicators can be used to analyze the relationship between Medicare policy changes and quality of care.

Computerization of the MDS–PAC data would make it easier and more practical for an IRF to use the MDS–PAC data to classify a patient into a CMG. Electronic transmission of the MDS–PAC data by the IRF makes the creation of an MDS–PAC database feasible. An MDS–PAC database, in turn, permits the data to be accessed easily in various formats for different analytical purposes, which can be used to support the Medicare program's fraud and abuse efforts, for medical review purposes, and for uses similar to how the SNF MDS data is used.

We propose that beginning on April 1, 2001, IRFs must collect MDS–PAC data as part of the IRF's inpatient assessment process for patients who are receiving Medicare-covered Part A services. This MDS–PAC data collection requirement applies to Medicare beneficiaries who are already inpatients as of April 1,

2001, as well as beneficiaries admitted as inpatients on or after April 1, 2001. In addition, we propose that the IRFs must use the MDS–PAC to assess inpatients in accordance with the MDS–PAC assessment schedule specified in section III.F. of this preamble.

The IRFs would encode the MDS–PAC data by entering the MDS–PAC data into a computer software program. MDS–PAC records would be considered ''locked'' when they passed all HCFA-specified edits and were accepted by the MDS–PAC database to which the IRF transmitted its records.

We propose in § 412.610 that IRFs must also maintain all completed MDS–PAC assessments for the previous 5 years, either in a paper format in the patient's clinical record or in an electronic computer file format that can be easily obtained, because the assessments may be needed as part of a retrospective review conducted at the IRF for various purposes, for example, as part of the documentation that the IRF used to determine the medical necessity of the Medicare-covered services the IRF furnished. Also, completed MDS–PAC assessments that are available at the IRF could be beneficial to other entities that appropriately have access to these records (for example, a State or Federal agency conducting an investigation due to a complaint of patient abuse or a suspicion of fraud). In addition, retention of the MDS–PAC assessment by the IRF would provide a backup to the electronic database.

Data from the initial MDS–PAC assessment would be used to classify patients into a CMG. The CMG would correlate with the payment rate that the IRF receives for the Medicare-covered Part A services furnished by the IRF during the Medicare beneficiary's episode of care.

3. Transmission of the MDS–PAC Data

We propose that between February 1 and February 28, 2001, IRFs must complete a successful transmission of test MDS–PAC data to the HCFA MDS–PAC system. A successful transmission by the IRFs of test MDS–PAC data to the HCFA MDS–PAC system is necessary to determine connectivity with the system and to identify any transmission problems. The HCFA MDS–PAC system would transmit a test data feedback report to each IRF indicating that the test data transmission was either completely successful or experienced problems. The problems would be specified in the test data transmission report.

On March 1, 2001, the HCFA MDS–PAC system would begin to purge all test data from the system to allow for acceptance of production data, that is, data that would be associated with the MDS–PAC assessment schedule and CMG payment rates, as specified in sections III. F. and V. of this preamble.

For example:

February 1, 2001, to February 28, 2001—Period for transmission of test MDS–PAC data.

March 1, 2001, to March 7, 2001—The HCFA MDS–PAC system purges test data.

April 1, 2001—Assessments completed on or after this date must be transmitted as production data.

As specified in section III. I. of this preamble, we would provide training and technical support to the IRFs on administering and completing the MDS–PAC, as well as transmitting the MDS–PAC data.

C. The MDS–PAC Assessment and Medical Necessity

The initial MDS–PAC assessment would be used to classify each Medicare patient into a CMG, with the CMG being the basis for IRF payment. One principle governing appropriate Medicare payment and utilization of Medicare inpatient services is that there must be documentation establishing appropriate medical necessity for the inpatient services furnished to a patient.

When the data recorded on the MDS–PAC accurately reflect the patient's clinical status, they form the basis for documenting the medical necessity of the services furnished to the IRF Medicare inpatient. There may be cases in which a medical review (or other type of facility or patient review) questions the accuracy of the recorded MDS–PAC items and, by extension, the associated medical necessity of the services that the IRF furnished. In these cases, other documentation would be examined to verify the information recorded on the MDS–PAC, and the medical necessity for the services as indicated by the MDS–PAC. Other documentation that would support the accuracy of the recorded MDS–PAC information (and the medical necessity for the services furnished to the inpatient) must be recorded in the patient's medical record and could include, but is not limited to: (1) physician's orders; (2) physician's notes; (3) nursing notes; (4) notes from therapists; (5) diagnostic tests and their results; and (6) other associated information, such as social worker or case manager notes.

A patient's clinical status for a given time period, as indicated by a completed MDS–PAC form, must be verifiable and consistent with the clinical information independently or separately recorded in the patient's clinical record. Otherwise, inaccurately completed MDS–PAC assessments might be used to classify patients into CMGs that would, in turn, form the basis for Medicare payment for medically inappropriate or unnecessary services. We will continue to conduct medical review activities to verify and monitor the medical necessity of services furnished in conjunction with our continuing efforts to eliminate Medicare payment errors.

In proposed § 412.614, facilities will transmit each Medicare inpatient's MDS–PAC assessments to the HCFA MDS–PAC system, and submit claims for Medicare payment to the fiscal intermediary, in accordance with the current claims procedures. Payment to the IRF would be made according to the CMG recorded on the claim sent to the fiscal intermediary. We will have the capability to analyze the claim information against the transmitted MDS–PAC data. The results of this analysis may necessitate additional review of a particular claim and the associated MDS–PAC data to determine if payment was made accurately.

D. The MDS–PAC Assessment Reference Date

In § 412.610(c) we propose that each assessment would have a specific assessment reference date. The purpose of the assessment reference date is to establish a common temporal reference point for the care team participating in the patient's assessment. Although staff members may work on completing a patient's MDS–PAC on different days, establishment of the assessment reference date ensures the commonality of the assessment period (that is, ''starting the clock''), so that all assessment items refer to the patient's objective performance and clinical status during the same period of time. The assessment reference date is a specific endpoint in the MDS–PAC assessment observation time period. Almost all MDS–PAC items refer to the patient's status over a continuous three calendar day time period, which is the observation time period.

During the patient's current hospitalization, an IRF must indicate on the MDS–PAC one of the following assessment reference dates—

- For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization the date that is the third calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that covers calendar days 8 through 10 of the

patient's current hospitalization the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

- For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization the date that is the 30th calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that must be completed when the patient stops receiving Medicare-covered Part A services but is not discharged from the IRF, the assessment reference date must be the actual date that the patient stops receiving Medicare-covered Part A services.
- For the assessment that is completed when the patient stops receiving Medicare-covered Part A services and is discharged from the IRF the assessment reference date must be the actual date of discharge from the patient rehabilitation facility.

The general concept is that the assessment reference date sets the designated endpoint of the common 3-day observation period, and the MDS–PAC items will usually refer back in time from this point. The assessment reference date establishes the end of the assessment time period that the clinician(s) will use for the data gathering. As specified in proposed § 412.606(c), these data are obtained through patient observation, patient interview, the clinical record or other means, in order for the clinician(s) to complete an MDS–PAC assessment that covers a given data-gathering time period.

For discharge assessments, the date when the patient either is discharged or stops receiving Medicare-covered Part A services is the assessment reference date. The observation time period includes either the date that the patient is discharged, or the date that the patient stops receiving Medicare-covered Part A services, along with the preceding 2 calendar days. In a situation when the discharge occurs unexpectedly, the clinical record would become a prime source of the data recorded on the MDS–PAC.

E. Performing the MDS–PAC Assessment

In § 412.606, we propose that Medicare beneficiaries who are inpatients of an IRF must be assessed by a professional clinician(s), and that the MDS–PAC must be used to perform the patient assessment. Because the MDS–PAC will be used to obtain a variety of assessment data, we believe that the assessment process should be a collaborative team effort, employing the clinical skills of a variety of professional clinicians.

The data recorded for a specific MDS–PAC item may be more accurate if the information used to record the data for that specific item was obtained by a professional clinician with specialized training related to that specific MDS–PAC item. A professional clinician may be a dietitian, an occupational therapist, a physical therapist, a physician, a practical (vocational) nurse, a registered nurse, a speech-language pathologist or a social worker.

For purposes of this proposed rule, we propose to incorporate the existing definition of a qualified dietitian specified in § 483.35(a)(2). For purposes of this proposed rule, we propose to incorporate the existing standard at § 482.56(a)(2) of who may perform occupational therapy and physical therapy as defining the terms occupational therapist and physical therapist. Section 482.56(a)(2) states that physical therapy and occupational therapy ''must be provided by staff who meet the qualifications specified by the medical staff, consistent with State law.'' Therefore, an occupational therapist and a physical therapist are individuals who meet the qualifications of the provider's medical staff and State law.

A practical (vocational) nurse, a registered nurse, and a speech-language pathologist are individuals who meet the applicable definitions of § 484.4. For purposes of this proposed rule, an individual would be considered a social worker if that person meets either the definition in § 483.15(g)(3) or the one in § 483.430(b)(5)(vi), because these two sections define a social worker in terms of varying levels of education and experience.

For purposes of this proposed rule, we propose to define the term physician as an individual who is a doctor of medicine or osteopathy who is currently legally licensed to practice medicine and surgery by the State in which that function or action is performed.

Performing an MDS–PAC assessment is a process that involves patient interview, patient observation, and, if necessary, obtaining information from other sources, such as the clinical record or the patient's family. The data recorded on the MDS–PAC would be the result of that total assessment process, and the manner in which data is obtained for a specific MDS–PAC item would depend on a combination of the instructions on the MDS–PAC form itself, the Item-by-Item Guide to the MDS–PAC, and provisions set forth via rulemaking. Although different professional clinicians may be involved in the MDS–PAC assessment process, in order to ensure that the MDS–PAC assessment process is properly followed, we propose that only specific clinicians be authorized to sign item AB1a of the MDS–PAC.

In general, we believe that physicians, registered nurses, physical therapists, and occupational therapists are the only disciplines equipped with the education and experience to accurately assess the entire range of an individual's functional/motor performance and medical/clinical status. Additionally, the licensure requirements of some States restrict the human services disciplines that may perform a clinical assessment. Therefore, we propose that only an occupational therapist, a physical therapist, a physician, or a registered nurse be authorized to sign item AB1a of the MDS–PAC and provide the data for items AB1b thru AB1g of the MDS–PAC. Item AB1a is where the clinician who is attesting to the completion of the assessment signs. Items AB1b thru AB1g are the items that identify the clinician who signed item AB1a and the date that item AB1a was signed.

The clinician who signs item AB1a would be responsible for the accuracy and thoroughness of a specific patient's MDS–PAC assessment, and would be responsible for the accuracy of the date inserted in item AB1g. The signatures of other professional clinicians who contributed to the data recorded on the MDS–PAC would be recorded in item AB, lines 2a through item 2f.

The data for the MDS–PAC items that require the collection of data that is not associated with the observation of an activity by the patient can be obtained from the patient, the patient's clinical record, and, if necessary, from the patient's family. If the patient is uncooperative we believe that the data that is not associated with the observation of an activity by the patient can be obtained from the patient's clinical record, or other easily obtained documentation that contains patient information. We believe that the data for the MDS–PAC items related to the observation of a particular activity would always be recorded on the MDS–PAC, because these items allow for the recording of the data in different ways, including recording that the activity did not occur. For the items related to observation of a patient activity we want to emphasize that the clinician assessor should not require a patient to perform

an activity that in the clinician's professional judgment is clinically contraindicated or hazardous. The Item-by-Item Guide to the MDS–PAC in Appendix BBB contains information concerning observational techniques and provides more guidance for clinicians in performing the MDS–PAC assessment.

F. The MDS–PAC Assessment Schedule

1. General Rule

We propose in § 412.610 that an IRF Medicare patient be assessed by a clinician(s) using the MDS–PAC to gather and record the patient assessment data. The length of the patient's hospitalization would determine how many MDS–PAC assessments are required. Table 4C below, entitled ''MDS–PAC Assessment Schedule and Associated Dates,'' illustrates the proposed MDS–PAC assessment schedule for the following ''MDS–PAC Assessment Type'': Day 4, Day 11, Day 30, and Day 60 assessments. The term ''day'' as used in the assessment schedule is a calendar day, and is counted as including the first day of the patient's current IRF hospitalization when the patient started receiving Medicare-covered Part A services, (which is generally the day of admission to the IRF). As specified in proposed § 412.620(a)(3), in general only data from the Day 4 assessment would determine the CMG classification that would in turn determine the payment that the IRF would receive for the entire episode of the patient's hospitalization. If a patient is not hospitalized in the IRF for the time period needed for the Day 4 assessment, then the patient's CMG would be determined as specified in section V.C. of this preamble.

TABLE 4C.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period*	MDS–PAC assessment reference date*	MDS–PAC must be completed by:*	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:*	MDS–PAC must be transmitted by:*
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73

Currently, on the MDS–PAC, item B4 ''Indicators of Delirium—Periodic Disordered Thinking/Awareness,'' requires an assessment time period that is 7 days in length. Item F1 ''Bladder Continence,'' and item F4 ''Bowel Continence'' require an assessment time period that is 7 to 14 days in length. Therefore, the assessment time period and associated coding for these three items affect the dates for the ''Hospitalization Time Period and Observation Time Period,'' the ''MDS–PAC Assessment Reference Date,'' the ''MDS–PAC Must Be Completed by:,'' the ''MDS–PAC Must be Encoded By:,'' and the ''MDS–PAC Must be Transmitted By:''. As stated previously, we will be conducting additional testing of the MDS–PAC. This additional testing will determine if the assessment time period for items B4, F1, and F4 can be changed, or if the instructions on assessing these items should be changed. If our additional testing indicates that the assessment time periods or the instructions for assessing items B4, F1, and F4 should not be changed, then in the final rule we will change the proposed MDS–PAC assessment schedule and associated dates to reflect the current assessment time periods of these three items.

Table 4C represents the generic assessment schedule and other associated MDS–PAC dates. Table 5C.—Example Applying the MDS–PAC Assessment Schedule and Associated Dates, below is an example of how Table 4C would be applied using actual calendar dates. In Table 5C it is assumed that the patient was admitted on April 3, 2001.

TABLE 5C.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

Each patient is assessed by a clinician(s) using an MDS–PAC to perform a comprehensive assessment according to the schedule stated above. More than one clinician can contribute to completion of the MDS–PAC. We believe that MDS–PAC assessment accuracy would be enhanced if the data collected for an MDS–PAC item is collected by a clinician with specialized training and experience in the area of the data being collected. For example, although a registered nurse could fully assess all aspects of a patient and collect all the MDS–PAC data, a physical therapist or an occupational therapist has the specialized training which may contribute to a more accurate assessment of some neuro-muscular items. Our objective is to have data collected that would best reflect the patient's unique circumstances and clinical status during the assessment observation period, considering that an MDS–PAC item may provide for several possible responses and that the accuracy of patient assessment is contingent on the training and experience of the clinician assessor.

In section IV. of this preamble, we specify the MDS–PAC items that would be used to classify a patient into a specific CMG. We propose to require

that data be collected not only for the items that would be used to classify a patient into a CMG, but also for any of the other MDS–PAC items for which data collection is appropriate according to one or more of the following: (1) the instructions on the MDS–PAC; (2) the Item-by-Item Guide to the MDS–PAC; and (3) applicable rulemaking provisions.

The example that follows, with ''day'' referring to a calendar day, illustrates a typical IRF's Medicare beneficiary hospitalization assessment schedule:

- Hospitalization Day 1. Patient admission day and the day that the IRF begins to furnish Medicare-covered Part A services. This is the day that starts the count as ''day 1'' when determining the assessment time periods for the MDS–PAC assessments.
- Hospitalization Day 3. The last day of the 1 through 3 calendar day assessment observation period and, as a general rule, the last day that can be used to set the assessment reference date for the initial (Day 4) MDS–PAC assessment.
- Hospitalization Day 4. The day by which the Day 4 MDS–PAC must be completed.
- Hospitalization Day 10. The last day of the 8 through 10 calendar day assessment observation period and, as a general rule, the last day that can be used to set the assessment reference date for the first re-assessment.
- Hospitalization Day 11. The day by which the Day 11 MDS–PAC must be completed.
- Hospitalization Day 30. The last day of the 28 through 30 calendar day assessment time period and, as a general rule, the last day that can be used to set the assessment reference date for the second re-assessment.
- Hospitalization Day 31. The day by which the Day 30 MDS–PAC must be completed.

In the above example, if the patient is instead discharged on day 22 of the hospitalization, then the discharge day is the assessment reference date.

2. Interrupted Stays

a. *Definition of an Interrupted Stay.*

As specified in proposed § 412.602 an interrupted stay is one in which an IRF patient is discharged from the IRF and returns to the same IRF within 3 calendar days. For purposes of the MDS–PAC assessment process, if a patient has an interrupted stay, then: (1) the initial CMG classification from the ''initial'' (Day 4) MDS–PAC assessment would remain in effect (no new initial MDS–PAC assessment would be performed); and (2) the required scheduled MDS–PAC update assessments must still be performed. A patient who returns to the same IRF more than 3 calendar days after being discharged is considered a ''new'' patient for purposes of the MDS–PAC assessment schedule process. Being considered a ''new'' patient for the MDS–PAC assessment schedule process means that a new Day 4 assessment needs to be performed. That new Day 4 assessment would determine a new CMG. That new CMG may or may not be the same CMG into which the patient classified prior to the interrupted stay.

In counting the 3 calendar day time period to determine the length of the interrupted stay, the first day of the start of the interrupted stay is counted as ''day 1,'' with midnight of that day serving as the end of that calendar day. The 2 calendar days that immediately follow would be days 2 and 3. If the patient returns to the IRF by midnight of the third calendar day, then it would be determined that the patient had an interrupted stay of 3 calendar days or less.

When a patient has an interrupted stay, the interrupted stay must be documented on the MDS–PAC interrupted stay tracking form. The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date the patient returns to the IRF.

b. Effect of an Interrupted Stay Upon the Assessment Schedule

When an interruption of a patient's IRF stay occurs it may affect the MDS–PAC—(1) assessment reference dates; (2) completion dates; (3) encoding dates; and (4) transmission dates.

As discussed in section III. D. of this preamble, the assessment reference date generally is the designated endpoint of the common 3-day observation period, and the MDS–PAC items will usually refer back in time from this point. Therefore, in order to set an assessment reference date, the patient must be an inpatient of the IRF during the 3-day observation time period. The 3-day observation time period must be continuous.

In order to facilitate the discussion that follows regarding the effect of an interrupted stay upon the assessment schedule Table 5C has been reproduced below.

TABLE 5C—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	04/05/01	04/06/01	04/12/01	04/18/01
Day 11	Days 8 to 10	04/12/01	04/13/01	04/19/01	04/25/01
Day 30	Days 28 to 30	05/02/01	05/03/01	05/09/01	05/15/01
Day 60	Days 58 to 60	06/01/01	06/02/01	06/08/01	06/14/01

In Table 5C above, if an interruption of 3 calendar days or less occurred for any of the ''MDS–PAC Assessment Type'' assessment observation time periods (for example, the days specified in the ''Hospitalization Time Period and Observational Time Period'' column in the Table), then the associated assessment reference dates, MDS–PAC completion dates, MDS–PAC encoded by dates, and MDS–PAC transmitted by dates for that particular ''MDS–PAC Assessment Type'' would be shifted forward by the number of days that the patient was not an inpatient of the IRF.

We refer to Table 5C to illustrate the shifting forward of dates. With regard to the Day 4 assessment assume that the patient's stay began with admission to the IRF on April 3, 2001, but was interrupted on April 4, 2001, which would be day 2 of the patient's IRF hospitalization. The patient returned to the same IRF prior to midnight of April 6, 2001, and had an interrupted stay of 3 calendar days. The assessment reference date observation time period for the Day 4 assessment would be shifted to April 6, 7, and 8. (Without the interrupted stay, the Day 4 assessment reference date observation time period would have been April 3, 4, and 5, with the assessment reference date being April 5, 2001). Because of the interruption in stay, the MDS–PAC Day 4 assessment reference date would be

reset to April 8, 2001. The Day 4 MDS–PAC completion date would be reset to April 9, 2001. The Day 4 ''MDS–PAC Must Be Encoded By'' date would be reset to April 15, 2001. The Day 4 ''MDS–PAC Must Be Transmitted By'' date would be reset to April 21, 2001.

Before this interrupted stay, the Day 11 assessment reference date was set to be day 10 of the patient's hospitalization, which would be April 12, 2001. Because of the shifting forward of the Day 4 assessment reference date from April 5, 2001, to April 8, 2001, the Day 11 assessment dates, and only the Day 11 assessment dates, would also be shifted forward. The Day 11 assessment reference date would then be April 15, 2001. The Day 11 MDS–PAC completion date would be reset to April 16, 2001. The Day 11 ''MDS–PAC Must Be Encoded By'' date would be reset to April 22, 2001. The Day 11 ''MDS–PAC Must Be Transmitted By'' date would be reset to April 28, 2001. When there is a shifting forward of the Day 4 or Day 11 assessment dates they would not affect the assessment timeframes for the subsequent (for example, Day 30 or Day 60) assessments, because the purpose of shifting forward an assessment due to an interruption in stay is to keep the time periods between assessments to at least 7 calendar days.

Again, we refer to Table 5C to illustrate the shifting forward of dates. Assume that for the Day 11 reassessment the patient, who was admitted to the IRF on April 3, 2001, started an interrupted stay on April 11, 2001, which would be day 9 of the patient's IRF hospitalization. (For this example, do not assume that the patient also had a Day 4 interrupted stay.) The patient returned to the same IRF prior to midnight of April 13, 2001, and had an interrupted stay of 3 calendar days. The assessment reference date observation time period for the Day 11 assessment would be shifted to April 13, 14, and 15. (Before the interrupted stay, the Day 11 assessment reference date observation time period was April 10, 11, and 12, with the assessment reference date being April 12, 2001.) Due to the interruption in stay, the MDS–PAC assessment reference date would be reset to April 15, 2001. The MDS–PAC completion date would be reset to April 16, 2001. The ''MDS–PAC Must Be Encoded By'' date would be reset to April 22, 2001. The ''MDS–PAC Must Be Transmitted By'' date would be reset to April 28, 2001. The various dates, as illustrated in Table 5C, for the Day 30 and Day 60 assessments would not be affected by the shifting forward of the Day 11 assessment associated dates. However, if the patient had an interrupted stay during the time period that is associated with the Day 30 or Day 60 assessment as indicated in the Table 5C column entitled ''Hospitalization Time Period and Observation Time Period'' then the same shifting forward methodology described above for the Day 11 assessment would apply.

3. MDS–PAC Dates Associated with the Discharge Assessment

As specified in proposed § 412.610(c)(5) and (6) the assessment reference date for the discharge assessment is the day when one of two events occurs first: (1) the day the patient is discharged from the IRF or (2) the day the patient ceases receiving Medicare-covered Part A inpatient rehabilitation services. The MDS–PAC assessment is performed only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

After the assessment reference date for the discharge MDS–PAC assessment is determined the completion date for the discharge MDS–PAC assessment must be set. As specified in proposed § 412.610(e)(2) the completion date for the discharge MDS–PAC assessment is the 5th calendar day in the period beginning with the discharge MDS–PAC assessment reference date. To count the 5 calendar days, count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The method used to determine the completion date for the discharge MDS–PAC assessment is not the same method used to determine the completion date for the Day 4, Day 11, Day 30 or Day 60 MDS–PAC assessments. The reason for using a different method to determine the discharge MDS–PAC completion date is because of the definition of an interrupted stay. Previously we specified that after the patient returns to the IRF after an interrupted stay another Day 4 assessment is not performed, and the CMG into which the patient classified prior to starting the interrupted stay is still in effect. Therefore, in order to ensure that a clinician does not perform a discharge assessment on a patient who meets the criteria of an interrupted stay, it is necessary to make the completion date of the discharge MDS–PAC assessment a date that exceeds the interrupted stay defined time period. This safeguard prevents the performance of unnecessary MDS–PAC discharge assessments by the IRF.

In addition, any discharge MDS–PAC assessment that is transmitted to the HCFA MDS–PAC system is used by the system to indicate that a patient is no longer hospitalized in the IRF. Therefore, if a discharge assessment that is only associated with an interrupted stay is transmitted to the HCFA MDS–PAC system, it would result in the HCFA MDS–PAC system rejecting any subsequent update (either a Day 11, Day 30 or Day 60) assessments that are associated with the patient's continued hospitalization in the same IRF following an interrupted stay.

As specified in proposed § 412.610(e)(3) the discharge MDS–PAC ''must be encoded by'' date is the 7th calendar day in the period beginning with the discharge MDS–PAC completion date. To count the 7 calendar days, count the discharge MDS–PAC assessment completion date as day 1 of the 7 calendar days. For example, if the MDS–PAC assessment completion date is May 5, 2000, then the MDS–PAC must be encoded by date would be May 11, 2000.

As specified in proposed § 412.614(c) the discharge MDS–PAC ''must be transmitted by'' date is the 7th calendar day in the period beginning with the discharge MDS–PAC ''must be encoded by'' date. To count the 7 calendar days, count the discharge MDS–PAC assessment ''must be encoded by'' date as day 1 of the 7 calendar days. For example, if the MDS–PAC assessment must be encoded by date is May 11, 2000, then the MDS–PAC must be transmitted by date would be May 17, 2000.

Table 6C below illustrates the discharge MDS–PAC dates discussed above:

TABLE 6C.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date*	MDS–PAC assessment reference date	MDS–PAC must be completed on:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/1/00	5/1/00	5/5/00	5/11/00	5/17/00

*This is either: (1) the day the patient is discharged from the IRF; or (2) the day the patient ceases receiving Medicare-coverred Part A inpatient rehabilitation services.

Data from recent studies indicate that the vast majority of patients are discharged from IRFs within the first twenty calendar days of their hospitalization. Therefore, we believe that, in most cases, IRFs would only perform three assessments under this proposal: The Day 4, Day 11, and the discharge assessment. Early data indicated that the mean length of stay was 18.9 days, that the median length of stay was 16 days, with a standard deviation of 13. More recent data from the RAND Institute indicates that the mean length of stay is 15.81 days, and that the median length of stay is 14 days. The recent RAND data also indicates that less than 9 percent of patients would require a Day 30 assessment and less than ½ of 1 percent of patients would require a Day 60 assessment. We are especially interested in Day 30 and Day 60 assessments because these cases will be very unusual when compared to the average length of stay; therefore, we want to understand what characteristics make these cases atypical. In addition, Day 30 assessment data may be useful in making any future CMG refinements; for example, providing outlier information after the IRF prospective payment system has been implemented. We are specifically soliciting comments on the benefits of performing interim assessments on days 11, 30, and 60.

4. Assessment Rule to Use If Medicare Beneficiaries Are Receiving IRF Services on the Effective Date of this Regulation

We propose a special MDS–PAC assessment rule for the Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective. For these patients we are proposing that only one MDS–PAC assessment must be performed. The one MDS–PAC assessment would be used to classify a patient into a CMG, and that CMG would determine the payment the IRF would receive for all the Part A services the IRF furnished to the patient during the patient's current hospitalization. For Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective the one MDS–PAC assessment would, as applicable, cover one of the following calendar day time periods and associated conditions: (1) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for at least 3 calendar days, then the data for the MDS–PAC assessment items must be collected according to the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC. (2) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 2 calendar days, then the data for the MDS–PAC assessment items that must be collected would pertain to only these 2 calendar days, unless the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC specify a shorter time period. (3) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 1 or less than 1 calendar day then the data for the MDS–PAC assessment items that must be collected would pertain to 1 or less than 1 calendar day, unless the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC specify a shorter time period.

For this special MDS–PAC assessment we propose that, no later than 30 calendar days from the date this regulation becomes effective, all the following would apply—(1) the data for this special MDS–PAC assessment must be collected; (2) this special MDS–PAC must be completed; (3) the MDS–PAC data for this special assessment must be encoded; and (4) the MDS–PAC data for this special assessment must not only be transmitted to but also be accepted by the HCFA MDS–PAC system. We propose that if the IRF does not, as specified above, collect, complete, encode, and transmit the data for this special MDS–PAC assessment, then the IRF would receive no payment for any of the Part A services furnished to Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective.

5. What MDS–PAC Items Are Collected On Each Assessment

The MDS–PAC assessments must be performed according to the schedule specified previously. Table 7C's.—MDS–PAC Items Required by Type of Assessment, title indicates the data for each MDS–PAC item that we propose to require collecting for the Day 4, Day 11, Day 30, Day 60, and discharge assessments.

It should be noted that recording data on the MDS–PAC for a particular item may require, according to the instructions for that item on the MDS–PAC form, that the clinician not record data for certain other items. For example, the MDS–PAC instructions state that if data is recorded indicating a patient is comatose in item B1, the clinician assessing the patient must proceed from item B1 to item E1. This means that the data for the items between B1 and E1 are not recorded. (The term ''update'' in Table 7C below refers to the Day 11, Day 30, and Day 60 assessments. An ''X'' indicates that the MDS–PAC item is required for that assessment type.)

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM AA1 and ITEM A1. Legal Name of Patient	X	X	X
ITEM AA2 and ITEM A2. Admission Date (2a and, if applicable, also 2b)	X	X	X

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT—Continued

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM AA3 and ITEM A3. Reason for Assessment	X	X	X
ITEM AA4. Assessment Reference Date	X	X	X
ITEM AA5a and AA5b. Discharge Status	.....	.....	X
ITEM AA6a and AA6b. Social Security (6a) and Medicare Numbers (6b)	X	X	X
ITEM AA7. Medical Record Number	X	X	X
ITEM AA8. Facility Provider Number (Both 8a and 8b)	X	X	X
ITEM AA9. Medicaid Number	X	X	X
ITEM AA10. Gender	X	X	X
ITEM AA11. BirthDate	X	X	X
ITEM AA12. Ethnicity/Race	X	X	X
ITEM AA13a and AA13b. Interrupted Stay* (Only appears on the interrupted stay tracking form. Record and submit data if applicable.).			
ITEM AA14a thru AA14f. Clinician Completing Assessment* (Only appears on the interrupted stay tracking form. Record and submit data if Item 13 data is recorded and submitted.).			
Item AB1a thru AB1g. Person Completing Assessment	X	X	X
Item AB2a thru AB2f. Signature of Staff Completing Part of the Assessment	X	X	X
ITEM A4. Admission Status	X	X	X
ITEM A5. Goals for Stay	X	X	X
ITEM A6. Admitted From	X	X	X
ITEM A7. Precipitating Event Prior to Admission	X	X	X
ITEM A8. Primary and Secondary Payment Source For Stay	X	X	X
ITEM A9. Marital Status	X	X	X
ITEM A10. Education	X	.....	.....
ITEM A11a and A11b. Language	X	X	X
ITEM A12. Dominant Hand	X	.....	.....
ITEM A13. Mental Health History	X	.....	.....
ITEM A14. Conditions Related to MR/DD Status	X	.....	.....
ITEM A15a thru A15e. Responsibility/Legal Guardian	X	.....	.....
ITEM A16a thru A16e. Advance Directives	X	.....	.....
ITEM B1. Comatose	X	X	X
ITEM B2a thru B2d. Memory/Recall Ability	X	X	X
ITEM B3a and B3b. Cognitive Skills for Daily Decision Making	X	X	X
ITEM B4a thru B4f. Indicators of Delirium-Periodic Disordered Thinking/Awareness	X	X	X
ITEM C1. Hearing	X	X	X
ITEM C2a thru C2e. Modes of Communication	X	X	X
ITEM C3a and C3b. Making Self Understood	X	X	X
ITEM C4. Speech Clarity	X	X	X
ITEM C5a and C5b. Ability to Understand Others	X	X	X
ITEM C6a and C6b. Vision	X	X	X
ITEM D1a thru D1k. Indicators of Depression, Anxiety, Sad Mood	X	X	X
ITEM D2. Mood Persistence	X	X	X
ITEM D3a thru D3e. Behavioral Symptoms	X	X	X
ITEM E1a thru E1l. 3-Day ADL Self-Performance	X	X	X
ITEM E2a thru E2l. ADL Assist codes	X	X	X
ITEM E3a and E3b. ADL Changes	X	X	X
ITEM E4a thru E4f. Instrumental Activities of Daily Living	X	X	X
ITEM E5. IADL Areas Now More Limited	X	X	X
ITEM E6a thru E6j. Devices/Aides	X	X	X
ITEM E7a and E7b. Stamina	X	X	X
ITEM E8a thru E8c. Walking and Stair Climbing	X	X	X
ITEM E9a and E9b. Balance Related to Transitions	X	X	X
ITEM E10a thru E10c. Neuro-musculoskeletal Impairment	X	X	X
ITEM F1a and F1b. Bladder Continence	X	X	X
ITEM F2a thru F2g. Bladder Appliance	X	X	X
ITEM F3. Bladder Appliance Support	X	X	X
ITEM F4. Bowel Continence	X	X	X
ITEM F5a thru F5d. Bowel Appliances	X	X	X
ITEM F6. Bowel Appliance Support	X	X	X
ITEM G1. Impairment Group	X	.....	.....
ITEM G2a thru G2aq. Other Diseases	X	X	X
ITEM G3a thru G3l. Infections	X	X	X
ITEM G4A and G4B. Other Current or More Detailed Diagnoses and ICD–9–CM Codes (Line ''a'' thru line ''e'' as applicable.)	X	X	X
ITEM G5. Complications/Co-Morbidities (Line ''a'' thru line ''d'' as applicable.)	X	X	X
ITEM H1. Vital Signs	X	X	X
ITEM H2a, H2b, H2d thru H2t, and H2w. Problem Conditions	X	X	X
ITEM H2c, H2u, and H2v. Problem Conditions	X	.....	.....
ITEM H3a thru H3h. Respiratory Conditions	X	X	X
ITEM H4a thru H4f. Pressure Ulcers	X	X	X
ITEM H5a and H5b. Other Skin Integrity	X	X	X

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT—Continued

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM H5c. Other Skin Integrity	X		
ITEM H6a thru H6e. Other Skin Problems or Lesions Present	X	X	X
ITEM I1a and I1b. Pain Symptoms	X	X	X
ITEM I1c. Pain Symptoms	X		
ITEM J1a and J1b. Oral Problems	X	X	X
ITEM J2. Swallowing	X	X	X
ITEM J3a. Height	X		
ITEM J3b. Weight	X	X	X
ITEM J4a and J4b. Weight Change	X		
ITEM J5a and J5b. Parenteral or Enteral Intake	X	X	X
ITEM K1a thru K1e. Clinical Visits and Orders	X	X	X
ITEM K2a thru K2ai. Treatments and Services	X	X	X
ITEM K3a thru K3k. Nursing Practice or Restorative Care	X	X	X
ITEM K4a thru K4f. Therapy Services	X	X	X
ITEM K5a thru K5d. Devices and Restraints	X	X	X
ITEM L1a thru L1h. Functional Improvement Goals	X	X	X
ITEM L2a thru L2c. Attributes Relevant to Rehabilitation	X	X	X
ITEM L3a and L3b. Change over last 3 days	X	X	X
ITEM L4. Estimated Length of Stay from Date of Admission	X	X	X
ITEM M1a thru M1e. Available Social Supports	X	X	X
ITEM M2a and M2b. Caregiver Status	X		X
ITEM M3a and M3b. Living Arrangement	X	X	X

*Note: Data for items AA13 and AA14 would only be recorded and submitted to the HCFA MDS–PAC system if the patient has an interrupted stay according to how interrupted stay is defined in this preamble. This means each time the patient has an interrupted stay, as that term is defined in this preamble, data for items AA13 and AA14 would be recorded and submitted to the HCFA MDS–PAC system. The other items on the interrupted stay tracking form would also be submitted. However, these other interrupted stay tracking form items are identification information items that have previously been collected and recorded by the IRF clinician and, therefore, do not require collection as new items of data.

6. The MDS–PAC Completion Date

We propose in § 412.610(e) that for the Day 4, Day 11, Day 30, and Day 60 assessments that IRFs ''complete'' the MDS–PAC on the calendar day that follows the assessment reference date. Previously we discussed the completion date for the discharge assessment. For all assessments ''completion'' of the MDS–PAC means that accurate information has been recorded for each MDS–PAC item, and that the MDS–PAC has been signed and dated by the clinicians that recorded information on the MDS–PAC. It is our belief that the IRF clinician(s) can easily access or recall specific patient information if only a short period of time has elapsed, between the patient interview/patient observation time period and the recording of that information on the MDS–PAC.

7. Penalties for Late Assessments

In § 412.610(d) we propose that the MDS–PAC assessment is late if the assessment is not in accordance with the assessment reference date specification for the Day 4 assessment discussed previously in this preamble. If the MDS–PAC assessment is late then the IRF would either receive a reduced CMG-determined payment or no payment. If the MDS–PAC assessment is less than or equal to 10 calendar days late then the reduced CMG-determined payment would be a default rate. We propose to set the default rate at 25 percent less than the CMG-determined payment that the IRF would otherwise have received. If any assessment is more than 10 calendar days late, then the IRF would receive no payment for the Medicare-covered Part A services furnished.

G. Computerization of the MDS–PAC Data

1. Encoding the MDS–PAC Data

The data for all MDS–PAC assessments must be encoded. Encoding the data means entering the MDS–PAC data into the IRF's computer using appropriate software, including performing data edits. In § 412.610(e)(3), we propose that IRFs encode and edit the data for Medicare patients within 7 calendar days of the date that the MDS–PAC is completed. We propose to specify a maximum of 7 calendar days because we believe that this is a reasonable amount of time for IRFs to complete these tasks.

In determining the first day to count as being ''within 7 calendar days of the date that the MDS–PAC is completed,'' the assessment completion date itself would be counted as ''day 1'' of the 7 calendar days. For example, if the MDS–PAC completion date is April 6, 2001, then the MDS–PAC must be encoded by April 12, 2001. As previously stated, MDS–PAC records are considered ''locked'' when they pass all HCFA-specified edits and are accepted by the MDS–PAC database to which the IRF transmits its records.

To encode the MDS–PAC data, the IRF may: use a commercial application from a private software vendor; develop its own data entry program based on our specifications; or use the free data entry and data transmission software program developed by HCFA, which is the MDS–PAC Tool (MPACT). The IRF will be able to download MPACT from our Inpatient Rehabilitation Facility Prospective Payment System website. The MPACT data entry tool accommodates standard HCFA edit specifications for MDS–PAC data.

It is preferable for the edits and corrections to be made as soon as possible after the assessment activity, because the clinician's recall of the patient assessment at that point is likely to be more detailed and easier to associate with any clinical notes related to the assessment. Therefore, it is reasonable to expect that IRFs will have the MDS–PAC data encoded, edited, and ready for transmission within 7 calendar days of the completion date. In addition, if the IRF chooses to use the MDS–PAC information in patient care planning, our timeframes would contribute to the facility's efforts to produce a current and workable plan of care.

IRFs will have flexibility in the process used to encode their data. Once the assessment is completed by the clinician(s), the data may be encoded by a clinician, or by a clerical staff member using a paper copy of a completed MDS–PAC, or by a data entry technician. Non-clinical staff may not assess patients or complete clinical assessment items. However, clerical staff or data entry operators may enter the MDS–PAC data that has been collected by the clinician into the computer.

In entering the data, IRFs must comply with requirements for safeguarding the confidentiality of patient identifiable information, as specified in section III.*I.*1. of this preamble. In addition, IRFs must train personnel with access to patient information to disclose that patient information only to those recipients who are authorized to have access to it.

On August 12, 1998, we published in the **Federal Register** a proposed rule entitled ''Security and Electronic Signature Standards'' (63 FR 43242), and on November 3, 1999, we published another proposed rule entitled ''Standards for Privacy of Individually Identifiable Health Information'' (64 FR 59918). When these proposed rules are published as final rules, the security and privacy criteria specified in these rules may supplement or supersede the security and privacy criteria specified in this proposed rule.

Once the IRF encodes the MDS–PAC information, the computer software is used to review and edit the data to create a file that will be transmitted to the HCFA MDS–PAC system. The software program edits are designed to help preclude the transmission of erroneous or inconsistent information.

2. Accuracy of the Encoded MDS–PAC Data

In § 412.610(f) we propose that the encoded MDS–PAC data must accurately reflect the patient's status at the time the data are collected. Because the patient's clinical status may change over time, the MDS–PAC data must accurately represent a patient's clinical status as of a particular assessment reference date. Before transmission, the IRF must ensure that the data items on the MDS–PAC paper copy match the encoded data that are sent to the HCFA MDS–PAC system. We are requiring that once the clinician(s) completes the MDS–PAC assessment, using either a paper copy of the MDS–PAC or an electronic version, the IRF must ensure that the data encoded into the computer and transmitted to the HCFA MDS–PAC system accurately reflects the data collected by the clinician. We will leave to the IRFs the development of methods that ensure the accuracy of the MDS–PAC data that is transmitted. However, it should be noted that because the policies of the IRF prospective payment system only apply to Medicare beneficiaries, the HCFA MDS–PAC system will reject all transmitted assessment data for which a non-Medicare payment source is indicated.

3. Transmission of the MDS–PAC Data

We will utilize the most current technology to secure the safety of the information transmitted to and from the HCFA MDS–PAC system. In § 412.614, we propose to require that the IRF electronically transmit to the HCFA MDS–PAC system accurate, complete, and encoded MDS–PAC data for each Medicare patient. We also propose that the data must be transmitted in a format that meets the general requirements specified in § 412.614. We believe that once the MDS–PAC data are encoded and edited, it is a relatively simple procedure to complete the preparation of the data for transmission to the HCFA MDS–PAC system. Therefore, we are proposing that encoded and edited data that has not previously been transmitted, must be transmitted within 7 calendar days of the day by which the data must be encoded by as specified in Table 4C ''MDS–PAC Assessment Schedule and Associated Dates''. In addition, the data must be transmitted in a manner that meets the locked data criteria previously discussed in this section of the preamble. At the end of the transmission file, an entry concerning the number of records being transmitted is required to complete the transmission process.

We believe that the 7 calendar day transmission requirement would support claim review efforts, because prompt transmission of MDS–PAC data would facilitate our ability to compare a claim promptly against the associated MDS–PAC data which, in turn, would enhance our ability to make any necessary adjustment to the IRF's payment amount in a timely manner. We will maintain a national MDS–PAC repository to which State Agencies, fiscal intermediaries and peer review organizations will have access. An adjustment to the IRF claim may be made if a discrepancy is discovered between what the MDS–PAC data indicated the CMG on the claim should be and what is actually on the claim.

The IRF must have a system that supports dial-up communications for the transmission of MDS–PAC data to the HCFA MDS–PAC system. The MDS–PAC data will be submitted to the HCFA MDS–PAC system via HCFA's Medicare Data Collection Network (MDCN). The MDCN is a secured private network. Specific instructions and telephone numbers will be provided to the IRFs to access the MDCN. For security purposes, there are two levels of user authentication required. To obtain access to the MDCN, the IRF must obtain an individual network-identification code for each person submitting the HCFA MDS–PAC data. This identification code is distributed by the HCFA system administrator or HCFA's agents. To obtain access to the HCFA MDS–PAC system, an IRF must also obtain a facility-identification code from the HCFA system administrator.

The IRF will transmit the MDS–PAC data via secured lines, and not via the Internet, to the HCFA MDS–PAC system, where the data will be checked to ensure it complies with HCFA MDS–PAC system data formatting specifications. The IRF will receive two reports, the initial and final validation reports. The initial validation report will notify the IRF if the submission is accepted or rejected. If the submission is rejected, the IRF is notified of the reason for the rejection. If the submission is accepted, the report alerts the IRF of any changes or discrepancies in the facility and vendor information. After the initial edit checks and acceptance of the file, the MDS–PAC data are validated to ensure that the data conforms to the HCFA specifications. If there are errors found in an assessment record, it will be rejected. Upon completion of the validation, the IRF receives the final validation report. This report includes the total number of assessment records submitted and the total number of assessment records rejected, as well as the total number of assessment records added to the database. The final validation also includes alert messages pertaining to an assessment record when appropriate; for example, ''Assessment was submitted out of sequence.''

In order to test transmission of MDS-PAC data using the HCFA MDS–PAC system IRFs must make a successful test transmission of test MDS–PAC data to the HCFA MDS–PAC system between February 1 and February 28, 2001. The initial test must include the following: (1) a transmission of MDS–PAC data that passes the HCFA edit checks built into the software program used by the IRF to encode the assessment data; and (2) a validation report back from the HCFA MDS–PAC system confirming transmission of data. This test data will not be included in the HCFA national repository. The test data are to contain MDS–PAC data on all Medicare

inpatients, both newly admitted and those previously receiving care, that are inpatients during the test transmission time period.

If an IRF does not have Medicare inpatients receiving care during the specified test transmission time period, we propose that the IRF transmit test MDS–PAC data for Medicare inpatients that received care in the most recent 30 calendar day time period. This would require that these IRFs use the clinical record and professional clinical judgment to obtain the information required for the MDS–PAC items. In this way, these facilities could transmit test data in order to ascertain how well their system is functioning, and become familiar with entering data into the computerized version of the MDS–PAC. In order to both assist all IRFs in constructing MDS–PAC test data and to test the volume data capacity of the HCFA MDS–PAC system we may use and provide the IRFs with ''dummy'' MDS–PAC records or test data.

We will provide training to the IRFs on the MDS–PAC instrument (including any modification arising from research examining the equivalence of the MDS–PAC and the FIM for classifying patients), the HCFA provided MPACT, the data transmission process, and the interpretation of the validation reports. Training will be provided prior to the implementation of IRF prospective payment system. The most current MDS–PAC will be available on our HCFA Inpatient Rehabilitation Facility Prospective Payment System website. IRFs and software vendors will be able to access the website and download the most current MDS–PAC. In addition, the MPACT will be available on the HCFA Inpatient Rehabilitation Facility Prospective Payment System website, and IRFs and software vendors will be able to download the MPACT at no charge. This website will include the data specifications, data dictionaries, the Item-by-Item Guide to the MDS–PAC, and the IRF data submission procedures.

We may also post other educational materials for IRFs on the website. We intend the website to provide current information to IRFs, State agencies, software vendors, professional organizations, and consumers. We encourage vendors, IRFs, and other interested parties to review the website regularly for information and issues related to the IRF prospective payment system.

4. Late Transmission Penalty

In section III.G.2. of this preamble, we propose §§ 412.606 and 412.610 to require that MDS–PAC data be collected and transmitted not only for the items that would be used to classify a patient into a CMG, but also for the other MDS–PAC items, if collection and transmission of that data are appropriate according to one or more of the following: (1) the instructions on the MDS–PAC; (2) the Item-by-Item Guide to the MDS–PAC; and (3) applicable rulemaking provisions. In addition, if the IRF transmits MDS–PAC data for a particular patient that is not in accordance with the data record specifications, that data would be rejected by the HCFA MDS–PAC system. If the data is rejected by the HCFA MDS–PAC system, then the data is not ''locked'' as that term was defined previously, and the data must be re-transmitted.

We propose in § 412.614 to impose a penalty for an IRF's late transmission of MDS–PAC data to the HCFA MDS–PAC system. ''Late transmission'' means that the IRF did not transmit MDS–PAC data in accordance with the transmission timeframes previously specified in Table 4C of section III of this preamble. We propose that if the IRF transmits the MDS–PAC data late, then the IRF is either paid a reduced CMG-determined payment or no CMG-determined payment. If the IRF transmits the MDS–PAC data 10 or less calendar days late then the IRF would receive a payment that is 25 percent less than the CMG payment that the IRF would otherwise have received. If the MDS–PAC data is transmitted more than 10 calendar days late, then the IRF would receive no payment for the Medicare-covered Part A services furnished.

5. The MDS–PAC and Computer Software

In § 412.614(c) we propose that the IRF encode and transmit the MDS–PAC data using the MPACT software available from HCFA or other software that conforms to the HCFA standard data specifications, data dictionary, and other HCFA-specified data requirements, and that includes the MDS–PAC data items that match the most updated version of the MDS–PAC. HCFA's MPACT software will be able to be used for several purposes, such as to encode MDS–PAC data, to maintain IRF and patient-specific MDS–PAC information, to create export files to submit MDS–PAC data, and to test alternative software. MPACT software will provide comprehensive on-line help to users in encoding, editing, and transmitting the MDS–PAC data. Additionally, there will be a toll-free hotline to support this software product.

We caution IRFs that the MPACT software system would provide only the minimum requirements to encode and format the data. We will support these functions and applications; however, we do not intend to provide any other applications related to care planning, financial information, durable medical equipment, medications, or personnel issues. Software vendors are encouraged to use the MPACT software as a minimum system, until they have developed their own software to accommodate HCFA specifications and other applications useful for IRFs.

H. Quality Monitoring

Before we present our specific strategies for quality monitoring in IRFs, we want to discuss our conceptual framework for understanding and advancing quality in the setting of IRFs, as well as other post-acute settings. Quality of care is complex, sometimes difficult to define, and is multi-dimensional in nature. One dimension is that the care achieve its intended result, which in the context of the IRF setting is most often to improve the patient's functioning in order to foster more independent living. A second dimension of quality is the prevention of avoidable complications or other adverse events and minimizing the effects of adverse events. A third related dimension is to improve management of the patient's medical impairments, with the goal being to promote ''improved'' health as well as function, or at least to improve the management of the patient's medical conditions. In addition, it is also important to use data to identify other sentinel events that may potentially impact care negatively. Our specific quality monitoring processes should be developed in a way that supports this multi-dimensional view of quality.

The consequences of detecting quality of care problems may be varied and could include increasing educational efforts to beneficiaries to help them make better informed selections of providers, guiding investigators to survey institutions (including verification surveys performed in JCAHO-accredited facilities), and if the problem(s) is not remedied consideration of whether the IRF should be permitted to continue to participate in the Medicare program. An IRF's own staff may use quality of care information from the MDS–PAC for their own quality assurance and, ultimately, quality improvement activities. We also have the potential to develop refinements to the case-mix methodology which provide incentives for improving quality.

As our payment policies continue to evolve, our objective is to move forward

with a quality assessment and improvement agenda that is based on standardized data, beneficiaries' clinical characteristics, and patient care outcomes. To achieve that objective, we need to collect common data elements and develop standardized assessment tools that will enable us to focus on beneficiary care needs rather than the characteristics of the provider. We believe that the most important short-term goal of post-acute care quality monitoring is to assess the effects of implementing the changes in the payment system and the quality of post-acute care.

We are aware of MedPAC's concern that we may have only a limited ability to assess the impact of Medicare payment changes that either have been implemented or will soon be initiated—for example, the IRF prospective payment system. There is a need to enhance our ability to assess this impact in order to improve the policies associated with our Medicare prospective payment systems.

In the March 2000 MedPAC Report to Congress, MedPAC states that quality monitoring systems are important to ensure that payment systems are designed so that providers are responding appropriately to the system's incentives. MedPAC believes that such information could assist in tracking trends over time or provide an early warning of impending problems in quality. ''Attaining any of these ends requires routine, systematic measurement of health care quality.'' (p. 62) We believe that the MDS–PAC is a first step towards developing such a measure.

The MDS–PAC is a multi-dimensional assessment instrument which provides a detailed picture of the patient. The non-payment related items in the instrument are necessary to provide a comprehensive inventory of patient factors that are necessary to monitor quality and risk adjust. This data can be used by facilities to identify patients at risk for adverse outcomes. In addition, MDS–PAC information may contribute to development of the patient care plan. Information collected can identify patients at risk for adverse outcomes, such as weight loss, aspiration, or pressure ulcers, and support the monitoring of these patients to prevent outcomes that might negatively impact patients' likelihood of optimal rehabilitation.

We believe that the MDS–PAC items are needed to monitor the impact of the IRF prospective payment system upon IRFs and beneficiaries, including beneficiary access to care. Section 125 of the BBRA directs the Secretary to conduct a monitoring study, and to submit a report to the Congress no later than 3 years from the date that the IRF prospective payment is implemented. To both monitor the impact of the IRF prospective payment system upon IRFs and beneficiaries, and support this BBRA-mandated report to the Congress, we need a data-driven monitoring system that would give us the capability to acquire objective (as opposed to anecdotal) data for analysis.

The MDS–PAC discharge assessment would provide data about a patient's clinical status at discharge, and give us the ability to compare a patient's clinical status at discharge with the patient's clinical status at the Day 4 assessment. Comparison of the patient's clinical status at Day 4 and at discharge would give us the data to analyze the relationship between any changes in the patient's clinical status and the quantity and effectiveness of the services the IRF furnished to the patient. That comparison would provide us with data that would indicate the quality of the IRF services furnished, and if an IRF was not furnishing the level of Medicare-covered services the patient needed.

Many studies have examined overall and condition-specific functional gain from admission to discharge as a measure of the effectiveness of a rehabilitation program. National benchmarks of functional gain have been used by providers to measure their performance relative to other facilities. In addition, some work has also been devoted to understanding providers' efficiency by linking measures of length of stay and functional gain.

Update assessments would yield the type of structured data that we can use to analyze the effectiveness of treatment services at a point in time when the services were still being furnished. Update assessments provide the information during treatment and allow measurement of changes in the patient's clinical status during a defined time period when the patient is still in treatment. We can then compare the patient's clinical status at that point in time to the patient's clinical status at either the Day 4 or discharge assessments, which would provide us with data about any changes in the patient's clinical status between the update assessments and these other assessments.

In essence, update assessments provide a ''snapshot'' of the patient while the patient is still being treated. This snapshot provides a method to analyze the changes in the patient's clinical status that are a result of the IRF services furnished either up to, or from, a predetermined point in the patient's hospitalization stay. The snapshot is similar to how a clinician evaluates a patient's reaction to treatment at points in time after the clinician has implemented a plan of care, and, therefore, the snapshot can be used by the IRF in a similar manner. Because we propose to mandate the data requirements for update assessments, the snapshot will provide us with the same structured and detailed data that is comparable across IRFs, permitting us to analyze clinical outcomes related to the IRF services furnished up to, and from, a predetermined point in time at one or many IRFs. The update assessments could also provide us with the some of the data needed to analyze the effectiveness of the services being furnished at more than just the time period between the patient's admission and discharge. That analysis could be used to evaluate the quality and quantity of services the IRF furnished at different periods of time during the patient's hospitalization.

The data associated with each MDS–PAC item would enhance our ability to monitor and, thus, safeguard the quality of care that beneficiaries receive. A quality of care improvement monitoring system that is based on the MDS–PAC data is consistent with other information-based quality monitoring programs, such as the ORYX process used by the Joint Commission on Accreditation of Health Care Organizations.

While only some MDS–PAC items would be used to determine the CMG, we believe that the data provided by MDS–PAC items are an essential first step in developing the type of quality monitoring system that both MedPAC and HCFA favor. Possible uses of the data could include: (1) strengthening existing quality assurance mechanisms; (2) generating indicators that would allow providers to assess their performance, and to compare it against benchmarks derived from standards of care or the performance of peers; and (3) creating a system that assists beneficiaries in making informed decisions when choosing among providers. In addition, MDS–PAC items may be useful in developing core measures that provide meaningful information on patient characteristics and outcomes across post-acute care settings.

1. Monitoring the IRF Prospective Payment System

We are planning a system that can be used to monitor access to rehabilitation facilities as well as to monitor the quality of the care delivered in these

facilities. This will be done through the monitoring of payment for the care and the associated cost of the delivered care. Monitoring will include variables as length of IRF stay, percent of IRF discharges to SNF, long-term care hospital, or intensive outpatient rehabilitation program, change in motor function between admission and discharge, and the case-mix distribution of the facility. We plan to examine changes within ''market areas'' as well as individual facilities.

In addition, we will be developing a variety of methods for monitoring the impact of the IRF prospective payment system. Monitoring may describe changes in access to rehabilitation, in payments to rehabilitation facilities, in quality of care, and in the cost of rehabilitation care. This monitoring would also help to identify unintended changes in the operations of providers, and would help to identify refinements needed in the IRF prospective payment system. In addition, because the IRF prospective payment system may have effects on non-IRF providers, and because changes in the payment systems for other providers may affect IRFs once common core data elements are required across post-acute providers and linked with other data, the monitoring system could also describe changes in access, utilization, quality, and cost of care in different types of post-acute sites including but not limited to HHAs and SNFs. We could start these activities as early as 2002.

2. Quality Indicators

Quality indicators are markers that indicate either the presence or absence of potentially poor facility care practices or outcomes. The development of quality indicators depends on the collection and analysis of sufficient MDS–PAC data from a representative national sample. We are attempting to design a monitoring system that would not only describe quality indicators, but also show how they can be used together to obtain a clear description of access, outcomes, and cost in IRFs. Quality indicators will be developed around the different dimensions of quality discussed earlier in this section. We believe that quality indicators developed for individual IRFs would help identify the IRFs that require attention because they may be coding incorrectly or providing lower quality care. Analysis of the distribution of hospital indicators within specific classes of hospitals (for example, teaching hospitals, rural hospitals, etc.) would help us to evaluate whether facility level adjustments are warranted.

We currently have a contractor conducting analysis for purposes of developing quality indicators to be used in IRFs. Quality indicators are not direct measures of quality but rather point towards potential areas that require further investigation. Quality indicators identify the percent of a patient population with a certain condition and compare this percent to a state level and a national level. If a facility ''flags'' for scoring ''high'' on a particular quality indicator, this does not necessarily mean that the facility has a quality of care problem but simply that further focussed review of care practices may be required. Quality indicators have already been developed by the University of Wisconsin for use in SNFs and are being effectively used by State surveyors to target facilities for closer on-site review of care practices as well as by some nursing homes to identify potential problems within their facility.

We have already begun consideration of quality indicators that may be collected from MDS–PAC data to evaluate care delivered in IRFs. We agree with MedPAC's advice that quality monitoring efforts be closely coordinated across different types of post-acute care providers. We expect to develop measures to be applied across different settings. We anticipate that measures of functional improvement from admission to discharge will be examined. In addition, during 2000, the infrastructure to collect the data to identify quality indicators for IRFs will be under development. Field validation of these indicators is expected to begin in 2001. Once the indicators have been field tested, the State quality infrastructure can begin to utilize these data to monitor quality and to target facilities to survey for accreditation. The next step will be validation of the assessment data. Piloting the reporting of data will be ongoing during this time period. There is funding in the 2001 budget for analysis of the accuracy of the assessment data collected. ''Tool kits'' will be developed for targeted interventions to address common quality issues in these facilities. Examples of quality indicators currently being considered for IRFs are described below.

3. Functional Independence

The main goal of an IRF is to assist the patient in regaining his or her prior level of functional ability. A measure of the quality of a rehabilitation program is the patient's ability to function independently upon discharge to the community. Using MDS–PAC data, it will be possible to measure the percent of all cases discharged to the community who are functionally independent or whose functional status has improved at the time of discharge. Functional independence on the MDS–PAC would be measured using Section E of the instrument. The information collected in this section may be used by staff to calculate the Activities of Daily Living for Post-Acute Care (ADL–PAC) Summary Scale for each patient. The ADL–PAC computes patients' level of dependence on a scale from 0 (fully independent) to 6 (fully dependent). The scale considers level of dependence for each of the following activities: bed mobility, transfer between the bed and chair, locomotion, walking in facility, dressing upper body, dressing lower body, eating, toilet use, transfer to toilet, grooming and personal hygiene, bathing, transfer to and from the tub or shower. This information about the patient's levels of dependence on these various activities of daily living on admission, at intervals during the stay, and at discharge will be particularly useful to describe the patient's progress as a result of rehabilitation care. A patient's progress can be evaluated with respect to thresholds or milestones, developed after analysis of data collected during rehabilitation stays rather than based upon theoretical assumptions. The data will also assist in the development of quality indicators to predict the types of patients who have the best prognosis for improvement in rehabilitation programs. This information may also encourage referrals to IRFs for patients who might otherwise not have been referred. The data derived from functional information may also serve to better match patients with program characteristics to ''fine tune'' the delivery of rehabilitation services.

Additional variables on the MDS–PAC would allow the facility to consider factors which may affect a patient's ability to return to his or her previous level of functional ability or live independently in the community. Item E7 (stamina) helps staff predict how much therapy the patient can tolerate daily. This will impact the intensity of rehabilitation to help the patient regain functional independence. Assessment of stamina will likely affect a patient's ability to function independently once he or she is discharged back to the community. Items M1 (available social supports), M2 (caregiver status) and M3 (living arrangement) will help predict the characteristics of the community to which the patient is being discharged in order to make sure the environment is optimal to the patient's success. Finally,

item L2 (Attributes relevant to rehabilitation) measures whether a patient recognizes his or her limitations. This information will be important to determine whether the patient can function in the community and to determine how much help the patient will need, without taking risks that may cause a fall or other harmful events when not supervised.

Indicators based on functional gain will be useful in public reporting to help beneficiaries make more educated decisions about the facility from which they choose to receive care. In addition, Peer Review Organizations (PROs) can use the data from successful facilities to identify factors that are better at assisting patients in achieving functional independence and returning to the community. This information can be shared with other facilities to help improve their success rate as well.

4. Incidence of Pressure Ulcers

Pressure ulcers (also known as Decubitus Ulcers) are a problem in IRFs as well as in other post-acute and acute settings. In some situations the patient is admitted with these ulcers. Facilities cannot be held responsible for ulcers which were present upon admission, but if these ulcers increase in size or grade, or if new ulcers develop, this can be an indicator of poor quality of care.

Information about pressure ulcers would be collected in section H of the MDS–PAC. Information about bed mobility and transfer ability (items E1a and E1b), bladder incontinence (item F1a), and nutritional status (item J5a and J5b) is useful in identifying patients at high risk for developing new pressure ulcers. A pressure ulcer quality indicator could be used by the facility to institute such measures as staff training or more attention to techniques and equipment intended to prevent the development of pressure ulcers (such as frequent change of position of patients unable to move themselves and use of pressure relieving devices). In addition, quality indicators at the facility and State level can be compared to national averages for a better understanding of a facility's performance relative to its peers. Focused review will help identify which factors are contributing to the higher incidence of pressure ulcers. Analysis of MDS–PAC data can also be used to identify facilities that are successful in resolving and treating existing pressure ulcers. These facilities may have effective pressure ulcer reduction programs in place that can be shared with other facilities that are experiencing difficulty treating and reducing the incidence of pressure ulcers. Public reporting of the rate of pressure ulcers based on quality indicator information may help consumers make more informed choices when choosing a facility.

5. Falls Prevention

Falls prevention is an important component of a rehabilitation program and is critical to avoiding repeat hospitalizations which, in turn, will delay return to independence. Items in the MDS–PAC such as D3a and D3e on wandering and resisting care, item E9 on balance, and item H2 on dizziness and falls, provide critical information regarding fall risk to help facilities identify patients who may be at risk for falls. This indicator may also be used to identify facilities with poorer track records in fall avoidance. Information about falls prevention also provides information so that facilities serving different types of patients can be distinguished. PROs may also use these data to teach facilities how to better identify patients at risk for falls and set up programs to reduce the incidence of falls through such methods as low beds or better monitoring of at-risk patients.

As illustrated by these examples, there are several ways the quality information gathered through the MDS–PAC may be used. As noted, quality indicator data does not necessarily illustrate that a facility is providing a lower level of care, but this information can be useful to surveyors in targeting facilities for closer review of their patient care practices and facility layout. Quality indicators can also be used to identify facilities with best practices. Identifying how these facilities maintain a high-quality level of care may provide valuable information to assist facilities.

6. Quality Improvement

Quality assurance involves the establishment of standards and having a system to enforce compliance with these standards. Quality improvement fosters and facilitates continuous enhancement of whatever service or product an organization is engaged in or produces. The JCAHO require facilities to have quality improvement programs. Currently, the Medicare Conditions of Participation require hospitals to do quality assurance, which we believe can be supported with the information obtained from the MDS–PAC. The proposed change in the Medicare Conditions of Participation for Hospitals, proposed December 19, 1997, would require hospitals, including IRFs, to have quality improvement programs. Also, we are identifying opportunities in which PROs can use their expertise and skill mix to provide valuable information on quality improvement to post-acute providers. PROs have been working with SNFs for the past year, and feedback from facilities has indicated that the information shared by the PRO in a penalty-free environment has been valuable in helping facilities learn how to use the MDS to identify their own opportunities for quality improvement. In addition, many IRFs already have data-based quality improvement systems addressing some aspects of quality. PROs may build on their experience in SNFs and on the current experience of IRFs to become a resource on how to use information derived from the MDS–PAC to identify potential quality concerns. Quality improvement activities may include providing each facility with information derived from its MDS–PAC submissions for use in self-monitoring, providing facilities with information comparing their performance with that of their peers, and maintaining a clearinghouse of ''best practices'' that can be used by facilities to improve the quality of care they deliver.

IRFs may also use MDS–PAC data to generate quality indicators on their own and use this information to help them target specific problems within their facility or identify areas where quality improvement projects may be most effective. IRFs can also use the MDS–PAC to perform their own monitoring of changes in quality of care within the facility.

7. Consumer Information

We plan to use the comprehensive quality information derived from MDS–PAC for use in our public reporting strategy. MDS–PAC data, after appropriate evaluation and validation, can be used to inform consumers about the performance of facilities in their area so that they can make informed decisions when selecting a rehabilitation facility. In addition, information derived from MDS–PAC and the comparable information available in SNFs and other settings will help us understand which patients fare better in which types of post-acute settings, or even within subsets of IRFs, thus informing and shaping future long-term care quality initiatives.

As part of our efforts in designing a monitoring system, we are soliciting comments on whether we should also collect data related to medications and medication administration.

I. MDS–PAC Training and Technical Support for IRFs

We will provide educational and technical resources to IRFs, to support both implementation of the MDS–PAC

assessment instrument and the computerization and transmission of the MDS–PAC data. We will provide training and technical support on the use of the MDS–PAC by clinical staff and on the use of MPACT software to encode and transmit MDS–PAC data.

Although we will be providing both initial and ongoing training and technical support, IRFs will probably find it advantageous to designate a staff member as an IRF trainer, in order to have in-house capability both to train newly hired staff, and to have a designated person who can serve as the in-house resource for other staff.

We would train and support the IRFs in the implementation of the IRF prospective payment system and automation of the MDS–PAC by—

- Training IRFs on MDS–PAC data set administration;
- Answering questions on the clinical aspects of the MDS–PAC and providing information to IRFs on the use of the MDS-PAC to determine CMGs;
- Providing training to State agency staff in using MDS–PAC data for survey activities;
- Training IRFs in interpreting validation reports;
- Providing information relative to hardware and software requirements; and
- Providing support for transmission of test data, supporting callers who request technical assistance, providing passwords to IRFs, and answering questions about the computer edits and reports.

1. Release of Information Collected Using the MDS–PAC

In § 412.616, we propose that the IRF and its agents must ensure the confidentiality of the information collected using the MDS–PAC in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at § 482.24(b)(3). The facility must ensure that information may be released only to authorized individuals and must ensure that unauthorized individuals cannot gain access to or alter patient records. Information must be released by the facility or its agent only in accordance with Federal or State laws, court orders or subpoenas. In addition, we propose that an agent acting on behalf of an IRF in accordance with a written contract with that IRF may only use the information for the purposes specified in the contract.

We believe that this provision will ensure that access to MDS–PAC data (paper copy as well as electronic data) is secured and controlled by the IRF, in accordance with Federal and State laws. We believe that proposed § 412.616 would provide an adequate safeguard against the unauthorized use of a patient's clinical record and the information it contains, regardless of form or storage method. As discussed in section III.G.1 of this preamble, however, the confidentiality provisions at proposed § 412.616 may be supplemented or superseded by the security and privacy requirements contained in the ''Standards for Privacy of Individually Identifiable Health Information'' regulation (64 FR 59918) and the ''Security and Electronic Signature Standards'' regulation (63 FR 43242), when they are finalized.

As with other regulations that result in the creation of a new system of records, we are in the process of developing a notice describing the new system of records that is unique to MDS–PAC. We have typically issued notices describing new systems of records in conjunction with the issuing of a final rule, rather than at the proposed rule stage. These notices, required by the Privacy Act of 1974, describe both the entities to whom identifiable and non-identifiable data can be routinely disclosed, as well as the safeguards that will protect the privacy and the security of the data. While each system of records notice is unique to the system and the data instrument, readers interested in understanding a recent approach are referred to the notice of the new system of records published June 18, 1999, (64 FR 32992) for the ''Home Health Agency Outcome and Assessment Information Set (OASIS).'' We would welcome comments on issues germane to the notice that we will develop for MDS–PAC.

J. Patient Rights

In § 412.608, we propose that, in order to receive payment for the Medicare IRF services furnished, the authorized clinician must inform the Medicare inpatient of the following rights with respect to the MDS–PAC assessment prior to performing the assessment. These rights include—

- The right to be informed of the purpose of the MDS-PAC data collection;
- The right to have any MDS–PAC information that is collected remain confidential and secure;
- The right to be informed that the MDS–PAC information will not be disclosed to others except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;
- The right to refuse to answer MDS–PAC questions; and
- The right to see, review, and request changes on the MDS–PAC assessment.

We propose requiring the IRF ensure that a clinician documents in the Medicare patient's clinical record that the patient has been informed of the above patient rights. IRFs should note that the above patient rights are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

Our statements of patient rights with regard to the MDS–PAC would also be available via the HCFA Inpatient Rehabilitation Facility Prospective Payment System website. These statements may be revised in accordance with the Office of Management and Budget Paperwork Reduction Act re-approval process. Future revisions to these statements will be available via the HCFA Inpatient Rehabilitation Facility Prospective Payment System website, and in other instructional materials that we issue.

K. Medical Review Under the IRF Prospective Payment System

Under a discharge-based prospective payment system IRFs might have financial incentives to reduce the quality and quantity of services furnished to a patient. To monitor for any reduction in the quality or quantity of services IRFs furnish, medical review may be conducted on both a random and targeted basis. Targeting may include claim-specific data and patterns of case-mix upcoding, as well as the general issues of the medical need for the episode of care and technical eligibility. There will be the capability for both prepayment and post-payment medical review that will deny claims in total or adjust payment to the correct case mix. Medical review will validate MDS–PAC data items against clinical records.

IV. Case-Mix Group Case Classification System

A. Background

As discussed in section I.C.2. of this preamble, section 1886(j)(2)(A) of the Act requires the Secretary to establish a method of classifying patients in rehabilitation facilities within case-mix groups. Further, the Act, as amended by section 125 of the BBRA, requires the Secretary to establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, comorbidities, functional capability of the patient, and other factors as the Secretary considers appropriate to improve the explanatory power of the functional independence measure-function related groups. Under

the classification system that we are proposing, as described at § 412.620(a), patients would be classified into case-mix groups called CMGs based on clinical characteristics and resource needs.

We began our efforts to establish an appropriate classification system by examining the FIM–FRGs, a classification methodology developed by Stineman *et al.* (1994) and extended to incorporate comorbidities in Carter, Relles, *et al.* (1997). In developing the proposed CMGs, we updated the earlier FIM–FRG analysis with more recent data from calendar years 1996 and 1997 Medicare bills as well as functional status measures from UDSmr and Caredata.com for the same calendar years (see Appendix A for a detailed description of the data used to create the CMGs). The results of using more recent data showed that the earlier FIM–FRG classification system continues to be an appropriate basis to predict resource use. Based on our analysis of the more recent data, we are proposing a classification system that reflects general enhancements, including: a refined set of rehabilitation impairment categories; a modified set of relevant comorbidities; groups for cases that expire; and other types of atypical discharges, such as short-stay cases.

B. Case-Mix Groups

1. General Description of the Case-Mix Groups

The data elements used to construct the proposed CMGs include rehabilitation impairment categories (RICs), functional status (both motor and cognitive), age, and comorbidities. We also used other factors to define the CMGs that allow us to improve the explanatory power of the groups. Specifically, we created CMGs to account for short-stays and expired cases. The CMGs are based on an analysis of the Medicare inpatient rehabilitation cases described in Appendix A of this proposed rule. We separated those cases that we believe received a typical, full course of inpatient rehabilitation care from those cases that may not have received a typical, full course of inpatient rehabilitation care such as transfer cases and special cases that are not transfers. As described below, (1) the analysis of cases that receive a typical, full course of inpatient rehabilitation care results in the construction of 21 RICs and 92 CMGs; and (2) the analysis of special cases that are not transfers results in the construction of 4 CMGs for cases that expire and 1 CMG for cases that have a length of stay of 3 days or less. In addition, as described in section V.B. of this preamble, the analysis of transfer cases results in a payment policy that is dependent on which CMG the patient is classified to prior to the patient's transfer.

2. Criteria for Establishing CMGs

We used the following criteria for establishing specific groups within the proposed classification system:

- Group cases that are clinically similar. To do this, we began with the 20 RICs defined by Stineman *et al.* (1997) and examined a variety of changes that were suggested might improve either clinical or resource homogeneity.
- Group cases that have similar resource needs. To do this, we used a statistical classification method, the Classification and Regression Trees (CART), to partition the cases within RICs into groups that are homogeneous with respect to resource use and functional impairment. Thus, each CMG consists of cases that have similar clinical and resource needs.
- Determine which comorbidities affect the cost of rehabilitation cases by RIC.

We describe in more detail the methodology that we used to construct the CMGs.

3. Rehabilitation Impairment Categories

The first partition in creating the CMGs is based on the RIC of the case. RICs are groups of codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. The patient is first grouped into a RIC based on the impairment identified in the data described above. Table 1D below lists the RICs used to define and construct the first partition of the inpatient rehabilitation cases.

The earlier RAND research of 1994 data resulted in 20 RICs. We analyzed RAND's statistical analysis of 1997 data, and that showed that the 1997 data performed as well as the 1994 data in predicting resource use in RICs 01 through 20 (except that the impairment code 14.9 ''Status post major multiple fractures'' grouped better in RIC 17). In addition, the 1997 data indicated the need to create a separate RIC for burn cases.

For the majority of CMGs, the RIC represents the first two digits of the CMG. Thus, in Table 2D below, CMGs 0101 through 0111 are cases that are classified to the stroke (01) RIC.

TABLE 1D.—REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES

Rehabilitation impairment category	Associated impairment group codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain) 01.2 Right body involvement (left brain) 01.3 Bilateral Involvement 01.4 No Paresis 01.9 Other Stroke
02 Traumatic brain injury (TBI)	02.21 Open Injury 02.22 Closed Injury
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic 02.9 Other Brain
04 Traumatic spinal cord (TSCI)	04.210 Paraplegia, Unspecified 04.211 Paraplegia, Incomplete 04.212 Paraplegia, Complete 04.220 Quadriplegia, Unspecified 04.2211 Quadriplegia, Incomplete C1–4 04.2212 Quadriplegia, Incomplete C5–8 04.2221 Quadriplegia, Complete C1–4 04.2222 Quadriplegia, Complete C5–8 04.230 Other traumatic spinal cord dysfunction

TABLE 1D.—REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES—Continued

Rehabilitation impairment category	Associated impairment group codes
05 Nontraumatic spinal cord (NTSCI)	04.110 Paraplegia, unspecified 04.111 Paraplegia, incomplete 04.112 Paraplegia, complete 04.120 Quadriplegia, unspecified 04.1211 Quadriplegia, Incomplete C1–4 04.1212 Quadriplegia, Incomplete C5–8 04.1221 Quadriplegia, Complete C1–4 04.1222 Quadriplegia, Complete C5–8 04.130 Other non-traumatic spinal cord dysfunction
06 Neurological (Neuro)	03.1 Multiple Sclerosis 03.2 Parkinsonism 03.3 Polyneuropathy 03.5 Cerebral Palsy 03.8 Neuromuscular Disorders 03.9 Other Neurologic
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture 08.12 Status post bilateral hip fractures 08.2 Status post femur (shaft) fracture 08.3 Status post pelvic fracture
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement 08.52 Status post bilateral hip replacements 08.61 Status post unilateral knee replacement 08.62 Status post bilateral knee replacements 08.71 Status post knee and hip replacements (same side) 08.72 Status post knee and hip replacements (different sides)
09 Other orthopedic (Ortho)	08.9 Other orthopedic
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK) 05.4 Unilateral lower extremity below the knee (BK) 05.5 Bilateral lower extremity above the knee (AK/AK) 05.6 Bilateral lower extremity above/below the knee (AK/BK) 05.7 Bilateral lower extremity below the knee (BK/BK)
11 Amputation, other (AMP–NLE)	05.1 Unilateral upper extremity above the elbow (AE) 05.2 Unilateral upper extremity below the elbow (BE) 05.9 Other amputation
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis 06.9 Other arthritis
14 Cardiac (Cardiac)	09 Cardiac
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease 10.9 Other pulmonary
16 Pain Syndrome (Pain)	07.1 Neck pain 07.2 Back pain 07.3 Extremity pain 07.9 Other pain
17 Major multiple trauma, no brain injury or spinal cord injury (MMT–NBSCI).	08.4 Status post major multiple fractures 14.9 Other multiple trauma
18 Major multiple trauma, with brain or spinal cord injury (MMT–BSCI).	14.1 Brain and spinal cord injury 14.2 Brain and multiple fractures/amputation 14.3 Spinal cord and multiple fractures/amputation
19 Guillian Barre (GB)	03.4
20 Miscellaneous (Misc)	12.1 Spina Bifida* 12.9 Other congenital 13 Other disabling impairments 15 Developmental disability 16 Debility 17.1 Infection 17.2 Neoplasms 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition 17.4 Circulatory disorders 17.51 Respiratory disorders—Ventilator Dependent 17.52 Respiratory disorders—Non-ventilator Dependent 17.6 Terminal care 17.7 Skin disorders 17.8 Medical/Surgical complications 17.9 Other medically complex conditions
21 Burns (Burns)	11 Burns

*We are in the process of analyzing the effect of moving the few cases within this impairment category to one of the other spinal cord RICs (either 05 or 04 depending upon the ''fit'').

4. Functional Status Measures and Age

After using the RIC to define the first split among the inpatient rehabilitation cases, we used functional status measures and age to partition the cases further. We describe below the statistical methodology (Classification and Regression Trees or CART) that we used to incorporate a patient's functional status measures (motor score and cognitive score), and age into the construction of the proposed CMGs.

The CART methodology was used to split the rehabilitation cases further within each RIC. In general, CART can be used to identify statistical relationships among data and, using these relationships, construct a predictive model for organizing and partitioning a large set of data into smaller homogeneous groups. Further, in constructing the proposed CMGs, we analyzed the extent to which the independent variables (motor score, cognitive score, and age) help predict the value of the dependent variable (the log of the cost per case).

The CART methodology will ensure that the proposed CMGs recognize that patients with clinically distinct resource needs are treated separately in the classification and payment systems. CART is an iterative process that creates initial groups of patients then searches for ways to split the initial groups that may further decrease the clinical and cost variances within a group and increase the explanatory power of the CMGs. (Further information regarding this methodology can be found in the seminal literature on CART (Classification and Regression Trees, Leo Breiman, Jerome Friedman, Richard Olshen, Charles Stone, Wadsworth Inc., Belmont CA, 1984: pp 78–80.)

We also used a validation method to assess the predictive accuracy of the RICs and CMGs. Half of the 1996 and 1997 data described in Appendix A was used initially to create the CMGs. Once this was done, the other half of the data was used to test or validate the predictive accuracy of the CMGs. We concluded that the RICs and CMGs we are proposing are valid because the groups performed as well using the second half of the data as they did with the first half. The final definitions of the specific RICs and CMGs was based on 100 percent of the 1997 Medicare cost data with corresponding UDSmr/COS data.

As a result of this analysis, Table 2D lists 92 CMGs and their respective descriptions, including the motor and cognitive scores and age that will be used to classify discharges into CMGs. As described in section II.B. of this preamble, some CMGs may change based on further analysis of available data and comments we receive in response to this proposed rule.

5. Comorbidities

We found comorbidities have major effects on the cost of furnishing inpatient rehabilitation care. RAND's previous analysis, based on 1994 data, found that these comorbidities also increased the cost of furnishing inpatient rehabilitation care. A list of the major comorbidities appears in Appendix C of this proposed rule. A case has to have only one of the listed comorbidities to be classified as a case with comorbidity. We found that the presence of major comorbidities multiplies the expected resource use of a case by the same amount for each CMG in the same RIC.

We matched frequently occurring comorbidities to impairment categories in order to ensure that all of the chosen comorbidities are, in fact, relevant to the RIC. Providing rehabilitation services to a beneficiary with a total hip replacement can become both more complex and more costly if the beneficiary also has pneumonia. By contrast, some pulmonary diagnoses might be determined not to have a cost impact for beneficiaries with chronic obstructive pulmonary disease.

We found comorbidities to affect cost per case for some of the CMGs, but not all. When comorbidities substantially increased the average cost of the CMG and were determined to be clinically relevant, we developed CMG relative weights adjusted for comorbidities. We will continue to analyze the data to determine if refinements to the list of comorbidities in Appendix C are necessary. Further discussion of the effect of comorbidities is described in section V.A.2. of this preamble.

6. Analysis of Special Cases

We analyzed payment-to-cost ratios of special types of cases that were not transfer cases to determine if costs could be predicted. From this analysis, we believe that cases that expire and cases with a length of stay of 3 days or less (not including transfer cases) would be substantially ''overpaid'' if facilities receive the full CMG payment for these cases. To improve the explanatory power of the groups, we added four CMGs to account for cases that expire and one CMG for all cases that have a length of stay of 3 days or less (not including transfer cases). These types of special cases are further explained in section V.C. of this preamble. Therefore, the total number of proposed CMGs is 97 as shown in Table 2D.

7. Methodology To Classify Patients Into CMGs

Data from the MDS–PAC, described in section III of this preamble and specified in proposed § 412.620(a)(3) of the regulations, will be used to classify a patient into a CMG. In Table 3D, we have identified the specific MDS–PAC items that must be completed in order to classify a patient into a CMG and to effectively implement the proposed prospective payment system. (These items, along with other MDS–PAC items, will be used to administer, monitor, and analyze possible refinements to the proposed prospective payment system as described in section III of this preamble.) The MDS–PAC items will be used to establish the motor score, cognitive score, and age of the patient that corresponds with a specific CMG description.

8. Case Example To Classify a Patient Into a CMG

The following example illustrates how a Medicare beneficiary would be classified to a CMG under the proposed classification system. An 82 year old woman has a left total hip replacement because of osteoarthritis, and is admitted to the IRF because of the need for rehabilitation after the hip replacement surgery. The beneficiary is first classified into RIC 08: Replacement of Left Extremity Joint with Associated Impairment Group Code 08.51: Status Post Unilateral Hip Replacement.

Assessment

MDS–PAC SCORE

0 Independent in eating (MDS–PAC section E, 1g);
1 Requires set up to dress upper body (MDS–PAC section E, 1e);
5 Requires maximum assistance to dress lower body (MDS–PAC section E, 1f);
1 Requires set up for grooming (MDS–PAC section E, 1j);
2 Requires minimal assistance for bed mobility (MDS–PAC section E, 1b);
5 Requires maximum assistance for bed to chair transfer (MDS–PAC section E, 1b);
5 Requires maximum assistance for walking (MDS–PAC section E, 1d);
5 Requires maximum assistance for toilet transfer (MDS–PAC section E, 1i);
5 Requires maximum assistance for bathing (MDS–PAC section E, 1k);
6 Dependent shower transfer (MDS–PAC section E, 1k);
6 Dependent stair climbing (MDS–PAC section E, 8c); and
0 Independent bowel and bladder sphincter control (MDS–PAC section F, 1 and 4.

Total MDS–PAC Motor Score: 41

This motor score places the Medicare beneficiary in CMG 0802, which is ''Replacement of lower extremity joint'' with a motor score from 41–33. (See footnote at the bottom of Table 2D)

TABLE 2D.—DEFINITION OF CMGS

CMG number**	CMG description
0101	Stroke with motor score from 29–0
0102	Stroke with motor score from 34–30 and cognitive score from 27–135*
0103	Stroke with motor score from 40–35 and cognitive score from 28–35*
0104	Stroke with motor score from 34–30 and cognitive score from 5–26*
0105	Stroke with motor score from 40–35 and cognitive score from 5–27*
0106	Stroke with motor score from 45–41
0107	Stroke with motor score from 49–46
0108	Stroke with motor score from 55–50
0109	Stroke with motor score from 78–56 and patient is 84 years old or older
0110	Stroke with motor score from 60–56 and patient is 83 years old or younger
0111	Stroke with motor score from 78–61 and patient is 83 years old or younger
0201	Traumatic brain injury with motor score from 33–0 and cognitive score from 30–35*
0202	Traumatic brain injury with motor score from 33–0 and cognitive score from 5–29*
0203	Traumatic brain injury with motor score from 50–34 and cognitive score from 22–35*
0204	Traumatic brain injury with motor score from 50–34 and cognitive score from 5–21*
0205	Traumatic brain injury with motor score from 66–51
0206	Traumatic brain injury with motor score from 78–67
0301	Non-traumatic brain injury with motor score from 33–0 and cognitive score from 22–35*
0302	Non-traumatic brain injury with motor score from 33–0 and cognitive score from 5–21*
0303	Non-traumatic brain injury with motor score from 46–34
0304	Non-traumatic brain injury with motor score from 56–47
0305	Non-traumatic brain injury with motor score from 78–57
0401	Traumatic spinal cord injury with motor score from 36–0
0402	Traumatic spinal cord injury with motor score from 57–37
0403	Traumatic spinal cord injury with motor score from 74–58
0404	Traumatic spinal cord injury with motor score from 78–75
0501	Non-traumatic spinal cord injury with motor score from 23–0
0502	Non-traumatic spinal cord injury with motor score from 36–24
0503	Non-traumatic spinal cord injury with motor score from 45–37
0504	Non-traumatic spinal cord injury with motor score from 57–46
0505	Non-traumatic spinal cord injury with motor score from 78–58
0601	Neurological with motor score from 35–0
0602	Neurological with motor score from 45–36
0603	Neurological with motor score from 53–46
0604	Neurological with motor score from 78–54
0701	Fracture of lower extremity with motor score from 36–0
0702	Fracture of lower extremity with motor score from 45–37
0703	Fracture of lower extremity with motor score from 51–46
0704	Fracture of lower extremity with motor score from 78–52
0801	Replacement of lower extremity joint with motor score from 32–0
0802	Replacement of lower extremity joint with motor score from 41–33
0803	Replacement of lower extremity joint with motor score from 48–42
0804	Replacement of lower extremity joint with motor score from 78–49 and cognitive score from 34–35*
0805	Replacement of lower extremity joint with motor score from 55–50 and cognitive score from 5–33*
0806	Replacement of lower extremity joint with motor score from 78–56 and cognitive score from 5–33*
0901	Other orthopedic with motor score from 32–0
0902	Other orthopedic with motor score from 44–33
0903	Other orthopedic with motor score from 53–45
0904	Other orthopedic with motor score from 78–54
1001	Amputation, lower extremity with motor score from 38–0
1002	Amputation, lower extremity with motor score from 48–39
1003	Amputation, lower extremity with motor score from 78–49
1101	Amputation, non-lower extremity with motor score from 30–0
1102	Amputation, non-lower extremity with motor score from 44–31 and patient is 68 years old or older
1103	Amputation, non-lower extremity with motor score from 44–31 and patient is 67 years old or younger
1104	Amputation, non-lower extremity with motor score from 78–45
1201	Osteoarthritis with motor score from 42–0 and cognitive score from 34–35*
1202	Osteoarthritis with motor score from 42–0 and cognitive score from 5–33*
1203	Osteoarthritis with motor score from 54–43
1204	Osteoarthritis with motor score from 78–55
1301	Rheumatoid, other arthritis with motor score from 30–0
1302	Rheumatoid, other arthritis with motor score from 42–31
1303	Rheumatoid, other arthritis with motor score from 78–43
1401	Cardiac with motor score from 37–0
1402	Cardiac with motor score from 50–38
1403	Cardiac with motor score from 78–51
1501	Pulmonary with motor score from 40–0 and patient is 78 years old or older
1502	Pulmonary with motor score from 40–0 and patient is 77 years old or younger

TABLE 2D.—DEFINITION OF CMGS—Continued

CMG number**	CMG description
1503	Pulmonary with motor score from 63–41
1504	Pulmonary with motor score from 78–64
1601	Pain syndrome with motor score from 41–0 and cognitive score from 33–35*
1602	Pain syndrome with motor score from 41–0 and cognitive score from 5–32*
1603	Pain syndrome with motor score from 78–42
1701	Major multiple trauma with brain or spinal cord injury with motor score from 48–0
1702	Major multiple trauma with brain or spinal cord injury with motor score from 78–49
1801	Major multiple trauma, with brain or spinal cord injury with motor score from 56–0
1802	Major multiple trauma, with brain or spinal cord injury with motor score from 78–57
1901	Guillian Barre with motor score from 36–0
1902	Guillian Barre with motor score from 47–37
1903	Guillian Barre with motor score from 78–48
2001	Miscellaneous with motor score from 21–0 and patient is 59 years old or older
2002	Miscellaneous with motor score from 31–22
2003	Miscellaneous with motor score from 36–32
2004	Miscellaneous with motor score from 21–0 and patient is 58 years old or younger
2005	Miscellaneous with motor score from 43–37 and patient is 65 years old or older
2006	Miscellaneous with motor score from 52–44 and patient is 65 years old or older
2007	Miscellaneous with motor score from 43–37 and patient is 65 years old or younger
2008	Miscellaneous with motor score from 78–53 and patient is 84 years old or older
2009	Miscellaneous with motor score from 59–53 and patient is 84 years old or younger
2010	Miscellaneous with motor score from 52–44 and patient is 65 years old or younger
2011	Miscellaneous with motor score from 78–60 and patient is 84 years old or younger
2101	Burns
5001	Short-stay cases, length of stay is 3 days or fewer
5101	Expired, orthopedic, short stay
5102	Expired, orthopedic, not short stay
5103	Expired, not orthopedic, short stay
5104	Expired, not orthopedic, not short stay

*In developing this example of scoring conventions, we have displayed only the FIM motor scores as MDS–PAC scores. We have not included the cognitive scores as MDS–PAC scores. We are currently studying the aggregation of the MDS-PAC variable into the FIM cognitive categories. RAND, our contractor, will be performing additional analysis on the cognitive scoring conventions, and we will be including this research in the final regulations.

**The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown on Table 1D.

TABLE 3D.—CRITICAL MDS–PAC ITEMS

Section/item name	Item number
A. ITEMS FROM THE INTERRUPTED STAY TRACKING FORM	
SECTION AA. IDENTIFICATION INFORMATION:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Social Security and Medicare Numbers	6a–6b
Facility Provider Number	8a–8b
Medicaid Number	9
Gender	10
Birthdate	11
Ethnicity/Race	12a–12f
Interrupted Stay	13a–13b
Clinician Completing Assessment	14b–14f
B. ITEMS FROM THE BASIC ASSESSMENT TRACKING FORM	
SECTION AA. IDENTIFICATION INFORMATION:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Reason for Assessment	3
Assessment Reference Date	4
Discharge Status	5a–5b*
Social Security and Medicare Numbers	6a–6b
Facility Provider Number	8a–8b
Medicaid Number	9
Gender	10
Birthdate	11*
Ethnicity/Race	12a–12f
SECTION AB. ASSESSMENT ATTESTATION:	
Person Completing Assessment	1b–1g

TABLE 3D.—CRITICAL MDS–PAC ITEMS—Continued

Section/item name	Item number
C. ITEMS FROM COMPLETE ASSESSMENT (ASSESSMENT, READMISSION, DISCHARGE)	
SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Reason for Assessment	3
Admission Status	4
Goals for Stay	5a–5e
Admitted From	6
Precipitating Event Prior to Admission	7
Primary and Secondary Payment Source for Stay	8A–8B
Marital Status	9
Language	11
SECTION B. COGNITIVE PATTERNS:	
Comatose	1*
Memory/Recall Ability	2a–2d*
Cognitive Skills for Daily Decision Making	3a–3b*
Indicators of Delirium-Periodic Disorder Thinking/Awareness	4a–4f*
SECTION C. COMMUNICATION/VISUAL PATTERNS:	
Modes of Communication	2a–2e*
Making Self Understood	3a–3b*
Speech Clarity	4*
Ability to Understand Others	5a–5b*
SECTION E. FUNCTIONAL STATUS:	
3 Day ADL Self-Performance	1a–1l*
ADL Assist Codes	2a–2l*
ADL Changes	3
Devices and Aids	6a–6j*
Walking and Stair Climbing	8a–8c*
SECTION F. BLADDER/BOWEL MANAGEMENT:	
Bladder Continence	1a–1b*
Bladder Appliance	2a–2g*
Bladder Appliance Support	3*
Bowel Continence	4*
Bowel Appliances	5a–5d*
Bowel Appliance Support	6*
SECTION G. DIAGNOSES:	
Impairment Group	1*
Complications/Comorbidities	5a–5d*
SECTION M. RESOURCES FOR DISCHARGE:	
Living Arrangement	3a–3b (A–C)

*Must be recorded by category, variable, and item number, in order for a patient to be classified into a CMG.

9. Adjustment to the Case-Mix Groups

As described in proposed § 412.620(c) of the regulations and as provided by section 1886(j)(2)(c)(i) of the Act, we adjust the CMGs periodically to reflect changes in treatment patterns, technology, number of discharges, and other factors affecting the relative use of resources.

V. Payment Rates

The IRF prospective payment system proposed in this rule utilizes Federal prospective payment rates across 97 distinct CMGs. The Federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights which account for the relative difference in resource use across the CMGs is applied to the budget neutral conversion factor, and finally a number of facility level and case level adjustments may apply. The facility level adjustments include those which account for geographic variation in wages (wage index), Disproportionate Share (DSH), and location in a rural area. Case level adjustments include those which apply for transfer, short-stay and outlier cases, as described later in this section.

The budget neutral conversion factor provides the basis for determining the CMG based Federal payment rates. It is a standardized payment amount that is based on average costs from a base period and also reflects the combined aggregate effects of the payment weights, various facility and case level adjustments, and other policies discussed in this section. Consequently, in discussing the methodology for development of the Federal payment rates, we begin by describing the various adjustments and factors which serve as the inputs used in establishing the budget neutral conversion factor. Accordingly, we propose to develop prospective payments for IRFs using the following major steps:

- Develop the CMG relative weights.
- Determine the payment adjustments.
- Calculate the budget neutral conversion factor minus 2 percent.
- Calculate the Federal CMG prospective payments.

A detailed description of each step and a discussion of our proposed transfer policy, phase-in implementation and other policies follows.

A. Development of CMG Relative Weights

1. Overview of Development of the CMG Relative Weights

As previously stated, one of the primary goals for the implementation of the proposed IRF prospective payment system is to pay each rehabilitation

facility an appropriate payment for the efficient delivery of the care required by its set of Medicare patients. The system must be able to account adequately for each facility's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for beneficiaries whose care is provided at a higher cost. To accomplish these goals, payment for each case is adjusted for case-mix.

In this payment system, under proposed § 412.620(b)(1), relative weights are a primary element in accounting for the variance in cost per discharge and resource utilization among the payment groups. To ensure that beneficiaries classified to each CMG will have access to care and to encourage efficiency, we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2 will on average cost twice as much as cases in a CMG with a weight of 1.

To calculate the relative weights, we estimate operating (routine and ancillary services) and capital costs from inpatient rehabilitation facilities. Cost-to-charge ratios for ancillary services and per diem costs for routine services were obtained from the most recent available cost report data (FYs 1997, 1996, and/or 1995), charges were obtained from calendar year 1997 Medicare bill data, and corresponding functional measures were derived from the UDSmr/COS data. We omit data from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, as well as from the parameters that we use to define transfer cases, because these facilities are paid a single, negotiated rate per discharge and they do not maintain a charge structure.

For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from cost reports. Some departmental cost-to-charge ratios were missing or found to be outside a plausible range. We replace individual cost-to-charge ratios for all departments except anesthesiology when the values are either greater than 10, or less than 0.05. For anesthesiology, we replace the cost-to-charge ratio only when the value is greater than 10, or less than 0.01. The replacement value that we use for these aberrant cost-to-charge ratios is the mean value of the cost-to-charge ratio for the cost-center within the same type of hospital (either freestanding or unit).

For routine services, per diem operating and capital costs are used to develop the relative weights. In addition, per diem operating and capital costs for special care services are used to develop the relative weights. (Special care services are furnished in intensive care units. We note that fewer than 1 percent of rehabilitation days are spent in intensive care units.) Per diem costs are obtained from each facility's Medicare cost report data. We use per diem costs for routine and special care services because, unlike for ancillary services, cost-to-charge ratios cannot be obtained from Medicare data. To estimate the costs for routine and special care services included in developing the relative weights, we sum the product of routine cost per diem and Medicare inpatient days and the product of the special care per diem and the number of Medicare special care days.

We propose to use a hospital-specific relative value method to calculate relative weights. We believe this method allows us to account for more of the cross-facility variation in costs. Specifically, we remove the variation in costs across providers by converting a facility's cost for a case to a relative value based on the facility's case-mix index. The case-mix index is the average case weight (adjusted to eliminate the effect of comorbidities) for cases at a facility. Under the hospital-specific relative value method, costs are standardized at the facility level using facility-specific costs. Costs are standardized for each case by first dividing the adjusted cost for the case (which reflects comorbidities) by the average adjusted cost for the facility in which the case was treated. The average adjusted cost represents the average intensity of the health care services delivered by a particular facility. The resulting ratio is multiplied by the facility's own costliness (the facility's case-mix index) to determine the standardized cost for the case. The case-mix index accounts for the extent to which the intensity of the services is due to the needs of the facility's patients.

Because costs are standardized in this manner, costs for a beneficiary at a facility with high average costs are counted as less resource intensive than costs at a facility with low average costs. Therefore, the adjusted cost of an individual case more accurately reflects actual resource use for an individual facility. For example, a $7,000 case in a facility with an average adjusted cost of $10,000 reflects a higher level of relative resource use than a $7,000 case in a facility with the same case-mix, but an average adjusted cost of $20,000.

We used the following basic steps to calculate the relative weights in this proposed rule:

The first step in calculating the CMG weights is to estimate the effect that comorbidities have on costs. The second step is to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step are used to calculate ''relative adjusted weights'' in each CMG using the hospital-specific relative value method described above. The final steps are to calculate the CMG relative weights by modifying the ''relative adjusted weight'' with the effects of the existence of a comorbidity and normalize the weights to 1.

We describe each of these steps in greater detail below.

2. Steps for Calculating the Relative Weights

Step 1—Estimate the effect of comorbidities on costs. In general, comorbidities are defined as additional medical conditions that increase the complexity of care delivered. For example, treatment for a beneficiary with a total hip replacement can become more complex if the beneficiary also has pneumonia. Because we found comorbidities to be significant predictors of costs in most RICs, we propose to calculate separate relative weights for cases in a given CMG with comorbidity and without comorbidity to reflect the additional costs incurred by cases classified with a comorbidity. We use regression analyses to determine if the weight for a Medicare discharge (case) should reflect the costs of comorbidities. Specifically, separate regression analyses are performed for each RIC. In the analysis, we found that not all comorbidities have the same effect on each RIC. Therefore, if coefficients by RIC are positive and significant and the comorbidity is deemed to be clinically relevant to the CMG, then we calculate separate relative weights for cases with comorbidity in Step 3 below.

Step 2—Adjust the costs of each discharge for the effects of comorbidities. The second step in the calculation of the weights is to adjust the resource use for each case to eliminate the effect of comorbidities. The adjusted cost (A) for a discharge, with values x for comorbidity is:

A = cost per discharge/exp(a*x)

These adjusted cost for each discharge are then used to calculate the relative adjusted weight in each CMG k, w_k.

Step 3—Calculate the CMG relative weights adjusted for comorbidities, on an iterative basis. The process of calculating the CMG relative weights is iterative. First, we give an initial case-mix index value of 1 to each facility. Then, for each case, we calculate a facility-specific relative value by dividing the comorbidity-adjusted cost of the case by the average comorbidity-adjusted cost of all cases at the facility, and multiplying the result by the facility's case-mix index. The CMG-adjusted weights are then set in proportion to the average of the facility-specific relative values. The result is a new case-mix index for each facility and, therefore, new facility-specific, relative values. The process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001. After the first iteration, statistical outliers are defined as cases that differ from the CMG mean by more than three standard deviations in the log scale of standardized cost. These outliers are removed. Discharges that meet the definition of a transfer case are treated as a fraction of a case. (See discussion of transfers in section V.B, below.) A relative weight for each relevant combination of CMG ''with comorbidity'' and ''without comorbidity'' is calculated using the following formula:

$W(k,x) = \exp(a*x)w_k$

Where x equals 1 if the patient had one or more comorbidities or x equals 0 if no comorbidities were present. The variable (w_k) equals the comorbidity adjusted weight. If the coefficient (a) is not positive and significant as previously discussed in Step 1, then (a) will be set to equal 0 in the formula. This results in exp(a*x), in the formula, to equal 1 and the weight (W) will equal (w_k).

Step 4—Calculate the weight by modifying the relative adjusted weight with the effects of comorbidity and normalizing the weights to 1.0. This step entails calculating a relative weight for each relevant combination of CMG and comorbidity. In this step, we determine the average cost per discharge for all the cases and use that value as the divisor to calculate the relative weights. For example, if the average cost per discharge across all discharges is $12,000, then the relative weight for a CMG with an average cost of $12,000 is 1, and the relative weight for a CMG with an average cost per discharge of $20,000 is 1.67. If ''r'' is the relative adjusted weight for a case in a CMG with a comorbidity given by:

$w = k\ r \exp(a*x)$,

then k is determined so that the average value of w is 1.

Table 1E below lists the CMGs and their respective relative weights. The relative weights reflect the inclusion of cases with a very short interruption (return on day of discharge or either of the next 2 days). As stated previously, comorbidities were found to affect the cost of certain CMGs, but not all. Thus, the value for CMGs not affected by comorbidities is the same in both the ''No Comorbidity'' and the ''With Comorbidity'' columns. Information obtained from the first assessment (Day 4 assessment) will be used to determine the appropriate CMG and corresponding payment, including existence of a comorbidity. If a relevant comorbidity is indicated on this assessment, payment will be based on the relative weight from the comorbidity column. It should also be noted that Table 1E reflects cognitive scores that were derived from UDSmr/COS data.

TABLE 1E.—CMG RELATIVE WEIGHTS

CMG *	Definition (M=motor, C=cognitive, A=age)	Split by comorbidity	Average length of stay		Relative weight	
			No comorbidity	With comorbidity	No comorbidity	With comorbidity
0101	M = 29–0	Y	10.4	9.6	0.6058	0.6613
0102	M = 34–30 and C = 27–35	Y	12.0	11.4	0.7095	0.7746
0103	M = 40–35 and C = 28–35	Y	14.3	15.2	0.8605	0.9394
0104	M = 34–30 and C = 5–26	Y	14.2	16.7	0.8560	0.9344
0105	M = 40–35 and C = 5–27	Y	15.9	16.7	0.9620	1.0501
0106	M = 45–41	Y	17.7	17.2	1.0944	1.1947
0107	M = 49–46	Y	20.1	20.7	1.2630	1.3787
0108	M = 55–50	Y	22.7	21.2	1.4365	1.5682
0109	M = 78–56 and A >= 84	Y	24.0	24.9	1.5989	1.7455
0110	M = 60–56 and A <= 83	Y	25.9	23.4	1.6616	1.8139
0111	M = 78–61 and A <= 83	Y	29.5	29.6	1.9626	2.1425
0201	M = 33–0 and C = 30–35	N	9.4	9.4	0.5504	0.5504
0202	M = 33–0 and C = 5–29	N	13.3	13.3	0.8325	0.8325
0203	M = 50–34 and C = 22–35	N	16.0	16.0	0.9777	0.9777
0204	M = 50–34 and C = 5–21	N	18.3	18.3	1.1640	1.1640
0205	M = 66–51	N	22.3	22.3	1.4739	1.4739
0206	M = 78–67	N	31.6	31.6	2.2179	2.2179
0301	M = 33–0 and C = 22–35	Y	10.6	10.4	0.6399	0.7208
0302	M = 33–0 and C = 5–21	Y	13.5	13.3	0.8393	0.9454
0303	M = 46–34	Y	14.8	15.3	0.9467	1.0664
0304	M = 56–47	Y	19.2	19.3	1.2605	1.4198
0305	M = 78–57	Y	24.8	26.9	1.7517	1.9731
0401	M = 36–0	Y	12.6	10.3	0.7135	0.8560
0402	M = 57–37	Y	17.5	18.6	1.0506	1.2603
0403	M = 74–58	Y	26.6	25.5	1.7459	2.0944
0404	M = 78–75	Y	39.3	48.6	2.9252	3.5092
0501	M = 23–0	Y	8.4	8.2	0.4459	0.5528
0502	M = 36–24	Y	10.6	12.8	0.6197	0.7683
0503	M = 45–37	Y	13.5	15.7	0.8152	1.0107
0504	M = 57–46	Y	18.2	18.8	1.1515	1.4277
0505	M = 78–58	Y	25.9	30.2	1.7816	2.2089
0601	M = 35–0	Y	12.3	12.5	0.6971	0.7970
0602	M = 45–36	Y	15.2	15.6	0.9086	1.0389

TABLE 1E.—CMG RELATIVE WEIGHTS—Continued

CMG*	Definition (M=motor, C=cognitive, A=age)	Split by comorbidity	Average length of stay		Relative weight	
			No comorbidity	With comorbidity	No comorbidity	With comorbidity
0603	M = 53–46	Y	17.7	18.2	1.0833	1.2387
0604	M = 78–54	Y	21.4	22.6	1.3375	1.5292
0701	M = 36–0	Y	11.7	12.1	0.6525	0.7604
0702	M = 45–37	Y	14.3	15.5	0.8337	0.9716
0703	M = 51–46	Y	17.1	17.5	1.0129	1.1803
0704	M = 78–52	Y	19.6	20.9	1.1794	1.3743
0801	M = 32–0	Y	8.6	9.6	0.4822	0.5920
0802	M = 41–33	Y	10.1	11.3	0.5984	0.7346
0803	M = 48–42	Y	12.2	14.3	0.7464	0.9162
0804	M = 78–49 and C = 34–35	Y	13.5	16.8	0.8835	1.0845
0805	M = 55–50 and C = 5–33	Y	15.3	16.7	0.9540	1.1710
0806	M = 78–56 and C = 5–33	Y	18.4	21.2	1.1765	1.4441
0901	M = 32–0	Y	10.4	11.0	0.5587	0.6716
0902	M = 44–33	Y	13.3	14.5	0.7641	0.9185
0903	M = 53–45	Y	16.4	17.0	0.9685	1.1642
0904	M = 78–54	Y	20.0	19.7	1.2144	1.4597
1001	M = 38–0	Y	15.0	14.1	0.8488	0.9278
1002	M = 48–39	Y	18.2	17.5	1.1178	1.2219
1003	M = 78–49	Y	21.4	21.0	1.3785	1.5068
1101	M = 30–0	Y	10.6	9.6	0.6095	0.7489
1102	M = 44–31 and A >= 68	Y	13.4	13.5	0.8278	1.0171
1103	M = 44–31 and A <= 67	Y	17.4	17.8	1.0894	1.3386
1104	M = 78–45	Y	20.7	20.8	1.3232	1.6258
1201	M = 42–0 and C = 34–35	Y	10.7	12.1	0.5965	0.6847
1202	M = 42–0 and C = 5–33	Y	13.3	13.9	0.7181	0.8244
1203	M = 54–43	Y	16.4	17.0	0.9181	1.0540
1204	M = 78–55	Y	20.8	22.4	1.1492	1.3192
1301	M = 30–0	Y	11.3	11.2	0.5927	0.6859
1302	M = 42–31	Y	13.3	14.2	0.7116	0.8234
1303	M = 78–43	Y	18.0	19.1	1.0450	1.2093
1401	M = 37–0	Y	12.4	12.1	0.6511	0.7618
1402	M = 50–38	Y	15.4	16.4	0.9006	1.0537
1403	M = 78–51	Y	19.7	24.3	1.2689	1.4846
1501	M = 40–0 and A >= 78	Y	14.0	12.7	0.7741	0.8327
1502	M = 40–0 and A <= 77	Y	15.0	15.3	0.8529	0.9175
1503	M = 63–41	Y	19.2	19.6	1.1875	1.2774
1504	M = 78–64	Y	29.6	32.6	2.2797	2.4524
1601	M = 41–0 and C = 33–35	Y	11.0	10.6	0.6151	0.7313
1602	M = 41–0 and C = 5–32	Y	12.8	15.1	0.7257	0.8628
1603	M = 78–42	Y	15.9	16.0	0.9725	1.1562
1701	M = 48–0	Y	14.8	15.5	0.8513	1.0565
1702	M = 78–49	Y	22.5	24.9	1.3677	1.6974
1801	M = 56–0	N	16.7	16.7	0.9935	0.9935
1802	M = 78–57	N	29.5	29.5	2.0563	2.0563
1901	M = 36–0	N	11.5	11.5	0.7048	0.7048
1902	M = 47–37	N	18.0	18.0	1.0883	1.0883
1903	M = 78–48	N	31.4	31.4	2.0648	2.0648
2001	M = 21–0 and A >= 59	Y	9.2	8.8	0.5010	0.5604
2002	M = 31–22	Y	11.5	11.5	0.6435	0.7198
2003	M = 36–32	Y	13.0	13.0	0.7468	0.8353
2004	M = 21–0 and A <= 58	Y	13.9	11.2	0.7131	0.7977
2005	M = 43–37 and A >= 65	Y	14.4	14.4	0.8549	0.9562
2006	M = 52–44 and A >= 65	Y	16.5	17	1.0145	1.1348
2007	M = 43–37 and A < 65	Y	16.0	15.7	0.9998	1.1183
2008	M = 78–53 and A >= 84	Y	18.2	20.2	1.1359	1.2705
2009	M = 59–53 and A < 84	Y	19.8	19.9	1.2481	1.3960
2010	M = 52–44 and A < 65	Y	18.1	18.6	1.1570	1.2941
2011	M = 78–60 and A < 84	Y	23.2	24.3	1.4898	1.6664
2101	All burn cases	N	18.5	18.5	1.2863	1.2863
5001	Short stay cases—LOS is 3 days or fewer	N	2.6	2.6	0.1908	0.1908
5101	Expired orthopedic, short stay	N	7.1	7.1	0.4657	0.4657
5102	Expired orthopedic, not short stay	N	20.0	20.0	1.0777	1.0777
5103	Expired not ortho, short stay	N	8.4	8.4	0.5485	0.5485
5104	Expired not ortho, not short stay	N	25.1	25.1	1.5027	1.5027

*The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown on Table 1D in section IV of this proposed rule.

B. Transfer Payment Policy

1. Background

We are proposing, under § 412.624(f), a transfer policy to provide for payments that more accurately reflect facility resources used and services delivered. We believe that it is important to minimize the inherent incentives specifically associated with the early transfer of patients in a discharge-based payment system. Without a transfer policy, we are concerned that incentives might exist for IRFs to discharge patients prematurely as well as admit patients that may not be able to endure intense inpatient therapy services. Patients might be transferred before receiving the typical, full course of inpatient rehabilitation, but the IRF would be paid the full CMG payment rate in the absence of a transfer policy. Accordingly, the transfer policy that we are proposing would reduce the full CMG payment rate when a Medicare beneficiary is transferred (as defined below).

2. Statutory Background

Section 125(a)(3) of the BBRA amended section 1886(j)(1) of the Act by adding a new paragraph (E) that states ''Construction relating to transfer authority. ''Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.''

The statute does not define ''site of care''. ''Site of care'' could be defined as an ''institutional site'' that includes other rehabilitation facilities, long-term care hospitals (as described in section 412.23(e) of the regulations), inpatient hospitals, and nursing homes that accept payment under Title 18 (the Medicare program) or Title 19 (the Medicaid program), or both. ''Site of care'' can also be defined as a ''provider site'' that is more encompassing and could include home health, outpatient rehabilitation, ''day program'' services, as well as the ''institutional sites'' listed above. For the purposes of our transfer policy, we are proposing to define site of care as an ''institutional site'', although we are considering the option to extend the definition of site of care to the ''provider site'' definition. Further, we are soliciting comments regarding the inclusion of nursing homes in the definition of site of care.

3. Criteria for Defining Transfer Cases

We propose that, in order for a discharge from an IRF to be classified as an early transfer, the length of stay for the discharge must be less than the average length of stay for non-transfer cases (cases in which the patient is discharged to the community and the length of stay is more than 3 days) in a given CMG (as shown in Table 1E in this section), and the patient must be discharged to another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program, or both.

We believe that under a prospective payment system, an IRF may, also, be inclined to discharge beneficiaries prematurely while increasing the volume and intensity of HHA and outpatient therapy services. We expect that some beneficiaries may require HHA or outpatient therapy services as a normal progression of care after their inpatient rehabilitation stay. However, we are concerned that intensive use of these therapy services could be inappropriately used as a substitute for several days of an intensive therapy program in the IRF. We are analyzing claims data to determine the extent to which we can distinguish among services that could be considered a substitution of care rather than an extension of the normal progression for inpatient rehabilitation care and to determine the frequency and intensity of both HHA and outpatient therapy services. Estimating the potential substitution of HHA therapy services is made more challenging because we have just developed the HHA prospective payment system and it is difficult to anticipate how therapy services will be delivered after implementation of that system.

Accordingly, we are not proposing to include HHA, outpatient therapy, and ''day programs'' in our transfer policy. However, we are considering including these services to the extent we can distinguish when HHA and outpatient therapy services are more intensive and used as a substitution for inpatient rehabilitation care. If we can determine that the care is used as a substitution rather than just the normal progression of care, we believe these types of intensive HHA and outpatient therapy services should be included as part of the transfer policy. Therefore, we specifically solicit comments on this option.

In addition, we will be developing a monitoring system that includes transfers or discharges from an IRF to ''provider sites'', previously referenced. This will include transfers or discharges from an IRF to skilled nursing facility, long term care facilities, home health agencies and inpatient hospitals. This system will include discharges and transfers from one IRF to a different IRF including situations where the transfer occurs between organizations of common ownership. Although currently it does not appear that this type of transfer occurs frequently, further analysis of data regarding this type of transfer between IRFs may warrant an adjustment to payments. Therefore, we are specifically soliciting comments on this monitoring system.

4. Transfer Case Payment

We believe that matching payment as closely as possible to expected costs is the best way to reduce opportunities for financial considerations to affect clinical decisions. We found a significant correlation between the length of a patient's stay and the cost of the services received. This correlation indicates that the average length of stay can be used as a proxy measure of a facility's resources needed to treat a specific diagnosis with rehabilitation services. Thus, a per-diem-based payment for the number of days of care prior to a transfer will allow us to pay providers more appropriately for the facility resources used and services delivered.

We propose to compute the per-diem-based payment for a transfer case as follows: First, calculate the unadjusted per-diem amount for each CMG (except the short-stay CMG) by dividing the average length of stay for non-transfer cases (those cases discharged to the community with a length of stay more than 3 days) in the CMG into the Federal prospective payment (with or without comorbidities) for that CMG. Next, multiply the CMG per-diem payment from the first step by the number of days that the beneficiary was in the IRF prior to their transfer. The result equals the unadjusted Federal prospective payment for the transfer case. See section V.D of this preamble for specific adjustments that are applicable to this Federal prospective payment. We solicit comments on the appropriateness of our proposed methodology for computing payments for transfer cases.

We will examine the distribution of costs to determine if and to what extent costs vary during the course of an episode. If costs vary during the course of an episode, an alternative transfer policy could be developed to better reflect the costs of care. The results of this analysis will be considered as well as the incentives inherent in an alternative transfer payment methodology.

C. Special Cases That Are Not Transfers

Section 1886(j)(3)(A)(v) of the Act permits us to adjust the payment rates by factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

Certain cases that have stays of less than the typical length of time and that receive less than the full course of rehabilitation treatment for a specific CMG would be paid inappropriately if the facility were to receive the full CMG payment. Further, because of the budget neutrality requirements, ''overpayment'' for these cases would reduce payments for all other cases that warrant full payment based on the rehabilitation services actually delivered. We discuss the special cases below in terms of the definitions, policy rationale, and the proposed payment methodology. The three subsets are short-stay outliers, cases that expire, and interrupted stays.

1. Short-Stay Outlier

We propose, under § 412.620(b)(2), to define a short-stay outlier as a case that has a length of stay of 3 days or fewer (regardless of the CMG) and that does not meet the definition of a transfer as discussed in section V.B. of this preamble. A short-stay may occur when a beneficiary receives less than the full course of rehabilitative treatment because he or she leaves the facility against medical advice. Another circumstance warranting classification as a short-stay outlier involves patients who are admitted to rehabilitation facilities but are unable to tolerate intensive rehabilitative services. These patients may be discharged home and be readmitted once they are able to tolerate intensive rehabilitative services (see the interrupted stay policy in section V.C.3. of this preamble, for further clarification regarding length of stay criteria), or they may be discharged and not readmitted because they remain unable to tolerate these services.

An incomplete assessment submitted when the patient's length of stay is 3 days or fewer is another example of a short-stay case. In this situation, the facility may not have the appropriate information to complete the MDS–PAC patient assessment. We believe that a payment adjustment is necessary to reduce incentives for facilities to complete an assessment with inadequate information. Further, we believe that providing a special payment for incomplete assessments neither encourages facilities to submit incomplete assessments without obtaining the appropriate information, nor severely penalizes providers that occasionally may be unable, despite good faith efforts, to complete assessments.

Making a short-stay outlier payment for these types of cases will allow us to counteract the incentives inherent in a discharge-based prospective payment system for this pattern to emerge. Payment-to-cost ratios for the cases described above show that if facilities receive a full CMG payment, they would be ''overpaid'' for the resources they have expended. One of the primary objectives of the prospective payment system is to provide incentives for facilities to become more efficient and, in doing so, to ensure that they can still receive adequate and appropriate payments. Because the rates are set to be budget neutral minus 2 percent, excessive payment for those cases that do not actually entail the full course of rehabilitative treatment would reduce payments for cases that warrant full payment based on the rehabilitation services delivered. A short-stay outlier policy would permit more equitable payment to those facilities that manage to increase efficiencies while still providing the full course of rehabilitative treatment.

We propose to pay short-stay outliers a relative weight of 0.1908. We computed this relative weight for short-stay outlier discharges by identifying all cases in which the length of stay is 3 days or fewer and the discharge does not meet the policy criteria to be considered a transfer. The relative weight for these cases is calculated in the same manner discussed previously, using the hospital-specific relative value methodology.

However, we believe that the considerations underlying the short-stay policy might also apply to cases with a length of stay greater than 3 days. More specifically, we note that some beneficiaries may have longer lengths of stay, and yet may not require intensive inpatient rehabilitative care, or may lack the capacity to participate in an intensive rehabilitation program. Therefore, we are also considering a short-stay policy that would encompass cases with a length of stay longer than 3 days. We are in the process of further analyzing claims data for Medicare beneficiaries to determine the most appropriate number of days to use in the definition of a short-stay case. If analysis of the data supports increasing the number of days for the short-stay criteria, we might adopt in the final rule a definition covering a longer period than the 3-day period. We specifically solicit comments on the appropriate time period for our short-stay criteria.

2. Cases That Expire

In general, cases that end in death would be substantially ''overpaid'' if facilities received the full CMG payment for these cases; even excluding all of the very short-stay cases with a length of stay of 3 days or fewer, the remaining expired cases as a whole would still be ''overpaid''. We analyzed payment-to-cost ratios and found that we can improve the accuracy of the payments if we split expired cases into two categories based on the RIC—one for orthopedic cases and one for all other types of RICs. We further find that splitting these cases based on length of stay also improves the accuracy of the payment system. Therefore, we propose, under § 412.620(b)(3), that, for expired cases where a beneficiary dies within 3 days from admission or fewer, the case would be classified into the short-stay CMG. We propose that, for expired cases with a length of stay greater than 3 days, the case would be classified into one of four CMGs, based on length of stay and whether or not the discharge falls within the orthopedic RIC. More specifically, one group includes orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay for expired cases classified within the orthopedic RIC. The second group includes orthopedic discharges with a length of stay greater than the average length of stay for expired cases classified within the orthopedic RIC. The third group includes non-orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay of expired cases that are not classified within the orthopedic RIC. The fourth group includes non-orthopedic discharges with a length of stay greater than the average length of stay of expired cases that are not classified within the orthopedic RIC. Relative weights for each expired CMG are calculated using the hospital-specific relative value methodology discussed previously in this preamble.

3. Interrupted Stay

We propose to define interrupted stay cases as those involving cases in which the beneficiary returns to the rehabilitation facility by midnight of the third day following a discharge. We propose to pay one discharge payment for these cases. The assessment from the initial stay would be used to determine the appropriate CMG.

D. Adjustments

Section 1886(j)(6) of the Act requires an adjustment to the Federal

prospective payments to account for geographical wage variation. Section 1886(j)(3)(A)(v) of the Act confers broad discretion on the Secretary to adjust prospective payments ''by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.'' Section 1886(j)(4) of the Act authorizes (but does not require) the Secretary to make specified payment adjustments (including an adjustment for outlier cases). In addition to the geographical wage adjustment, we propose to adjust payments for facilities located in rural areas. Further, we propose to adjust payments to reflect the percentage of low income patients. These adjustments and the proposed payment methodologies are discussed below.

1. Area Wage Adjustment

Section 1886(j)(6) of the Act specifies that payment rates under the IRF prospective payment system must be adjusted to account for geographic area wage variation. The statute requires the Secretary to adjust the labor-related portion of the prospective payment rates for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the rehabilitation facility compared to the national average wage level for these facilities. We propose, under § 412.624(e)(1), to adjust the payment rates for geographic wage variations using the following methodology.

To account for wage differences, we first identify the proportion of labor and non-labor components of costs. In general, the labor-related share is the sum of relative importances of wages, fringe benefits, professional fees, postal services, labor-intensive services, and a portion of the capital share from an appropriate market basket. We determine a labor-related share for rehabilitation facilities by first estimating the portion related to operating costs. We use the excluded market basket with capital to determine the labor-related share. The excluded market basket with capital is derived from available cost data for facilities including rehabilitation, long-term care, psychiatric, cancer, and children's hospitals. Using the excluded hospital market basket with capital, the labor-related share of operating costs is 67.03 percent in fiscal year 2001. Table 2E shows that the sum of the relative importance for wages and salaries, employee benefits, professional fees, postal services and all other labor intensive services equals 67.03 percent for FY 2001. The labor-related share of capital costs needs to be considered as well. The portion of capital attributed to labor is estimated to be 46 percent, the same percentage used for the hospital inpatient capital-related prospective payment system. Because the relative importance for capital is 9.285 percent of the excluded hospital with capital market basket in FY 2001, we multiply 46 percent by 9.285 percent to determine the labor-related share for capital costs in FY 2001, which is 4.271 percent. We add 4.271 percent for capital costs to 67.03 percent for operating costs to determine the total labor-related share. Thus, the labor-related share that we propose to use for rehabilitation facilities in FY 2001 is 71.301 percent as shown in the Table 2E below.

TABLE 2E.—TOTAL LABOR-RELATED SHARE

Cost category	Relative importance (%) FY 2001
Wages and salaries	48.895
Employee benefits	10.790
Professional fees	1.979
Postal services	0.245
All other labor intensive services	5.121
SUBTOTAL	67.03
Labor related share of capital	4.271
TOTAL	71.301

We note that a precedent exists for using this method to adjust for geographic differences in costs. Specifically, the labor-related portion for acute care hospitals is determined from cost report data, and is established in conjunction with the hospital operating market basket. We further validated the labor-related share by analyzing the results of the wage index coefficient derived from the regressions. The wage index coefficient allows us to approximate the labor-related portion of cost per case. The coefficient confirms that 71.301 percent is an appropriate labor-related share.

The labor-related portion of the unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. We are proposing to use inpatient acute care hospital wage data to compute the wage indices. Wage data to compute IRF-specific wage indices are currently not available. We believe that the inpatient acute care hospital wage data reflect wage levels similar to those of post-acute care facilities, including IRFs. We believe that IRFs and other post-acute care facilities (such as, SNFs and HHAs) generally compete in the same labor market as inpatient acute care hospitals. (Inpatient acute care hospital data is currently being used to compute wage indices for the SNF and HHA prospective payment systems.) Accordingly, we believe that inpatient acute care hospital wage data is appropriate to use as a basis of computing the IRF wage index in accordance with section 1886(j)(6) of the Act.

The inpatient acute care hospital wage data that we propose to use includes the following categories of data associated with costs paid under the inpatient acute care hospital prospective payment system (as well as outpatient costs): salaries and hours from short-term, acute care hospitals, home office costs and hours, certain contract labor costs and hours, and wage-related costs. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because these services are not covered under the IRF prospective payment system. These wages are currently being phased out of the hospital inpatient prospective payment system wage index over a 5-year period. The wage data used to compute the FY 2000 SNF and hospital wage indices are based on a blend of 80 percent of an average hourly wage that includes these costs and 20 percent of an average hourly wage that excludes these costs. Unlike the inpatient prospective payment system for acute care hospitals, a transition is unnecessary for IRF prospective payment system because payment for inpatient rehabilitation services has never been based on a wage index that includes data for these services. The difference across geographic areas between a wage index that uses the 80/20 blend and a wage index that excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists is less than 2 percent on average.

Consistent with the wage index methodologies in other prospective payment systems, we propose to divide hospitals into labor market areas. For purposes of defining labor market areas, we are proposing to define an urban area as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. We are proposing to define a rural area as any area outside an urban area. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to

geographic reclassification under section 1886(d)(8) or (d)(10) of the Act.

We are proposing to use an IRF wage index that is based on FY 1996 inpatient acute care hospital wage data. These data were also used to compute the FY 2000 hospital inpatient PPS wage indices. The FY 1997 inpatient acute care hospital wage data was used to develop the FY 2001 hospital wage index, and we will consider using this data for developing the final Federal prospective payments.

The proposed IRF wage indices are computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage—the result is a wage index for each urban and rural area.

To calculate the adjusted facility payments, the prospectively determined Federal prospective payment is multiplied by the labor-related percentage (0.71301) to determine the labor-related portion of the Federal prospective payments. This labor-related portion is then multiplied by the applicable IRF wage index shown in Table 3E for urban areas and Table 4E for rural areas.

TABLE 3E.—WAGE INDEX URBAN AREAS

MSA	Urban area (Constituent counties or county equivalents)	Wage index
0040 ..	Abilene, TX	0.8275
	Taylor, TX	
0060 ..	Aguadilla, PR	0.3859
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080 ..	Akron, OH	1.0093
	Portage, OH	
	Summit, OH	
0120 ..	Albany, GA	1.6055
	Dougherty, GA	
	Lee, GA	
0160 ..	Albany-Schenectady-Troy, NY.	0.8751
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200 ..	Albuquerque, NM	0.8366
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220 ..	Alexandria, LA	0.7960
	Rapides, LA	
0240 ..	Allentown-Bethlehem-Easton, PA.	1.0226
	Carbon, PA	
	Lehigh, PA.	
	Northampton, PA.	
0280 ..	Altoona, PA	0.9410
	Blair, PA	
0320 ..	Amarillo, TX	0.8450
	Potter, TX	
	Randall, TX	
0380 ..	Anchorage, AK	1.3010
	Anchorage, AK	
0440 ..	Ann Arbor, MI	1.1354
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450 ..	Anniston,AL	0.8562
	Calhoun, AL	
0460 ..	Appleton-Oshkosh-Neenah, WI.	0.9018
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470 ..	Arecibo, PR	0.4871
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480 ..	Asheville, NC	0.8969
	Buncombe, NC	
	Madison, NC	
0500 ..	Athens, GA	0.9819
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520 ..	Atlanta, GA	1.0173
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Henry, GA	
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560 ..	Atlantic City-Cape May	1.1469
	Atlantic City, NJ	
	Cape May, NJ	
0580 ..	Auburn-Opelika, AL	0.7718
	Lee, AL	
0600 ..	Augusta-Aiken, GA–SC	0.9091
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640 ..	Austin-San Marcos, TX	0.9112
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680 ..	Bakersfield, CA	0.9622
	Kern, CA	
0720 ..	Baltimore, MD	0.9614
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	
0733 ..	Bangor, ME	0.9696
	Penobscot, ME	
0743 ..	Barnstable-Yarmouth, MA	1.3573
	Barnstable, MA	
0760 ..	Baton Rouge, LA	0.8782
	Ascension, LA	
	East Baton Rouge	
	Livingston, LA	
	West Baton Rouge	
0840 ..	Beaumont-Port Arthur, TX	0.8715
	Hardin, TX	
	Jefferson, TX	
	Orange, TX	
0860 ..	Bellingham, WA	1.1528
	Whatcom, WA	
0870 ..	Benton Harbor, MI	0.8557
	Berrien, MI	
0875 ..	Bergen-Passaic, NJ	1.2128
	Bergen, NJ	
	Passaic, NJ	
0880 ..	Billings, MT	1.0154
	Yellowstone, MT	
0920 ..	Biloxi-Gulfport-Pascagoula, MS.	0.7960
	Hancock, MS	
	Harrison, MS	
	Jackson, MS	
0960 ..	Binghamton, NY	0.8689
	Broome, NY	
	Tioga, NY	
1000 ..	Birmingham, AL	0.9009
	Blount, AL	
	Jefferson, AL	
	St. Clair, AL	
	Shelby, AL	
1010 ..	Bismarck, ND	0.7746
	Burleigh, ND	
	Morton, ND	
1020 ..	Bloomington, IN	0.8694
	Monroe, IN	
1040 ..	Bloomington-Normal, IL	0.9099
	McLean, IL	
1080 ..	Boise City, ID	0.9144
	Ada, ID	
	Canyon, ID	
1123 ..	Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH.	1.1327
	Bristol, MA	
	Essex, MA	
	Middlesex, MA	
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
	Worcester, MA	
	Hillsborough, NH	
	Merrimack, NH	
	Rockingham, NH	
	Strafford, NH	
1125 ..	Boulder-Longmont, CO	1.0030

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Boulder, CO	
1145 ..	Brazoria, TX	0.8616
	Brazoria, TX	
1150 ..	Bremerton, WA	1.1141
	Kitsap, WA	
1240 ..	Brownsville-Harlingen-San Benito, TX.	0.9294
	Cameron, TX	
1260 ..	Bryan-College Station, TX	0.8601
	Brazos, TX	
1280 ..	Buffalo-Niagara Falls, NY	0.9549
	Erie, NY	
	Niagara, NY	
1303 ..	Burlington, VT	1.0796
	Chittenden, VT	
	Franklin, VT	
	GrandIsle, VT	
1310 ..	Caguas, PR	0.4596
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320 ..	Canton-Massillon, OH	0.8770
	Carroll, OH	
	Stark, OH	
1350 ..	Casper, WY	0.9286
	Natrona, WY	
1360 ..	Cedar Rapids, IA	0.9082
	Linn, IA	
1400 ..	Champaign-Urbana, IL	0.9225
	Champaign, IL	
1440 ..	Charleston-North Charleston, SC.	0.9073
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480 ..	Charleston, WV	0.9157
	Kanawha, WV	
	Putnam, WV	
1520 ..	Charlotte-Gastonia-Rock Hill, NC–SC.	0.9471
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Stanly, NC	
	Union, NC	
	York, SC	
1540 ..	Charlottesville, VA	1.0662
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560 ..	Chattanooga, TN–GA	0.9824
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
1580 ..	Cheyenne, WY	0.8272
	Laramie, WY	
1600 ..	Chicago, IL	1.0889
	Cook, IL	
	De Kalb, IL	
	Du Page, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	Lake, IL	
	McHenry, IL	
	Will, IL	
1620 ..	Chico-Paradise, CA	1.0513
	Butte, CA	
1640 ..	Cincinnati, OH–KY–IN	0.9424
	Dearborn, IN	
	Ohio, IN	
	Boone, KY	
	Campbell, KY	
	Gallatin, KY	
	Grant, KY	
	Kenton, KY	
	Pendleton, KY	
	Brown, OH	
	Clermont, OH	
	Hamilton, OH	
	Warren, OH	
1660 ..	Clarksville-Hopkinsville, TN–KY.	0.8185
	Christian, KY	
	Montgomery, TN	
1680 ..	Cleveland-Lorain-Elyria, OH.	0.9667
	Ashtabula, OH	
	Geauga, OH	
	Cuyahoga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
1720 ..	Colorado Springs, CO	0.9326
	El Paso, CO	
1740 ..	Columbia MO	0.9072
	Boone, MO	
1760 ..	Columbia, SC	0.9456
	Lexington, SC	
	Richland, SC	
1800 ..	Columbus, GA–AL	0.8529
	Russell, AL	
	Chattanoochee, GA	
	Harris, GA	
	Muscogee, GA	
1840 ..	Columbus, OH	0.9952
	Delaware, OH	
	Fairfield, OH	
	Franklin, OH	
	Licking, OH	
	Madison, OH	
	Pickaway, OH	
1880 ..	Corpus Christi, TX	0.8848
	Nueces, TX	
	San Patricio, TX	
1890 ..	Corvallis, OR	1.1217
	Benton, OR	
1900 ..	Cumberland, MD–WV	0.8905
	Allegany MD	
	Mineral WV	
1920 ..	Dallas, TX	0.9559
	Collin, TX	
	Dallas, TX	
	Denton, TX	
	Ellis, TX	
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950 ..	Danville, VA	0.9167
	Danville City, VA	
	Pittsylvania, VA	
1960 ..	Davenport-Moline-Rock Island, IA–IL.	0.8787
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000 ..	Dayton-Springfield, OH	0.9478
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020 ..	Daytona Beach, FL	0.9048
	Flagler, FL	
	Volusia, FL	
2030 ..	Decatur, AL	0.8781
	Lawrence, AL	
	Morgan, AL	
2040 ..	Decatur, IL	0.8380
	Macon, IL	
2080 ..	Denver, CO	1.0202
	Adams, CO	
	Arapahoe, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120 ..	Des Moines, IA	0.8793
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160 ..	Detroit, MI	1.0310
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180 ..	Dothan, AL	0.7890
	Dale, AL	
	Houston, AL	
2190 ..	Dover, DE	0.9445
	Kent, DE	
2200 ..	Dubuque, IA	0.8620
	Dubuque, IA	
2240 ..	Duluth-Superior, MN–WI	1.0279
	St. Louis, MN	
	Douglas, WI	
2281 ..	Dutchess County, NY	1.0674
	Dutchess, NY	
2290 ..	Eau Claire, WI	0.9030
	Chippewa, WI	
	Eau Claire, WI	
2320 ..	El Paso, TX	0.9004
	El Paso, TX	
2330 ..	Elkhart-Goshen, IN	0.9490
	Elkhart, IN	
2335 ..	Elmira, NY	0.8634
	Chemung, NY	
2340 ..	Enid, OK	0.8047
	Garfield, OK	
2360 ..	Erie, PA	0.8880
	Erie, PA	
2400 ..	Eugene-Springfield, OR	1.0715
	Lane, OR	
2440 ..	Evansville-Henderson, IN–KY.	0.8329
	Posey, IN	
	Vanderburgh, IN	
	Warrick, IN	
	Henderson, KY	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
2520 ..	Fargo-Moorhead, ND–MN	0.8721
	Clay, MN	
	Cass, ND	
2560 ..	Fayetteville, NC	0.8594
	Cumberland, NC	
2580 ..	Fayetteville-Springdale-Rogers, AR.	0.7768
	Benton, AR	
	Washington, AR	
2620 ..	Flagstaff, AZ–UT	1.0470
	Coconino, AZ	
	Kane, UT	
2640 ..	Flint, MI	1.1037
	Genesee, MI	
2650 ..	Florence, AL	0.8020
	Colbert, AL	
	Lauderdale, AL	
2655 ..	Florence, SC	0.8668
	Florence, SC	
2670 ..	Fort Collins-Loveland, CO	1.0335
	Larimer, CO	
2680 ..	Ft. Lauderdale, FL	1.0297
	Broward, FL	
2700 ..	Fort Myers-Cape Cora, FL.	0.9056
	Lee, FL	
2710 ..	Fort Pierce-Port St. Lucie, FL.	1.0116
	Martin, FL	
	St. Lucie, FL	
2720 ..	Fort Smith, AR–OK	0.7936
	Crawford, AR	
	Sebastian, AR	
	Sequoyah, OK	
2750 ..	Fort Walton Beach, FL	0.8816
	Okaloosa, FL	
2760 ..	Fort Wayne, IN	0.9158
	Adams, IN	
	Allen, IN	
	De Kalb, IN	
	Huntington, IN	
	Wells, IN	
	Whitley, IN	
2800 ..	Forth Worth-Arlington, TX	0.9673
	Hood, TX	
	Johnson, TX	
	Parker, TX	
	Tarrant, TX	
2840 ..	Fresno, CA	1.0311
	Fresno, CA	
	Madera, CA	
2880 ..	Gadsden, AL	0.8791
	Etowah, AL	
2900 ..	Gainesville, FL	0.9879
	Alachua, FL	
2920 ..	Galveston-Texas City, TX	0.9767
	Galveston, TX	
2960 ..	Gary, IN	0.9494
	Lake, IN	
	Porter, IN	
2975 ..	Glens Falls, NY	0.8707
	Warren, NY	
	Washington, NY	
2980 ..	Goldsboro, NC	0.8432
	Wayne, NC	
2985 ..	Grand Forks, ND–MN	0.9199
	Polk, MN	
	Grand Forks, ND	
2995 ..	Grand Junction, CO	0.9102
	Mesa, CO	
3000 ..	Grand Rapids-Muskegon-Holland, MI.	1.0151
	Allegan, MI	
	Kent, MI	
	Muskegon, MI	
	Ottawa, MI	
3040 ..	Great Falls, MT	1.0582
	Cascade, MT	
3060 ..	Greeley, CO	0.9667
	Weld, CO	
3080 ..	Green Bay, WI	0.9224
	Brown, WI	
3120 ..	Greensboro-Winston-Salem-High Point, NC.	0.9091
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150 ..	Greenville, NC	0.9451
	Pitt, NC	
3160 ..	Greenville-Spartanburg-Anderson, SC.	0.9264
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180 ..	Hagerstown, MD	0.8946
	Washington, MD	
3200 ..	Hamilton-Middletown, OH	0.9051
	Butler, OH	
3240 ..	Harrisburg-Lebanon-Carlisle, PA.	0.9749
	Cumberland, PA	
	Dauphin, PA	
	Lebanon, PA	
	Perry, PA	
3283 ..	Hartford, CT	1.1758
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285 ..	Hattiesburg, MS	0.7723
	Forrest, MS	
	Lamar, MS	
3290 ..	Hickory-Morganton-Lenoir, NC.	0.9219
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320 ..	Honolulu, HI	1.1599
	Honolulu, HI	
3350 ..	Houma, LA	0.7878
	Lafourche, LA	
	Terrebonne, LA	
3360 ..	Houston, TX	0.9405
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	
	Montgomery, TX	
	Waller, TX	
3400 ..	Huntington-Ashland, WV–KY–OH.	0.9859
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440 ..	Huntsville, AL	0.8926
	Limestone, AL	
	Madison, AL	
3480 ..	Indianapolis, IN	0.9802
	Boone, IN	
	Hamilton, IN	
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500 ..	Iowa City, IA	0.9532
	Johnson, IA	
3520 ..	Jackson, MI	0.8944
	Jackson, MI	
3560 ..	Jackson, MS	0.8379
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580 ..	Jackson, TN	0.8701
	Chester, TN	
	Madison, TN	
3600 ..	Jacksonville, FL	0.9020
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605 ..	Jacksonville, NC	0.7944
	Onslow, NC	
3610 ..	Jamestown, NY	0.7950
	Chautaqua, NY	
3620 ..	Janesville-Beloit, WI	0.9677
	Rock, WI	
3640 ..	Jersey City, NJ	1.1742
	Hudson, NJ	
3660 ..	Johnson City-Kingsport-Bristol, TN–VA.	0.8949
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott ,VA	
	Washington, VA	
3680 ..	Johnstown, PA	0.8589
	Cambria, PA	
	Somerset, PA	
3700 ..	Jonesboro, AR	0.7316
	Craighead, AR	
3710 ..	Joplin, MO	0.7766
	Jasper, MO	
	Newton, MO	
3720 ..	Kalamazoo-Battlecreek, MI.	1.0098
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740 ..	Kankakee, IL	0.8699

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Kankakee, IL	
3760 ..	Kansas City, KS–MO	0.9281
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800 ..	Kenosha, WI	0.9139
	Kenosha, WI	
3810 ..	Killeen-Temple, TX	1.0078
	Bell, TX	
	Coryell, TX	
3840 ..	Knoxville, TN	0.9238
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850 ..	Kokomo, IN	0.9023
	Howard, IN	
	Tipton, IN	
3870 ..	La Crosse, WI–MN	0.9020
	Houston, MN	
	La Crosse, WI	
3880 ..	Lafayette, LA	0.8437
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920 ..	Lafayette, IN	0.8913
	Clinton, IN	
	Tippecanoe, IN	
3960 ..	Lake Charles, LA	0.8056
	Calcasieu, LA	
3980 ..	Lakeland-WinterHaven, FL.	0.8919
	Polk, FL	
4000 ..	Lancaster, PA	0.9325
	Lancaster, PA	
4040 ..	Lansing-East Lansing, MI	1.0075
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080 ..	Laredo, TX	0.8421
	Webb, TX	
4100 ..	Las Cruces, NM	0.8606
	DonaAna, NM	
4120 ..	Las Vegas, NV–AZ	1.1285
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150 ..	Lawrence, KS	0.8319
	Douglas, KS	
4200 ..	Lawton, OK	0.9645
	Comanche, OK	
4243 ..	Lewiston-Auburn, ME	0.8962
	Androscoggin ME	
4280 ..	Lexington, KY	0.8568
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320 ..	Lima, OH	0.9010
	Allen, OH	
	Auglaize, OH	
4360 ..	Lincoln, NE	0.9723
	Lancaster NE	
4400 ..	Little Rock-North Little, AR.	0.8708
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420 ..	Longview-Marshall, TX	0.8841
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480 ..	Los Angeles-Long Beach, CA.	1.2103
	Los Angeles, CA	
4520 ..	Louisville, KY–IN	0.9415
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600 ..	Lubbock, TX	0.8512
	Lubbock, TX	
4640 ..	Lynchburg, VA	0.8908
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680 ..	Macon, GA	0.8501
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720 ..	Madison, WI	0.9869
	Dane, WI	
4800 ..	Mansfield, OH	0.8575
	Crawford, OH	
	Richland, OH	
4840 ..	Mayaguez, PR	0.4729
	Anasco, PR	
	CaboRojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR.	
4880 ..	McAllen-Edinburg-Mission, TX.	0.8208
	Hidalgo, TX	
4890 ..	Medford-Ashland, OR	1.0607
	Jackson, OR	
4900 ..	Melbourne-Titusville-Palm Bay, FL.	0.9405
	Brevard, FL	
4920 ..	Memphis, TN–AR–MS	0.8321
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940 ..	Merced, CA	1.0313
	Merced, CA	
5000 ..	Miami, FL	1.0368
	Dade, FL	
5015 ..	Middlesex-Somerset-Hunterdon, NJ.	1.1128
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080 ..	Milwaukee-Waukesha, WI	0.9848
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120 ..	Minneapolis-St. Paul, MN–WI.	1.0979
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
5140 ..	Missoula, MT	0.9192
	Missoula, MT	
5160 ..	Mobile, AL	0.8171
	Baldwin, AL	
	Mobile, AL	
5170 ..	Modesto, CA	1.0233
	Stanislaus, CA	
5190 ..	Monmouth-Ocean, NJ	1.1332
	Monmouth, NJ	
	Ocean, NJ	
5200 ..	Monroe, LA	0.8315
	Ouachita, LA	
5240 ..	Montgomery, AL	0.7794
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
5280 ..	Muncie, IN	1.0533
	Delaware, IN	
5330 ..	Myrtle Beach, SC	0.8612
	Horry, SC	
5345 ..	Naples, FL	0.9955
	Collier, FL	
5360 ..	Nashville, TN	0.9368
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Robertson, TN	
	Rutherford, TN	
	Sumner, TN	
	Williamson, TN	
	Wilson, TN	
5380 ..	Nassau-Suffolk, NY	1.4087
	Nassau, NY	
	Suffolk, NY	
5483 ..	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT.	1.2260
	Fairfield, CT	
	New Haven, CT	
5523 ..	New London-Norwich, CT	1.2572

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	New London, CT	
5560 ..	New Orleans, LA	0.9140
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	
	St. Tammany, LA	
5600 ..	New York, NY	1.4338
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640 ..	Newark, NJ	1.1729
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660 ..	Newburgh, NY–PA	1.1035
	Orange, NY	
	Pike, PA	
5720 ..	Norfolk-Virginia Beach-Newport News, VA–NC.	0.8483
	Currituck, NC	
	Chesapeake City, VA	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
5775 ..	Oakland, CA	1.5277
	Alameda, CA	
	Contra Costa, CA	
5790 ..	Ocala, FL	0.9728
	Marion, FL	
5800 ..	Odessa-Midland, TX	0.8951
	Ector, TX	
	Midland, TX	
5880 ..	Oklahoma City, OK	0.8551
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910 ..	Olympia, WA	1.1023
	Thurston, WA	
5920 ..	Omaha, NE–IA	1.0405
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945 ..	Orange County, CA	1.1720
	Orange, CA	
5960 ..	Orlando, FL	0.9845
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990 ..	Owensboro, KY	0.8199
	Daviess, KY	
6015 ..	Panama City, FL	0.9277
	Bay, FL	
6020 ..	Parkersburg-Marietta, WV–OH.	0.8503
	Washington, OH	
	Wood, WV	
6080 ..	Pensacola, FL	0.8529
	Escambia, FL	
	Santa Rosa, FL	
6120 ..	Peoria-Pekin, IL	0.8201
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160 ..	Philadelphia, PA–NJ	1.1076
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200 ..	Phoenix-Mesa, AZ	0.9420
	Maricopa, AZ	
	Pinal, AZ	
6240 ..	Pine Bluff, AR	0.7777
	Jefferson, AR	
6280 ..	Pittsburgh, PA	0.9478
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323 ..	Pittsfield, MA	1.0173
	Berkshire, MA	
6340 ..	Pocatello, ID	0.9063
	Bannock, ID	
6360 ..	Ponce, PR	0.4970
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403 ..	Portland, ME	0.9499
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440 ..	Portland-Vancouver, OR–WA.	1.1087
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483 ..	Providence-Warwick-Pawtucket, RI.	1.0766
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520 ..	Provo-Orem, UT	0.9916
	Utah, UT	
6560 ..	Pueblo, CO	0.8922
	Pueblo, CO	
6580 ..	Punta Gorda, FL	0.9620
	Charlotte, FL	
6600 ..	Racine, WI	0.9325
	Racine, WI	
6640 ..	Raleigh-Durham-Chapel Hill, NC.	0.9683
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660 ..	Rapid City, SD	0.8415
	Pennington, SD	
6680 ..	Reading, PA	0.9496
	Berks, PA	
6690 ..	Redding, CA	1.1376
	Shasta, CA	
6720 ..	Reno, NV	1.0781
	Washoe, NV	
6740 ..	Richland-Kennewick-Pasco, WA.	1.1356
	Benton, WA	
	Franklin, WA	
6760 ..	Richmond-Petersburg, VA	0.9569
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780 ..	Riverside-San Bernardino, CA	1.1256
	Riverside, CA	
	San Bernardino, CA	
6800 ..	Roanoke, VA	0.7971
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820 ..	Rochester, MN	1.1619
	Olmsted, MN	
6840 ..	Rochester, NY	0.9066
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880 ..	Rockford, IL	0.8885
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895 ..	Rocky Mount, NC	0.8837

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Edgecombe, NC	
	Nash, NC	
6920 ..	Sacramento, CA	1.2473
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960 ..	Saginaw-Bay City-Midland, MI.	0.9365
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980 ..	St. Cloud, MN	0.9525
	Benton, MN	
	Stearns, MN	
7000 ..	St. Joseph, MO	0.9048
	Andrews, MO	
	Buchanan, MO	
7040 ..	St. Louis, MO–IL	0.8943
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080 ..	Salem, OR	1.0065
	Marion, OR	
	Polk, OR	
7120 ..	Salinas, CA	1.4900
	Monterey, CA	
7160 ..	Salt Lake City-Ogden, UT	0.9919
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200 ..	San Angelo, TX	0.7938
	Tom Green, TX	
7240 ..	San Antonio, TX	0.8429
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320 ..	San Diego, CA	1.2100
	San Diego, CA	
7360 ..	San Francisco, CA	1.4287
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400 ..	San Jose, CA	1.3848
	Santa Clara, CA	
7440 ..	San Juan-Bayamon, PR	0.4698
	Aguas Buenas, PR	
	Barceloneta, PR	
	Bayamon, PR	
	Canovanas, PR	
	Carolina, PR	
	Catano, PR	
	Ceiba, PR	
	Comerio, PR	
	Corozal, PR	
	Dorado, PR	
	Fajardo, PR	
	Florida, PR	
	Guaynabo, PR	
	Humacao, PR	
	Juncos, PR	
	Los Piedras, PR	
	Loiza, PR	
	Luguillo, PR	
	Manati, PR	
	Morovis, PR	
	Naguabo, PR	
	Naranjito, PR	
	Rio Grande, PR	
	San Juan, PR	
	Toa Alta, PR	
	Toa Baja, PR	
	Trujillo Alto, PR	
	Vega Alta, PR	
	Vega Baja, PR	
	Yabucoa, PR	
7460 ..	San Luis Obispo-Atascadero-PasoRobles, CA.	1.0593
	San Luis Obispo, CA	
7480 ..	Santa Barbara-Santa Maria-Lompoc, CA.	1.0939
	Santa Barbara, CA	
7485 ..	Santa Cruz-Watsonville, CA.	1.4091
	Santa Cruz, CA	
7490 ..	Santa Fe, NM	1.0511
	Los Alamos, NM	
	Santa Fe, NM	
7500 ..	Santa Rosa, CA	1.3172
	Sonoma, CA	
7510 ..	Sarasota-Bradenton, FL	1.0022
	Manatee, FL	
	Sarasota, FL	
7520 ..	Savannah, GA	0.9995
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560 ..	Scranton-Wilkes-Barre-Hazleton, PA.	0.8442
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600 ..	Seattle-Bellevue-Everett, WA.	1.1376
	Island, WA	
	King, WA	
	Snohomish, WA	
7610 ..	Sharon, PA	0.8374
	Mercer, PA	
7620 ..	Sheboygan, WI	0.8299
	Sheboygan, WI	
7640 ..	Sherman-Denison, TX	0.9439
	Grayson, TX	
7680 ..	Shreveport-Bossier City, LA.	0.9126
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720 ..	Sioux City, IA–NE	0.8552
	Woodbury, IA	
	Dakota, NE	
7760 ..	Sioux Falls, SD	0.8813
	Lincoln, SD	
	Minnehaha, SD	
7800 ..	South Bend, IN	0.9732
	St. Joseph, IN	
7840 ..	Spokane, WA	1.0898
	Spokane, WA	
7880 ..	Springfield, IL	0.8710
	Menard, IL	
	Sangamon, IL	
7920 ..	Springfield, MO	0.8062
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003 ..	Springfield, MA	1.0488
	Hampden, MA	
	Hampshire, MA	
8050 ..	State College, PA	0.9212
	Centre, PA	
8080 ..	Steubenville-Weirton, OH–WV.	0.8716
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120 ..	Stockton-Lodi, CA	1.0571
	San Joaquin, CA	
8140 ..	Sumter, SC	0.8335
	Sumter, SC	
8160 ..	Syracuse, NY	0.9310
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200 ..	Tacoma, WA	1.1583
	Pierce, WA	
8240 ..	Tallahassee, FL	0.8529
	Gadsden, FL	
	Leon, FL	
8280 ..	Tampa-St. Petersburg-Clearwater, FL.	0.9136
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320 ..	Terre Haute, IN	0.8614
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360 ..	Texarkana, AR–TX	0.8101
	Miller, AR	
	Bowie, TX	
8400 ..	Toledo, OH	0.9764
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440 ..	Topeka, KS	0.9440
	Shawnee, KS	
8480 ..	Trenton, NJ	1.0180
	Mercer, NJ	
8520 ..	Tucson, AZ	0.8846
	Pima, AZ	
8560 ..	Tulsa, OK	0.8181
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600 ..	Tuscaloosa, AL	0.8104
	Tuscaloosa, AL	
8640 ..	Tyler, TX	0.9499
	Smith, TX	
8680 ..	Utica-Rome, NY	0.8370
	Herkimer, NY	
	Oneida, NY	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
8720 ..	Vallejo-Fairfield-Napa, CA	1.3503
	Napa, CA	
	Solano, CA	
8735 ..	Ventura, CA	1.1603
	Ventura, CA	
8750 ..	Victoria, TX	0.8476
	Victoria, TX	
8760 ..	Vineland-Millville-Bridgeton, NJ.	1.0640
	Cumberland, NJ	
8780 ..	Visalia-Tulare-Porterville, CA.	1.0533
	Tulare, CA	
8800 ..	Waco, TX	0.8099
	McLennan, TX	
8840 ..	Washington, DC–MD–VA–WV.	1.1088
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	
	Berkeley, WV	
	Jefferson, WV	
8920 ..	Waterloo-Cedar Falls, IA	0.8597
	BlackHawk, IA	
8940 ..	Wausau, WI	0.9556
	Marathon, WI	
8960 ..	West Palm Beach-Boca, FL	1.0130
	Palm Beach, FL	
9000 ..	Wheeling, OH–WV	0.7662
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040 ..	Wichita, KS	0.9559
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080 ..	Wichita Falls, TX	0.7743
	Archer, TX	
	Wichita, TX	
9140 ..	Williamsport, PA	0.8472
	Lycoming, PA	
9160 ..	Wilmington-Newark, DE–MD.	1.1000
	New Castle, DE	
	Cecil, MD	
9200 ..	Wilmington, NC	0.9818
	New Hanover, NC	
	Brunswick, NC	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
9260 ..	Yakima, WA	1.0331
	Yakima, WA	
9270 ..	Yolo, CA	0.9833
	Yolo, CA	
9280 ..	York, PA	0.9255
	York, PA	
9320 ..	Youngstown-Warren, OH	1.0025
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340 ..	Yuba City, CA	1.0787
	Sutter, CA	
	Yuba, CA	
9360 ..	Yuma, AZ	1.0040
	Yuma, AZ	

TABLE 4E.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7467
Alaska	1.2175
Arizona	0.8625
Arkansas	0.7317
California	1.0066
Colorado	0.8915
Connecticut	1.2559
Delaware	0.9240
Florida	0.9089
Georgia	0.8176
Guam	
Hawaii	1.0853
Idaho	0.8707
Illinois	0.8122
Indiana	0.8493
Iowa	0.7976
Kansas	0.7513
Kentucky	0.8127
Louisiana	0.7456
Maine	0.8679
Maryland	0.8730
Massachusetts	1.1499
Michigan	0.8896
Minnesota	0.8743
Mississippi	0.7374
Missouri	0.7802
Montana	0.8479
Nebraska	0.8024
Nevada	0.9197
New Hampshire	0.9827
New Jersey [1]	
New Mexico	0.8472
New York	0.8604
North Carolina	0.8378
North Dakota	0.7662
Ohio	0.8746
Oklahoma	0.7332
Oregon	0.9966
Pennsylvania	0.8559
Puerto Rico	0.4299
Rhode Island [1]	
South Carolina	0.8353
South Dakota	0.7625
Tennessee	0.7738
Texas	0.7545
Utah	0.8998

TABLE 4E.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage Index
Vermont	0.9518
Virginia	0.7991
Virgin Islands	
Washington	1.0548
West Virginia	0.8116
Wisconsin	0.8838
Wyoming	0.8955

[1] All counties within the State are classified urban.

The resulting wage-adjusted labor-related portion is added to the nonlabor related portion, resulting in a wage-adjusted payment. The following example illustrates how a Medicare fiscal intermediary would calculate the Adjusted Facility Federal prospective payment for inpatient rehabilitation facility services with a hypothetical Federal prospective payment of $10,000 for services provided in the rehabilitation facility located in Heartland, USA. The rehabilitation wage index value for facilities located in Heartland, USA is 1.0234. The labor-related portion (71.301 percent) of the Federal prospective payment is $7130.10=($10,000*71.301 percent), and the nonlabor related portion (28.699 percent) of the Federal prospective payment is $2869.90=($10,000*28.699 percent). Therefore, the wage-adjusted payment calculation, rounded to the nearest dollar is as follows:

$10,167=($7130.10*1.0234) + $2,869.90

2. General Specifications to Determine Other Adjustments

As indicated earlier, section 1886(j)(3)(A)(v) of the Act confers broad authority on the Secretary to adjust prospective payments ''by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities''. To determine whether other payment adjustments are warranted for the IRF prospective payment system, we conducted extensive regression analysis of the relationship between IRF costs (including both operating and capital costs per case) and several factors that may affect costs. The appropriateness of potential payment adjustments are based on both cost effects estimated by regression analysis and other factors, including simulated payments that we discuss in section VIII.B.2. of this preamble.

Our analyses included 624 facilities for which cost and case-mix data were available. We estimated costs for each case by multiplying facility specific,

cost-center specific cost-to-charge ratios by charges. Cost-to-charge ratios were obtained from FYs 1995, 1996, and/or 1997 cost report data and charges were obtained from the calendar years 1996 and 1997 Medicare claims data. The cost per case is calculated by summing all costs and dividing by the number of equivalent full cases. When we had cost per case data for both years, the number of cases and total costs are combined for both years. We accounted for the difference in the year by adjusting the 1996 cost per case by the case-weighted average change in cost per case between 1996 and 1997. Using the data from both years should provide more stability in the payment adjustments than would using data for a single year. When data for only one year are available, we use the costs and number of equivalent cases for that year.

Multivariate regression analysis is a standard way to examine facility cost variation and analyze potential payment adjustments. We looked at two standard models: (1) Fully specified explanatory models to examine the impact of all relevant factors that might potentially affect facility cost per case; and (2) payment models that examine the impacts of those factors specifically used to determine payment rates. The general specification for the multivariate regression is that the estimated average cost per case (the dependent variable) at the facility can be explained or predicted by several independent variables, including the case-mix index, the wage index for the facility, and a vector of additional explanatory variables that affect a facility's cost per case, such as its teaching program or the proportion of low-income patients. The case-mix index is the average of the CMG weights derived by the hospital-specific relative value method for each facility. Transfer cases are given a partial weight based on the ratio of the length of stay for the transfer to the average length of stay for nontransfer cases. Using the regression coefficients, we then simulated payments and calculated payment-to-cost ratios for different classes of hospitals, for specific combinations of payment policies.

We use payment variables from the hospital inpatient prospective payment system, including disproportionate share patient percentage, both capital and operating teaching variables (resident-to-average daily census and resident-to-bed ratios, respectively) as well as the teaching variable (resident-to-adjusted average daily census ratio) used in the analyses for the hospital outpatient prospective payment system, and variables to account for location in a rural or large urban area. A discussion of the major payment variables and our findings appears below.

3. Adjustments for Rural Location

We examined costs per case for both large urban and rural facilities. In the regression models, both explanatory and payment, the variable for rural facilities was positive and significant ($p<0.05$). The standardized cost per case for rural hospitals is 15 percent higher than the national average. On average, rural facilities tend to have fewer cases, a longer length of stay, and a higher average cost per case. The difference in costs becomes more evident when the average cost per case is standardized for the case-mix index and the wage index. In the regression models, large urban facilities were not significantly different from other urban facilities. We propose, under § 412.624(e)(3), to adjust for rural facilities by multiplying the payment by 1.1589. This adjustment was determined by using the coefficients derived from the regressions.

4. Adjustments for Indirect Teaching Costs

Facilities with major teaching programs tend to be located in large urban areas and have more cases, a higher case-mix and a higher proportion of low-income patients. We found that when only the payment variables that might warrant an adjustment (that is, DSH or rural/urban status, rather than for-profit/not for profit) under the prospective payment system are used in the regression models, the indirect teaching cost variable is not significant. We looked at different specifications for the teaching variable. We used a resident-to-average daily census ratio and a resident-to-bed ratio that we based on the estimated number of residents assigned to the inpatient area of the rehabilitation facility. We also used a resident-to-adjusted average daily census ratio based on the total number of residents at the hospital complex and outpatient as well as inpatient volume. We also looked for a teaching threshold. In all our payment regressions, the teaching variable was not significant. Therefore, we are not proposing an adjustment for indirect teaching costs.

5. Adjustments for Disproportionate Share of Low-Income Patients

We assessed the appropriateness of adjustments for facilities serving a disproportionate share of low income patients. We limited our analysis to the effects of serving low-income patients on costs per case, rather than a subsidy for uncompensated care.

We evaluated a facility-level adjustment that takes into account both the percentage of Medicare patients who are on Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. As a facility's percentage of low income patients increases, there is an incremental increase in the facility's cost. This suggests that additional payments are appropriate. We propose to use the same measure of disproportionate patient percentage currently used for the acute care hospital inpatient prospective payment system. Payments for each facility would be adjusted to reflect the facility's disproportionate share percentage.

Section 4403(b) of the BBA requires HCFA to develop a Report to the Congress containing a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Act. In determining the formula, the Secretary must:

- Establish a single threshold for costs incurred by hospitals serving low-income patients.
- Consider the costs incurred in furnishing hospital services to individuals who are entitled to benefits under Part A of Medicare and who receive Supplemental Security Income benefits under Title XVI.
- Consider the costs incurred in furnishing hospital services to individuals who receive medical assistance under the State plan under the Medicare program and are not entitled to benefits under Part A of Medicare.

Further, MedPAC recommends including the costs of uncompensated care in calculating low-income shares and using the same formula to distribute payments to all facilities covered by prospective payments. In light of HCFA's current study of a new payment formula for determining adjustments for hospitals serving low income patients and MedPAC's recommendations, we will consider these study results and other information as it becomes available and potentially refine the DSH adjustment in the future so that we ensure that facilities are paid in the most consistent and equitable manner possible. At this time, we propose, under § 412.624(e)(2), to adjust each rehabilitation facility payment by the following formula to account for the cost of furnishing care to low income patients: ((.0001+DSH) raised to the power of .0905)/(.0001 raised to the power of .0905));

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

6. Adjustments for Alaska and Hawaii

Section 1886(j)(4)(B) provides that the Secretary is authorized but not required to take into account the unique circumstances of IRFs located in Alaska and Hawaii. There are currently three IRFs in Hawaii and one in Alaska. However, we have cost and case-mix data for only one of the facilities in Hawaii (982 cases) and the facility in Alaska (117 cases). In the absence of a cost-of-living adjustment, our simulations indicate that the facility in Hawaii may profit and the facility in Alaska may experience a loss. Due to the small number of cases, analyses of the simulation results are inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we are not proposing an adjustment for rehabilitation facilities located in Alaska and Hawaii.

7. Adjustments for Cost Outliers

Section 1886(j)(4) of the Act specifies that the Secretary is authorized, but not required, to provide for additional payments for outlier cases. Further, section 1886(j)(4)(A)(iii) of the Act specifies that the total amount of the additional payments cannot be projected to exceed 5 percent of the total payments in a given year. Providing additional payments for costs that are beyond facilities' control can strongly improve the accuracy of the IRF prospective payment system in determining resource costs at the patient and facility level. In general, outlier payments reduce the financial risk which would otherwise be substantial because of the relatively small size of many rehabilitation facilities. These additional payments reduce the financial losses caused by treating patients who require more costly care and, therefore, will reduce the incentives to under serve these patients.

We considered various outlier policy options. Specifically, we examined outlier policies using 3, 4, and 5 percent of the total estimated payments. In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We believe an outlier policy of 3 percent will allow us to achieve a balance of the above stated goals. Additional increments of outlier payments reduce risk by successively smaller amounts. Further, additional amounts of outlier payments are funded by prospectively reducing the non-outlier payment rates in a budget neutral manner. Therefore, we propose an outlier policy of 3 percent of total estimated payments because we believe this option optimizes the extent to which we can protect vulnerable facilities, while still providing adequate payment for all other cases.

We propose, under § 412.624(e)(4), to make outlier payments for discharges whose estimated cost exceeds an adjusted threshold amount ($7,066 multiplied by the facility's adjustments) plus the adjusted CMG payment. Both the loss threshold and the CMG payment amount are adjusted for wages, rural location, and disproportionate share. The estimated cost of a case will be calculated by multiplying an overall facility-specific cost-to-charge ratio by the charge. Based on analysis of payment-to-cost ratios for outlier cases, and consistent with the marginal cost factor used under section 1886(d) of the Act, we propose to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the CMG payment and the loss amount of $7,066, as adjusted). The outlier threshold was calculated by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being equal to 3 percent of total payments under the simulation.

E. Calculation of the Budget Neutral Conversion Factor Minus Two Percent

1. Overview of Development of the Budget Neutral Conversion Factor

Section 1886(j)(3)(B) of the Act and proposed § 412.624(d) of the regulations specify that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and (6) of the Act, shall be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital costs of rehabilitation facilities had section 1886(j) not been enacted.

We propose, under § 412.624(c)(1), to calculate the budget neutral conversion factor using the following steps:

Step 1—Update the latest cost report data to the midpoint of the year 2001.

Step 2—Estimate total payments under the current payment system.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system.

Step 4—Estimate new payments under the proposed payment system without a budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor.

2. Steps for Developing the Budget Neutral Conversion Minus 2 Percent

- Data Sources

The data sources that we propose under § 412.624(a)(1) to construct the budget neutral adjustment factor include the cost report data from FYs 1995, 1996, and 1997, a list obtained from the fiscal intermediaries of facility-specific target amounts applicable for providers that applied to rebase their target amount in fiscal year 1998, and calendar year 1996 and 1997 Medicare claims with corresponding UDSmr or COS data. We used data from 508 facilities to calculate the budget neutral conversion factor. These facilities represent those providers for which we had cost report data available from FYs 1995, 1996, and 1997. We used the 3 years cost report data to trend the data to the midpoint of the year 2001 based on the facilities' historical relationship of costs and target amounts. The FY 1995 cost report data was used to determine the update to be used for FY 1999, the FY 1996 cost report data was used to determine the update to be used for FY 2000, and the FY 1997 cost report data was used to determine the update to be used for FY 2001. We were unable to calculate payment under the current payment system for some inpatient rehabilitation facilities because cost report data were unavailable. We will attempt to obtain the most recent payment amounts for these facilities through their Medicare fiscal intermediary and we will consider using this data to construct the payment rates for the final rule. We will also examine the extent to which certain facilities, such as new facilities, are not included in the construction of the budget neutral conversion factor and consider the appropriateness of an adjustment to better reflect total estimated payments for IRFs.

Step 1—Update the latest cost report data to the midpoint of the year 2001. Section 1886(j)(3)(A)(i) of the Act and proposed § 412.624(b) of the regulations

specify that the per-payment-unit amount is to be updated to the midpoint of the fiscal year 2000, using the weighted average of the applicable percentage increases provided under Section 1886(b)(3)(B)(ii) of the Act. The statute allows us more discretion in determining an appropriate methodology to update from the year 2000 to 2001. We propose, under § 412.624(c)(2), to update from the midpoint of the year 2000 to the midpoint of the year 2001 using the same methodology provided under Section 1886(b)(3)(B)(ii). We determine the appropriate update factor for each facility by using one of the four methodologies described below:

- For facilities with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase; or
- For facilities that exceed their target by less than 10 percent, the update factor would be equal to the market basket minus .25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0); or
- For facilities that are at or below their target but exceed two-thirds of the target amount, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0); or
- For facilities that do not exceed two-thirds of their target amount, the update factor is 0 percent.

Step 2—Estimate total payments under the current payment system.

Operating payments are calculated using the following methodology:

Step 2a—We determine the facility-specific target amount, subject to the applicable cap on the target amounts for rehabilitation facilities. There are two national caps on the target amounts for rehabilitation facilities. We used the cap amounts published in the July 30, 1999 **Federal Register**. For older facilities certified before October 1, 1997, the applicable cap amount for FY 2000 is $14,654 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,169 for the nonlabor-related share. For newer facilities certified on or after October 1, 1997, the cap amount applicable for FY 2000 is $12,574 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,999 for the nonlabor-related share. These target amounts are then inflated to the midpoint of the year 2001 by applying the excluded hospital operating market basket.

Step 2b—We calculate the lower of the results of step 2a.

- The facility-specific target amount (including application of the cap) times the Medicare discharges (the ceiling) or;
- The facility average operating cost per case times Medicare discharges. Payment for operating costs are determined by using one of the following methods:
- For facilities whose operating costs are lower than or equal to the ceiling, payment would be the lower of either the operating cost plus 15 percent of the difference between the operating cost and the ceiling or the operating costs plus 2 percent of the ceiling; or
- For facilities whose operating costs are more than 110 percent of the ceiling, payment would be the lower of either the ceiling multiplied by 1.10 or half of the difference between the 110 percent of the ceiling and the operating costs.
- For facilities whose operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment would be the ceiling.

Step 2c—After operating payments are computed, we determine capital payments. Section 4412 of the BBA amended section 1886(g) of the Act by reducing capital payments that would otherwise be made for rehabilitation facilities. Payments for capital costs are made on a reasonable cost basis. The BBA mandated the reduction of capital payments by 15 percent. Therefore, we reduce capital payments for inpatient rehabilitation facilities or units by multiplying the costs by .85.

Step 2d—The next step in determining total payments under the current payment system is to add operating and capital payments. Section 1886(j)(1)(A) of the Act specifies that the IRF prospective payment system will include both operating and capital costs. Once appropriate payments for operating costs are determined (including bonus and penalty payments as appropriate), and after reductions are made for capital payments, we would add the operating costs and the reduced capital costs together.

Step 2e—The statute provides for the Secretary to adjust the rates so that the amount of total payments under this section are projected to equal 98 percent of the payments that would have been paid under this section in the absence of this new payment methodology. Payments made for cost reporting periods beginning on or after the implementation of this prospective payment system through FY 2002 are based on both the facility-specific payment and the Federal prospective payment that we propose in this regulation. Therefore under proposed § 412.624(d)(2), we reduce total estimated payments calculated under the current payment system to ensure that the 98 percent budget neutrality provision is applicable to all payments. In addition, total estimated payments are adjusted to reflect the estimated proportion of additional outlier payments, under proposed § 412.624(d)(1) and for coding and classification changes under proposed § 412.624(d)(3). These payments are the proposed numerator of the equation used to calculate the budget neutral adjustment.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system. Once total payments are calculated under the current payment system, an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system can be calculated. This is done by first determining the average payment per discharge amount under the current payment system for each facility. Cost report data are used to calculate each facility's average payment per discharge by dividing the number of discharges into the total payments. The next step is to determine the weighted average per discharge payment amount. To calculate this amount, we multiply the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by each facility's average payment per discharge amount. We then sum the amounts for all facilities and divide by the total number of discharges from the Medicare bills (with corresponding UDSmr/COS data) to derive an average payment per discharge amount that is weighted by the number of Medicare discharges.

Step 4—Estimate payments under the proposed payment system without a budget neutral adjustment. Payments under the proposed payment system are then simulated without a budget neutral adjustment. To do this, we multiply the following: each facility's case-mix index, the number of discharges from the Medicare bills (with corresponding UDSmr/COS data), the appropriate wage index, the rural adjustment (if applicable), an appropriate disproportionate share adjustment, and the weighted average per discharge payment amount computed in Step 3. Total payments for each facility are then added together. This total is the denominator in the calculation of the budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor. The denominator of the budget neutral adjustment equation is the total estimated payments for the

proposed prospective payment system without a budget neutral adjustment (the total amount calculated in Step 4). The budget neutral adjustment is calculated by dividing total reduced payments under the current payment system (the total amount calculated in Step 2) by estimated payments for the proposed prospective payment system. The resulting budget neutral adjustment is then multiplied by the average weighted per discharge payment amount under the current payment system to derive the budget neutral conversion factor.

Because we do not have UDSmr and COS data for all rehabilitation facilities, for the final rule we will further analyze the extent to which the data used to construct the budget neutral conversion factor accurately reflect the relationship between case-mix and cost. We are considering the use of weighted averages to more fully account for those types of facilities that may be under-represented with the given data.

Once the budget neutral conversion factor is calculated, the factor is further adjusted to include a behavioral offset. As previously stated, to calculate the budget neutral conversion factor, we had to estimate what would have been paid under the current payment system. However, due to the incentives for premature discharge inherent in the new payment system, we expect that differences in the utilization of these services might result. In the case of the proposed payment system, discharges to other settings of care may take place earlier than under the current payment system. This would result in lower payments under the current payment system for this care, which must be taken into account when computing budget neutral payment rates. Accounting for this effect through an adjustment is commonly known as a behavioral offset. The budget neutral conversion factor with a behavioral offset is $6,024. This represents a .64 percent (that is, sixty four hundredths of one percent) reduction in the budget neutral conversion factor otherwise calculated under the methodology described in the preceding pages. In determining this adjustment, we assumed that the IRFs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with CMG or home health care at any point.

F. Development of the Federal Prospective Payment

Once the relative weights for each CMG and the budget neutral conversion factor are calculated, the Federal prospective payments can be determined. Under proposed § 412.624(c)(4), these CMG payments are calculated by multiplying the budget neutral conversion factor by each of the CMG relative weights. The equation is as follows:

Federal Prospective Payment = CMG Relative Weight * Budget Neutral Conversion Factor

Table 5E displays the CMGs and the corresponding Federal prospective payments.

TABLE 5E.—FEDERAL PROSPECTIVE PAYMENTS

CMG	Without comorbidities	With comorbidities
0101	$3,649.34	$3,983.67
0102	4,274.03	4,666.19
0103	5,183.65	5,658.95
0104	5,156.54	5,628.83
0105	5,795.09	6,325.80
0106	6,592.67	7,196.87
0107	7,608.31	8,305.29
0108	8,653.48	9,446.84
0109	9,631.77	10,514.89
0110	10,009.48	10,926.93
0111	11,822.70	12,906.42
0201	3,315.61	3,315.61
0202	5,014.98	5,014.98
0203	5,889.66	5,889.66
0204	7,011.94	7,011.94
0205	8,878.77	8,878.77
0206	13,360.63	13,360.63
0301	3,854.76	4,342.10
0302	5,055.94	5,695.09
0303	5,702.92	6,423.99
0304	7,593.25	8,552.88
0305	10,552.24	11,885.95
0401	4,298.12	5,156.54
0402	6,328.81	7,592.05
0403	10,517.30	12,616.67
0404	17,621.40	21,139.42
0501	2,686.10	3,330.07
0502	3,733.07	4,628.24
0503	4,910.76	6,088.46
0504	6,936.64	8,600.46
0505	10,732.36	13,306.41
0601	4,199.33	4,801.13
0602	5,473.41	6,258.33
0603	6,525.80	7,461.93
0604	8,057.10	9,211.90
0701	3,930.66	4,580.65
0702	5,022.21	5,852.92
0703	6,101.71	7,110.13
0704	7,104.71	8,278.78
0801	2,904.77	3,566.21
0802	3,604.76	4,425.23
0803	4,496.31	5,519.19
0804	5,322.20	6,533.03
0805	5,746.90	7,054.10
0806	7,087.24	8,699.26
0901	3,365.61	4,045.72
0902	4,602.94	5,533.04
0903	5,834.24	7,013.14
0904	7,315.55	8,793.23
1001	5,113.17	5,589.07
1002	6,733.63	7,360.73
1003	8,304.08	9,076.96
1101	3,671.63	4,511.37
1102	4,986.67	6,127.01
1103	6,562.55	8,063.73
1104	7,970.96	9,793.82
1201	3,593.32	4,124.63
1202	4,325.83	4,966.19
1203	5,530.63	6,349.30
1204	6,922.78	7,946.86
1301	3,570.42	4,131.86
1302	4,286.68	4,960.16
1303	6,295.08	7,284.82
1401	3,922.23	4,589.08
1402	5,425.21	6,347.49
1403	7,643.85	8,943.23
1501	4,663.18	5,016.18
1502	5,137.87	5,527.02
1503	7,153.50	7,695.06
1504	13,732.91	14,773.26
1601	3,705.36	4,405.35
1602	4,371.62	5,197.51
1603	5,858.34	6,964.95
1701	5,128.23	6,364.36
1702	8,239.02	10,225.14
1801	5,984.84	5,984.84
1802	12,387.15	12,387.15
1901	4,245.72	4,245.72
1902	6,555.92	6,555.92
1903	12,438.36	12,438.36
2001	3,018.02	3,375.85
2002	3,876.44	4,336.08
2003	4,498.72	5,031.85
2004	4,295.71	4,805.34
2005	5,149.92	5,760.15
2006	6,111.35	6,836.04
2007	6,022.80	6,736.64
2008	6,842.66	7,653.49
2009	7,518.55	8,409.50
2010	6,969.77	7,795.66
2011	8,974.56	10,038.39
2101	7,748.67	7,748.67
5001	1,149.38	1,149.38
5101	2,805.38	2,805.38
5102	6,492.06	6,492.06
5103	3,304.16	3,304.16
5104	9,052.26	9,052.26

G. Examples of Computing the Adjusted Facility Prospective Payments

The Federal prospective payments, described above, will be adjusted to account for geographic wage variation, disproportionate share and, if applicable, facilities located in rural areas.

To illustrate the methodology that we propose to use for adjusting the Federal prospective payments, we provide the following example. One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A has a disproportionate share adjustment of 1.0648, a wage index of 0.987, and is located in a rural area. Rehabilitation facility B has a disproportionate share amount of 1.1337, a wage index of 1.234, and is located in an urban area. Both Medicare beneficiaries are classified to CMG 0111 (without

comorbidity). This CMG represents a stroke with motor scores in the 78–61 range and the patient is 83 years old or younger. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment, and the rural adjustment (if applicable). Table 6E illustrates the components of the adjusted payment calculation.

TABLE 6E.—EXAMPLES OF COMPUTING A FACILITY'S FEDERAL PROSPECTIVE PAYMENT

		Facility A
Federal Prospective Payment (From Table 5E)	$11,822.70	$11,822.70
Labor Share (From Table 2E)	× .71301	× .71301
Labor Portion of Federal Payment	= $8,429.70	= $8,429.70
Wage Index (From Tables 3E or 4E)	× 0.987	× 1.234
Wage Adjusted Amount	$8,320.12	$10,402.25
Non-Labor Amount	+ $3,393.00	+ $3,393.00
Wage Adjusted Federal Payment	= $11,713.11	= $13,795.25
Rural Adjustment	× 1.1589	× 1.0000
Subtotal	= $13,574.33	= $13,795.25
DSH Adjustment	× 1.0648	× 1.1337
Total Adjusted Federal Prospective Payment	$14,453.94	$15,639.68

Thus, the adjusted payment for facility A will be $14,453.64 and the adjusted payment for facility B will be $15,639.68.

H. Computing Total Payments

As described in proposed § 412.626, for cost reporting periods beginning on or after April 1, 2001 and before October 1, 2001, payments will be based on 66⅔ percent of the facility specific payment and 33⅓ percent of the IRF adjusted facility Federal prospective payment. The facility specific payment is the amount the facility would have been paid if the prospective payment system had not been implemented. Medicare fiscal intermediaries will continue to compute the facility specific payment amount according to § 412.22(b) of the regulations and sections 1886(d) and (g) of the Act.

I. Method of Payment

A beneficiary will be classified into a CMG based on data obtained during the initial MDS–PAC assessment. The CMG will determine the Federal prospective payment the IRF will receive for the Medicare-covered Part-A services the IRF furnished during the Medicare beneficiary's episode of care. However, we are proposing, under § 412.632(a), that the payment be based on the submission of a discharge bill. This will allow us to account for the occurrence of an event during the stay which would result in a reclassification to one of the five special CMGs (for cases that expire or have a very short length of stay) or an adjustment to the payment to reflect an early transfer and determine if the case qualifies for an outlier payment. Accordingly, the CMG and other information to determine if an adjustment to the payment is necessary will be recorded by the IRF on the beneficiary's discharge bill and submitted to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under proposed § 412.622(b), for inpatient operating and capital costs, but not for the costs of an approved medical education program, bad debts, or other costs not paid for under the proposed IRF prospective payment system.

Under the current payment system, (1) An IRF may be paid using the periodic interim payment (PIP) method described in § 413.64(h) of the regulations, (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under § 412.116(b), and (3) IRFs may be eligible to receive accelerated payments as described in § 413.64(g) or for rehabilitation units under § 412.116(f). We presently see no reason to discontinue administratively our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, though we may choose to evaluate its continuing need in the future. Therefore, we are proposing to permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at proposed paragraphs (b) and (e) of § 412.632 of the regulations.

For those services paid under the PIP method, the amount is based on estimated prospective payments for the year rather than on estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in § 412.632 and receives approval by its intermediary. Likewise, if an intermediary determines that an IRF which received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in § 412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the regulations at § 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method it may qualify to receive an accelerated payment. Under § 412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. A request for an accelerated payment must be made by the IRF and approved by the intermediary and

HCFA. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment is made as bills are processed or by direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under proposed § 412.624(c)(3)(ii) of the regulations, future updates to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under the proposed IRF prospective payment system. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. A description of IRF market basket that we propose to use in developing an increase factor under section 1886(j)(3)(C) is found in Appendix D of this proposed rule.

VI. Provisions of the Proposed Rule

We are proposing to make a number of revisions to the regulations in order to implement the prospective payment system for inpatient rehabilitation facilities. We are proposing to make conforming changes in 42 CFR parts 412 and 413. We are proposing to establish a new subpart P in part 412, ''Prospective Payment for Inpatient Rehabilitation Facilities''. This subpart would implement section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. This subpart would set forth the framework for the inpatient rehabilitation facility prospective payment system, including the methodology used for the development of the payment rates and related rules. These revisions and others are discussed in detail below.

Section 412.1 Scope of Part

We are proposing to revise § 412.1 by redesignating paragraph (a) as paragraph (a)(1) and adding a paragraph (a)(2) that specifies that this part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services provided to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit for cost reporting periods beginning on or after April 1, 2001. As a result of our proposed changes to § 412.1, we would make a number of conforming changes to various sections of the regulations text. These changes include adding references to the inpatient hospital prospective payment systems as described in § 412.1(a)(1).

Currently, § 412.1(b) ''Summary of content'' describes the content of each subpart in part 412. To make this paragraph more user friendly, we would restructure the paragraph by dividing it into 12 subparagraphs. In addition, we would add references to § 412.1(a)(1)(where appropriate) and add a new subparagraph (b)(12) that summarizes the content of the new subpart P.

Section 412.20 Hospital Services to the Prospective Payment Systems

We propose to revise § 412.20 by revising paragraph (a) to add a reference to inpatient hospital prospective payment system, redesignating paragraph (b) as paragraph (c), and adding a new paragraph (b). Section 412.20(b) would specify that effective for all cost reporting periods beginning on or after April 1, 2001, the services furnished by an inpatient rehabilitation hospital or rehabilitation unit specified in § 412.604 are paid for under the prospective payment system described in subpart P. We would also add a reference to § 412.1(a)(1) to the introductory text of § 412.20(c).

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

We propose to revise §§ 412.22(a), (b), (e), and (h)(2) to add references to § 412.1(a)(1) or § 412.20 (b).

Section 412.23 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We propose to revise the introductory text of §§ 412.23 and 412.23(b)(2) to add references to § 412.1(a)(1) and (a)(2). We propose to revise the introductory text of paragraph (b) to add references to § 412.1(a)(1) and (a)(2). We proposed to revise paragraphs (b)(8) and (b)(9) to specify that in order to be classified as a rehabilitation hospital a patient assessment instrument must be completed in accordance with § 412.606 for each Medicare patient admitted or discharged on or after April 1, 2001.

Section 412.25 Excluded Hospital Units: Common Requirements

We propose to revise §§ 412.25(a) and (e)(2) to add references to § 412.1(a)(1).

Section 412.29 Excluded Rehabilitation Units: Additional Requirements

We propose to revise the introductory text of § 412.29 to add a reference to § 412.1(a)(1) and (a)(2).

Section 412.116 Method of Payments

We propose to restructure and revise paragraph (a) by creating paragraphs (a)(1) and (a)(2). New paragraph (a)(2) would be revised to specify that payments for inpatient hospital services furnished by an excluded psychiatric or rehabilitation unit (not paid under the provisions of subpart P of this part) are made as described in § 413.64(a), (c), (d) and (e) of this chapter. We also propose to add a new paragraph (a)(3) that specifies how payments for inpatient hospital services are made to a qualified IRF.

Section 412.130 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We would revise paragraphs (a)(1) and (a)(2) to add references to §§ 412.1(a)(1) and (a)(2). In addition, § 412.130 (a)(1) and (a)(2) would be revised to specify that for cost reporting periods on or after October 1, 1991, rehabilitation hospitals and units that were excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the inpatient rehabilitation prospective payment system, as a new rehabilitation hospital or unit will have its payments adjusted if the inpatient population actually treated in the hospital during the cost reporting period did not meet the requirements of § 412.23(b)(2). In § 412.130(b), we would add the provisions that specify that the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section for cost reporting periods beginning on or after April 1, 2001 as follows:

- The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1) for services furnished during that period.
- The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1).

Subpart P Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

We propose to reserve subparts N and O, and add a new subpart P.

Section 412.600 Basis and Scope of the Subpart

We are proposing to add a new § 412.600. Section 412.600(a) provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. In § 412.600(b), we would specify that this subpart sets forth the framework for the prospective payment system, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules for inpatient rehabilitation facilities for cost reporting periods beginning on or after April 1, 2001.

Section 412.602 Definitions

In § 412.602, we are proposing the following definitions for purposes of this new subpart:

- Assessment reference date;
- Authorized clinician;
- Discharge;
- Encode;
- Functional-related groups;
- Interrupted stay;
- MDS–PAC;
- Outlier payment;
- Rural area
- Transfer; and
- Urban area.

Section 412.604 Conditions for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities

In proposed § 412.604(a), we would specify that IRFs must meet the following general requirements to receive payment under the IRF prospective payment system:

- The IRF must meet the conditions of this section;
- If the IRF fails to comply with the provisions of the section then we can—
- Withhold (in full or in part) or reduce payment to the IRF; or
- Classify the IRF as an inpatient hospital subject to the inpatient hospital prospective payment system.

In proposed paragraph (b), we would specify that an IRF must meet the rehabilitation hospital or rehabilitation unit classification criteria set forth in §§ 412.22, 412.23(b) and 412.30 for exclusion from the inpatient hospital prospective payment system. In addition, we propose to specify that qualifying IRFs are subject to the payment provisions for the IRF prospective payment system.

Proposed paragraph (c) would specify that the IRF must complete a patient assessment instrument for each Medicare patient admitted or discharged on or after April 1, 2001.

Proposed paragraph (d) would specify the prohibited and permitted charges that can be imposed on Medicare beneficiaries. In proposed paragraph (d)(1), we would specify that an IRF may not charge a beneficiary for any services for which payment is made by Medicare, even if the IRF's costs are greater than the amount the facility is paid under the IRF prospective payment system. In addition, proposed paragraph (d)(2) would specify that an IRF receiving payment for a covered stay may charge the Medicare beneficiary or other person for only the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87.

Proposed paragraph (e) would specify the following provisions for furnishing IRF services directly or under arrangements:

- Applicable payments made under the IRF prospective payment system are in full for all inpatient hospital services (as defined in § 409.10) other than physicians' services to individual patients (as specified in § 415.102(a)) which are reimbursable on a reasonable cost basis.
- Payment is not made to a provider or supplier other than the IRF, except for physicians' services reimbursable under § 405.550(b) and the services of an anesthetist employed by a physician reimbursable under § 415.102(a).
- The IRF must furnish all necessary covered services to the Medicare beneficiary directly or under arrangements (as defined in § 409.3).

Lastly, proposed paragraph (f) would specify that IRFs must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24.

Section 412.606 Patient Assessments

In proposed § 412.606, we set forth the requirements regarding patient assessment. Proposed § 412.606(a) would specify that at the time each Medicare patient is admitted the facility must have physician orders for the patient's care during his or her hospitalization. Proposed § 412.606(b) would specify that MDS–PAC is the instrument used to assess Medicare inpatients who are admitted on or after April 1, 2001, or were admitted before April 1, 2001, and are still inpatients as of April 1, 2001. In proposed § 412.606(c), we would specify that an inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC. This assessment must be in accordance with the assessment schedule. A clinician must record appropriate and applicable data accurately and completely for each MDS–PAC item. The assessment process must include direct patient observation and communication with the patient; and when appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record and other sources. The authorized clinician must sign the MDS–PAC attesting to its completion and accuracy.

Section 412.608 Patients' Rights Regarding MDS–PAC Data Collection

Proposed § 412.608 specifies patient rights regarding MDS–PAC data collection. In proposed paragraph (a) we would specify the rights that a Medicare inpatient must be informed of by the IRF authorized clinician before an assessment can be performed. Proposed paragraph (b) would require the authorized clinician to document in the Medicare inpatient's clinical record that the patient was informed of the rights listed in paragraph (a). Proposed paragraph (c) specifies that the patient rights included in this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

Section 412.610 Assessment Schedule

In proposed § 412.610, we would specify the following:

- The start of the assessment schedule day count.
- The determination of the assessment reference date.
- The date when an MDS–PAC assessment reference is late.
- MDS–PAC completion and encoding dates.
- The accuracy of the MDS–PAC data.
- The length of time that an IRF has to retain MDS–PAC patient data sets.

Section 412.612 Coordination of MDS–PAC Data Collection

We proposed to add a new § 412.612. Paragraph (a) of this section would specify the responsibilities of the IRF's authorized clinician. Section 412.612(b) states that the IRF's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of section AB of the MDS–PAC. Proposed paragraph (c) specifies the signature requirements for any clinician who contributes data for an MDS–PAC item. Proposed paragraph (d) specifies the penalty for falsification of a patient assessment.

Section 412.614 Transmission of MDS–PAC Data

Proposed § 412.614 specifies the requirements for transmittal of MDS–PAC data that include the following:

- The format for submitting data.
- How the data is to be submitted.
- The timeframe for submitting data.
- The penalties for late transmission of data.

Section 412.616 Release of Information Collected Using the MDS–PAC

In proposed § 412.616, we specify that the IRF and its agents must ensure the confidentiality of the information collected using the MDS–PAC in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at § 482.24(b)(3). An IRF may release patient-identifiable information to an agent of the IRF only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purpose specified in the contract and only to the extent that the IRF itself is permitted to so under § 412.616(a).

Section 412.618 Interrupted Stay

In proposed § 412.618 (a), we specify that for purposes of the MDS–PAC assessment process, if a Medicare inpatient has an interrupted stay then the following applies:

- The initial case-mix group classification from the ''initial'' (Day 4) MDS–PAC assessment remains in effect.
- The required scheduled MDS–PAC Day 11, Day 30, Day 60, and discharge assessments must be performed.
- The authorized clinician must record the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.
- The recorded and encoded interrupted stay data must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to IRF. In proposed paragraph (d), we specify the revised assessment schedule. Proposed paragraph (d)(1) specifies that if the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the Medicare patient's interrupted stay. Proposed paragraphs (d)(2), (d)(3) and (d)(4), specify the provisions under which the Day 11, Day 30, and Day 60 are advanced in the same manner.

Section 412.620 Patient Classification System

Proposed § 412.620 specifies the classification methodology, weighting factors, and case-mix adjustments as they relate to the patient classification system.

Section 412.622 Basis of Payment

Proposed § 412.622(a), we would specify that under the prospective payment system, IRFs received a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries. This paragraph also specifies the basis for the amount of payment under the prospective system.

Proposed § 412.622(b) specifies that payments made under the prospective payment system represent payment in full for inpatient operating and capital costs associated with services furnished in an IRF, but not for the costs of an approved medical education program. Paragraph (b) also specifies the additional payments that an IRFs receive.

Section 412.624 Methodology for Calculating the Prospective Payment Rates

This proposed section specifies the methodology for calculating the prospective payment rates for IRFs. The items specified in this section are as follows:

- Proposed paragraph (a) specifies the data used to calculate the prospective payment rates;
- Proposed paragraph (b) specifies the methodology for calculating the Federal per discharge payment rates that includes—
- Determination of the per discharge payment rate; and
- Adjustments to the data.
- Proposed paragraph (c) specifies how the Federal prospective payment rates for IRFs will be determined. This includes the general rules, the update per discharge, the computation of the budget neutral conversion factor and the determination of the Federal prospective payment rate for each case-mix group.
- Proposed paragraph (d) specifies the adjustments to the budget neutral conversion factor. The adjustments include the following: (1) outlier payments; (2) budget neutrality; and (3) coding and classification changes.
- Proposed paragraph (e) specifies the calculation of the adjusted Federal prospective payment is computed for each discharge on the basis of the Federal prospective payment rate determined in paragraph (c) of this section and adjusted to account for area wage levels, payments for outliers, transfers, and other appropriate factors.

Section 412.626 Transition Period

Proposed § 412.626(a) specifies the duration of the transition period to IRF prospective payment system. It also specifies that IRFs will receive a payment that is comprised of a blend of the adjusted facility Federal prospective payment and the facility-specific payment. Proposed paragraph (b) specifies how the facility-specific payment is calculated.

Section 412.628 Publication of the Federal Prospective Payment Rates

Proposed § 412.628 specifies that we will publish information pertaining to the IRF prospective payment system effective for each fiscal year in the **Federal Register**. In addition, it specifies that the information regarding the IRF prospective payment system will be published on or before August 1 prior to the beginning of each fiscal year.

Section 412.630 Limitation on Review

Proposed § 412.630 specifies that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

Section 412.632 Method of Payment Under the Inpatient Rehabilitation Facility Prospective Payment System

Proposed § 412.632 specifies the method of payment under the inpatient rehabilitation facility prospective payment system. This section specifies the following:

- General rule for receiving payment, including exceptions;
- The requirements for periodic interim payments that include—
- Criteria for receiving periodic interim payments;
- Frequency of payments; and
- Termination of periodic interim payments;
- Interim payment for Medicare bad debts and for Part A costs not paid under the prospective payment system.
- Outlier payments.
- The requirements for accelerated payments that include—
- General rule regarding request for accelerated payments;
- Approval of request for accelerated payments;
- Amount of the accelerated payment; and

• Recovery of the accelerated payment.

Section 413.1 Introduction

We propose to revised § 413.1(d)(ii) to remove the reference to rehabilitation hospitals and units. We also propose to add a new § 413.1(d)(iv) that specifies that for cost reporting periods beginning on or before April 1, 2001, payment to rehabilitation hospitals and units that are excluded under subpart B of part 412 of this subchapter from the prospective payment system is on a reasonable cost basis in accordance with the provisions of § 413.40. In addition, we propose to add a new § 413.1(d)(v) that specifies that for cost reporting periods on or after April 1, 2001, payment to rehabilitation hospitals and units (as described in § 412.604) is based on the prospectively determined rates under the provisions of subpart P of part 412.

Section 413.40 Ceiling on the Rate of Increase in Hospital Costs

Section 413.40(a)(2)(i) specifies the types of facilities to which the ceiling on the rate of increase in hospital inpatient costs is not applicable. We propose to add a new paragraph § 413.40(a)(2)(i)(C) to specify that for cost reporting periods beginning on or after October 1, 2002, § 413.40 is not applicable to rehabilitation hospitals and rehabilitation units that meet the conditions for payment under § 412.604 and are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) and subpart P of part 412.

We propose to revise § 413.40(a)(2)(ii) and to add (a)(2)(iii) to specify the cost reporting periods under which rehabilitation hospitals and units that are excluded from the prospective payment system specified in § 412.1(a)(1) meet the terms of this section

Section 413.64 Payment to Providers: Specific Rules

We propose to revise § 413.64 to include hospitals paid under the IRF prospective payment system and add a reference to § 412.1(a)(1).

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and we will respond to the comments in the preamble to the final rule.

VIII. Regulatory Impact Analysis

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

• Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises to compete with foreign based enterprises in domestic and export markets.

We have examined the impacts of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), the Regulatory Flexibility Act (RFA) (Public Law 96–354), and EO 13132 (Federalism). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This proposed regulation would be a major rule because the aggregate amount of savings is estimated to be 1.54 billion dollars over 7 years.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, businesses include small businesses, non-profit organizations and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. Intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or Tribal governments, in the aggregate, or by the private sector, of at least $100 million. This rule will not have an effect on the governments mentioned nor will it affect private sector costs, rather, the proposed rule will affect Medicare payments.

In addition, we examined this rule in accordance with Executive Order 13132 and determined that this proposed rule would not have any negative impact on the rights, roles, or responsibilities of State, local, or Tribal governments.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

For these reasons, we are preparing analyses under the RFA and section 1102(b) of the Act because we determine, and we certify, that this proposed rule would have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. As discussed earlier in this preamble, we propose to adjust payments for facilities located in rural areas. Therefore, the impacts shown below reflect the adjustments that are designed to minimize or eliminate the negative impact that the prospective payment system would otherwise have on rural facilities.

A. Background

This proposed rule sets forth the prospective payments to be used to determine payments under the Medicare program for inpatient rehabilitation facilities.

While section 1886(j) of the Act specifies the basic methodology of constructing a case-mix adjusted prospective payment system, the statute does allow us some discretion in designing the key elements of the system, and we had some opportunity to consider alternatives for these elements. These include the patient assessment instrument, the patient classification methodology based on functional-related groups, and adjustments to the prospective payments. These elements, and alternatives that we considered, were discussed in detail earlier in the preamble of this proposed rule.

B. Anticipated Effects of This Proposed Rule

We discuss the impact of this proposed rule in terms of its fiscal impact on the budget and in terms of its

impact on providers. The estimated fiscal impact is discussed first.

1. Budgetary Impact

Under section 1886(j)(3)(B) of the Act, payment rates set forth in this proposed rule must be set at levels such that total payments under this prospective payment system are projected to equal 98 percent of the amount that would have been paid for operating and capital costs if this prospective payment system had not been implemented. The provision to implement the IRF prospective payment system is projected to save the Medicare program $1.54 billion over 7 years, as follows:

$60 million for FY 2001
$200 million for FY 2002
$220 million for FY 2003
$240 million for FY 2004
$250 million for FY 2005
$270 million for FY 2006
$300 million for FY 2007

2. Impacts on Providers

In order to understand the impact of the new prospective payment system on different categories of facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the proposed prospective payment system (proposed prospective payments). To estimate the impacts among the various classes of providers it is imperative that current payments and proposed prospective payments contain similar inputs. More specifically, we simulate proposed prospective payments only for those providers that we are able to calculate current payment. Further, we calculate current payment only for those providers that we are able to simulate proposed prospective payments.

As previously stated in section V. of this preamble, we have both case-mix and cost data for 624 rehabilitation facilities. Data from these facilities were used to analyze the appropriateness of various adjustments to the Federal unadjusted payment rates. However, for the impact analyses shown in the following tables, we simulate payments for 505 facilities. These impacts reflect the estimated losses/gains among the various classifications of providers for FY 2001. The methodology used to update the data to the midpoint of FY 2001, necessitated the use of historical cost report data to determine the relationship of the facilities' costs and target amount. Thus, the number of providers reflects only those providers for which we had cost report data available from FYs 1995, 1996, and 1997 (see discussion in section V.E.1. of this proposed rule).

3. Calculation of Current Payments

To calculate current payments, cost report data is trended forward from the midpoint of the cost reporting period to the midpoint of FY 2001 using the methodology set forth in section V. of this preamble. To estimate current payments, we calculate operating payments for each rehabilitation facility in accordance with section 1886(b). Further, we compute capital payments by reducing reasonable costs by 15 percent, consistent with section 1886(g)(4) of the Act, as added by section 4412 of the BBA. To determine each facility's average per discharge payment amount under the current payment system, operating and capital payments are added together, and then the total payment is divided by the number of Medicare discharges from the cost reports. Total payments for each facility are then computed by multiplying the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by the average per discharge payment amount.

4. Calculation of Proposed Prospective Payments

To estimate payments under the proposed prospective payment system, we multiply each facility's case-mix index by the facility's number of Medicare discharges, the budget neutral conversion factor, the applicable wage index, a disproportionate share adjustment, and a rural adjustment, (if applicable). The specific adjustments follow:

- The wage adjustment is calculated as (.2897 + (.7103 × Wage Index)),
- The disproportionate share adjustment is calculated as:

((.0001 + Disproportionate Share) raised to the power of .0905)/(.0001 raised to the power of .0905)),

- The rural adjustment, if applicable, is calculated by multiplying payments by 1.1589.

After the proposed Federal rate payments are calculated for each facility, the appropriate percentages of the current payments and the proposed Federal rate payments are blended together to determine the appropriate amount for the first three years of implementation of the IRF prospective payment system. Specifically, for cost reporting periods beginning on or after implementation of the prospective payment system through FY 2001 we combine 66⅔ percent of the current payment amount with 33⅓ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2002, we combine 33⅓ percent of the current payment amount with 66⅔ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2003, we show the impacts of the fully phased-in IRF prospective payment amount. All payment simulations reflect data trended to the midpoint FY 2001. These data were not trended out to the midpoint of FYs 2002 or 2003.

Tables 1G, 2G, and 3G illustrate the aggregate impact of the proposed payment system among various classifications of facilities. The first column, Facility Classifications, identifies the type of facility. The second column identifies the number of cases. The third column lists the number of facilities of each classification type, and the fourth column is the ratio of proposed prospective payments to current payments. The impacts reflect the adjustments that we propose, including the specific geographic wage adjustment, the adjustment for rural facilities (if applicable), and a disproportionate share adjustment for all facilities.

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.98
Other Urban	88232	238	0.98

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS—Continued

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
Rural	9814	49	1.00
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.98
South Atlantic	34845	79	0.99
East North Central	33018	120	0.98
East South Central	12344	26	1.00
West North Central	9175	44	0.98
West South Central	22995	73	0.95
Mountain	5659	25	0.96
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.98
Urban—South Atlantic	31314	72	1.00
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	0.99
Urban—West North Central	7979	36	0.98
Urban—West South Central	21929	64	0.95
Urban—Mountain	5349	22	0.96
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.01
Rural—Middle Atlantic	586	3	1.01
Rural—South Atlantic	3531	7	0.99
Rural—East North Central	2025	12	1.03
Rural—East South Central	495	2	1.09
Rural—West North Central	1196	8	0.98
Rural—West South Central	1066	9	0.96
Rural—Mountain	310	3	1.02
Rural—Pacific	487	4	0.97
Type and Size of Facility			
Unit of acute hospital	101518	398	0.99
Average Daily Census < 10	12962	102	0.98
Average Daily Census 10–24	51783	211	0.99
Average Daily Census > 24	36773	85	0.99
Freestanding hospital	65872	107	0.96
Average Daily Census less than 25	3527	18	0.96
Average Daily Census 25–50	19248	40	0.97
Average Daily Census greater than 50	43097	49	0.96
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.98
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	0.99
Missing	14379	28	0.97
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.98
Resident to ADC 10%–19%	7309	20	0.97
Resident to ADC greater than 19%	1267	11	0.97
Alaska/Hawaii	1099	2	0.99

TABLE 2G.—IMPACTS REFLECTING ⅔ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅓ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.01
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.01
East North Central	33018	120	0.98
East South Central	12344	26	1.01
West North Central	9175	44	0.98
West South Central	22995	73	0.93
Mountain	5659	25	0.94
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.01
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.01
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.93
Urban—Mountain	5349	22	0.93
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.04
Rural—Middle Atlantic	586	3	1.03
Rural—South Atlantic	3531	7	1.00
Rural—East North Central	2025	12	1.08
Rural—East South Central	495	2	1.20
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.95
Rural—Mountain	310	3	1.06
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.00
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.00
Average Daily Census > 24	36773	85	1.00
Freestanding hospital	65872	107	0.95
Average Daily Census less than 25	3527	18	0.93
Average Daily Census 25–50	19248	40	0.95
Average Daily Census greater than 50	43097	49	0.95
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.01
Missing	14379	28	0.96
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.96
Resident to ADC greater than 19%	1267	11	0.95
Alaska/Hawaii	1099	2	1.00

TABLE 3G.—IMPACTS REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.03
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.02
East North Central	33018	120	0.99
East South Central	12344	26	1.03
West North Central	9175	44	0.99
West South Central	22995	73	0.90
Mountain	5659	25	0.92
Pacific	9097	55	1.00
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.03
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.02
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.90
Urban—Mountain	5349	22	0.91
Urban—Pacific	8610	51	1.00
Rural by Region			
Rural—New England	118	1	1.07
Rural—Middle Atlantic	586	3	1.06
Rural—South Atlantic	3531	7	1.01
Rural—East North Central	2025	12	1.13
Rural—East South Central	495	2	1.31
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.93
Rural—Mountain	310	3	1.10
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.01
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.02
Average Daily Census > 24	36773	85	1.02
Freestanding hospital	65872	107	0.93
Average Daily Census less than 25	3527	18	0.91
Average Daily Census 25–50	19248	40	0.94
Average Daily Census greater than 50	43097	49	0.93
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	1.00
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.03
Missing	14379	28	0.94
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.95
Resident to ADC greater than 19%	1267	11	0.94
Alaska/Hawaii	1099	2	1.00

5. Costs Associated With The MDS-PAC

We propose that all IRFs furnishing Medicare-covered Part A services assess their Medicare patients using the standardized data set known as the MDS–PAC. Costs associated with MDS–PAC data collection and data reporting are related to both personnel and equipment. These two classes of costs include the costs associated with using the MDS–PAC to assess patients (MDS–PAC data collection costs), the IRF's costs to start the MDS–PAC process, and the IRF's ongoing costs after the MDS–PAC process has been initiated. It should be noted that many of the components of the costs associated with initiation of the MDS–PAC process and the IRF's ongoing costs are the same.

a. MDS–PAC Data Collection Costs

In calculating the cost to perform an MDS–PAC assessment we made the following assumptions: (1) That physicians, registered nurses, occupational therapists, or physical therapists are the only clinicians with the training to complete all, or the vast majority, of the MDS–PAC items. Other clinicians may contribute data to complete some MDS–PAC items. (2) That a physician would not record the data for all or most of the MDS–PAC items. We believe that the majority of the items would be completed by registered nurses, occupational therapists, or physical therapists.

We then applied the above assumptions to the following data:

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of registered nurses in 1998 were $40,690. That is equivalent to a median hourly wage of $19.56. ($40,690/52 weeks = $782.50/week. $782.50/40 hours = $19.5625).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of occupational therapists in 1998 were $48,230. That is equivalent to a median hourly wage of $23.19. ($48,230/52 weeks = $927.50. $927.50/40 hours = $23.1875).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of physical therapists in 1998 were $56,600. That is equivalent to a median hourly wage of $27.21. ($56,600/52 weeks = $1088.46/week. $1088.46/40 hours = $27.2115).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of dietitians and nutritionists in 1998 were $35,020. That is equivalent to a median hourly wage of $16.84. ($35,020/52 weeks = $673.46/week. $673.46/40 hours = $16.8365).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of social workers in 1998 were $30,590. That is equivalent to a median hourly wage of $14.71. ($30,590/52 weeks = $588.27/week. $588.27/40 hours = $14.7067).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of speech-language pathologists and audiologists in 1998 were $43,080. That is equivalent to a median hourly wage of $20.71. ($43,080/52 weeks = $828.46/week. $828.46/40 hours = $20.7115).

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 85 minutes to complete an initial intake assessment.

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 48 minutes to complete an update assessment.

• According to one external source IRF staff familiar with the UDSmr FIM required a median of 20 minutes to complete the initial FIM instrument.

• According to another external source IRF staff familiar with the FIM required a range of 30 to 45 minutes to complete the FIM instrument. It was not specified if this was the UDSmr or COS instrument. Also, although it was not specified, we believe that this range of time was the time to complete an initial FIM assessment.

• It should be noted that the information from both external sources concerning the length of time it takes to complete the FIM instrument has not been verified.

• Our data indicates that in 1997 there were 359,032 IRF admissions and 1,123 IRFs. Therefore, there were an average of 319.70 admissions per IRF.

Based on the above data and assumptions, and depending on the type of clinician that completes all, or the vast majority, of the MDS–PAC items, the range of the incremental average cost difference per year per IRF to complete the initial MDS–PAC when compared to the initial FIM is illustrated in Table 4G below. In addition, considering the hourly wage rates specified above it would make no difference in cost if a dietitian or social worker completed all or most of the MDS–PAC items, and only a slight difference at the low end of the range if a speech-language pathologist completed all or most of the MDS–PAC items.

TABLE 4G.—RANGE OF INCREMENTAL COST—COMPARISON OF THE INITIAL MDS–PAC TO THE INITIAL FIM

Range of hourly wages per clinician	Minimum incremental time of 40 minutes—range of Incremental Cost per IRF per year	Maximum incremental time of 65 minutes—range of incremental cost per IRF per year
$19.56 (R.N.)	$4,169.02	$6,774.61
23.19 (O.T.)	4,942.72	8,031.86
27.21 (P.T.)	5,799.54	9,424.18

We believe that the FIM data are inconclusive, and we have several concerns and observations regarding the data. The data from both external sources were collected from a survey of a sample of IRFs. We do not know the size of one of the samples, and if either sample is representative of all IRFs. We do not know if the data are estimates of time or controlled measurements of time. Nor do we know the details of the survey method that was used to collect the data. The data may be biased at the source where the data was collected, that is, the sources of the data may be reflecting institutionalized biases when reporting their data. In addition, the data was reported by organizations with vested interests in the FIM, and they may have used a different approach than the one we used in estimating completion time of an assessment instrument. For example, we do not know whether they measured only the time necessary to enter information on the FIM form or also included—(1) the time it took to obtain information from

the patient and/or clinical record; (2) the time it took to actually assess the patient; and (3) the time it took clinicians before filling out the FIM to apply clinical judgment, or to consult with other clinicians, or to examine the clinical record regarding their assessment observations. In addition, unlike the MDS–PAC estimates, the information from both external sources was survey information, instead of a controlled study. For the above reasons, when we conduct a test of the UDSmr, COS, and the MDS–PAC instruments we will include in the test measurements of the time it takes to complete each one.

Previously in this preamble we state that testing indicated that IRF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 48 minutes. SNF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 45 minutes.

Although we are proposing to require more items to be collected on an update assessment, the update assessment still requires less data collection than an initial assessment. Table 7C (found in section II of this preamble), entitled ''MDS–PAC Items Required by Type of Assessment,'' listed the items that we propose be collected on the Day 4 (admission), update (Day 11, Day 30, Day 60), and the discharge assessments. Counting the items in each column gives a simple total of the items required on each type of assessment. The update assessment requires that 85.2 percent of the items on the initial assessment be addressed on the update assessment. The discharge assessment requires that 87.5 percent of the items on the initial assessment be addressed on the discharge assessment. Consequently, we believe that the time required by IRF staff to complete an update MDS–PAC assessment is likely more than 48 minutes but less than the time it takes to complete the initial MDS–PAC assessment. We do not have data that specifically states the time it takes to complete a patient's discharge FIM, which, in essence, is the patient's update FIM. Therefore, we cannot currently compare MDS–PAC update or discharge assessment completion times to FIM update or discharge assessment completion times.

Most patients would require a Day 11 update assessment, because our data indicates that the mean length of stay is 15.81 days and the median length of stay is 14 days. Patients would also require a discharge assessment. But our data indicates that less than 9 percent of patients would require a Day 30 assessment, and less than ½ of one percent of patients would require a Day 60 assessment.

b. Start-Up Costs

The IRF's costs to start the MDS–PAC process consists of material costs and personnel costs. Our data indicates that in 1997 there were 1,123 IRFs. As presented in detail in Table 5G below entitled ''MDS–PAC IRF Start-up Costs'' we estimate that the costs for all IRFs to start the MDS–PAC process, excluding the MDS–PAC data collection costs discussed above, to be approximately $5,121,722 to $5,247,498, which is equal to approximately $4,561 to $4,673 per IRF.

The costs presented below are based on the profile of an average IRF, because certain costs are constant regardless of the size of the IRF. For both start-up costs and on-going costs, cost estimates are based on an assumption that IRFs would perform the encoding and transmission functions themselves.

TABLE 5G.—MDS–PAC IRF START-UP COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff per IRF to be trained	Total per IRF	National costs
Hard drive, printer, RAM, MODEM, Internet Browser.		$0 [a]		$0 [a]	None
Training on MDS–PAC data collection at initial assessment, update assessment, discharge assessment, and data auditing.	16	PT [b] $27/hr; OT [b] $23/hr; RN [b] $20/hr	1 [c]	PT [d] $432; OT [e] $368; RN [f] $320	$359,360–$485,136 [g]
	12	$23/hr (average cost of the 3 disciplines)	9 [h]	$2,484 [i]	$2,789,532 [j]
Data Entry (encoding/transmission) training.	5.5	$12.50/hr [k]	1	$68.75 [l]	$77,206.25 [m]
Data Entry	96 [n]	$1,200 [o]		$1,200	$1,347,600 [p]
Data Entry Audits [q]		$38 [r]		$38	$42,674 [s]
Data Transmissions—Staff time.	1	$150 [t]		$150	$168,450 [u]
Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.					
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Total					$5,121,722–$5,247,498

[a] We believe that all IRFs have the computer capability to process the MDS–PAC-related software.

[b] These are the 1998 median hourly wages for these occupations based on the US Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition.* We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training.

[c] We expect the IRF to send a lead clinician to a HCFA sponsored training session and then that lead clinician would train the other IRF clinicians.

[d] 16 × $27.

[e] 16 × $23.

[f] 16 × $20.
[g] 1,123 × $320 to 1,123 × $432.
[h] This number represents the average number of clinicians per IRF that would require training. These clinicians would be trained in their facility.
[i] 12 hrs × $23/hr × 9 staff=$2,484.
[j] 1,123 × $2,484.
[k] We estimate that the hourly wage for data entry personnel is $12.50 per hour.
[l] 5.5 hrs × $12.50.
[m] 1,123 × $68.75.
[n] The average total of admissions per year per IRF is a approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.
[o] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1200.
[p] 1,123 × $1200.
[q] We estimate a 15 minute monthly data entry audit for quality assurance purposes.
[r] $12.50 hr/4 × 12 months=$37.50 per year.
[s] 1,123 × $38.
[t] 1 hr × 12 (mos.) × $12.50/hr.
[u] 1,123 × $150.

Note: We anticipate that the IRFs will designate a lead licensed clinician to attend all training. That lead clinician would then provide training to other IRF staff.

(1) Computer Hardware and Software

Because we will supply to the IRFs free of charge the MDS–PAC software that performs the MDS–PAC process electronic functions, the IRFs will incur no software costs. We believe that IRFs possess the computer hardware capability to handle the MDS–PAC computerization, data transmission, and grouper software requirements. Our belief is based upon indications that—(1) Approximately 99 percent of hospital inpatient claims currently are submitted electronically; (2) close to 100 percent of IRFs submit their cost reports electronically; and (3) approximately 55 percent of IRFs submit FIMs electronically. Although we will supply the MPACT software, IRFs may incur costs, which we are not able to estimate, associated with making changes to their information management systems to incorporate the MPACT software. Therefore, we are specifically soliciting comments regarding MDS–PAC computerization issues.

IRFs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing) or other regulatory requirements for reporting patient information. However, we are developing an MDS–PAC data system (that is, MPACT) that would be available to IRFs at no charge through our website. MPACT would allow users to computerize their MDS–PAC assessment data and transmit the data in a HCFA-standard format to the HCFA MDS–PAC system. Therefore, IRFs that plan to use MPACT will need Internet access and a dial-up Internet Service Provider account in order to be able to download and install MPACT into their computer system. We believe that all IRFs currently have the capability to access the Internet. However, we are specifically soliciting comments from any IRFs that do not possess Internet access capability, in order for us to consider if we should make MPACT available to these facilities by some other means.

(2) Training

IRF staff will require training in performing MDS–PAC assessments, encoding assessments, preparing MDS–PAC data for electronic submission, and actually transmitting the data. We believe that the initial training of IRF personnel would require about 75.5 hours of staff time. We estimate training to cost an IRF approximately $1,242 for training of clinical staff, based on an average hourly payroll rate of $23 for licensed clinical staff. We estimate training to cost an IRF approximately $69 for training data entry staff, based on an average hourly payroll rate of $12.50 for data entry staff.

(3) Data Entry

IRFs have flexibility in choosing the data entry software used to computerize the MDS–PAC data, but the software must, at a minimum, perform the MPACT functions. In addition, when IRFs are performing data entry functions themselves, or contracting for the performance of these functions, the IRFs must ensure that performance of data entry complies with our requirement for safeguarding the confidentiality of clinical records.

IRFs must collect and transmit MDS–PAC data to the HCFA MDS–PAC system in accordance with the assessment schedule and transmission requirements specified elsewhere in this preamble. The data may be entered by an IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs must allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system. We estimate that an average IRF will incur a cost of an hourly rate for data entry of $12.50. This cost includes data review and entry, as well as a (recommended) 15 minute monthly data entry audit for quality assurance purposes.

(4) Data Transmission

MDS–PAC data would be transmitted to the HCFA MDS–PAC system. This system is similar to the ones that HHAs use to report OASIS data and that SNFs use to report MDS 2.0 data. IRF staff must also manage the data transmission function, correct transmission problems, and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program. This staff time will cost an average-sized IRF about $150 per year based on an hourly rate of $12.50. IRFs will be able to transmit the MDS–PAC data using the toll-free MDCN line.

(5) Systems Maintenance

There are costs associated with normal maintenance related to computer equipment, such as the replacement of disk drives or memory chips. Typically, this maintenance is provided through warranty agreements with the original equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than $100 per year IRF.

(6) Supplies

Supplies necessary for collection and transmission of data, including forms, diskettes, computer paper, and toner, will vary according to the size of the IRF, the number of patients served, and the number of assessments conducted.

We anticipate that an average IRF with approximately $200 in costs for supplies.

c. Ongoing Costs

We wanted to differentiate between one-time start-up costs for the IRF and costs we believe the IRFs will incur on a regular, yearly basis. Therefore, Table 6G entitled ''Agency Ongoing Costs'' include only data that we consider will be a repeated cost to the IRF.

TABLE 6G.—MDS–PAC IRF ONGOING COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff	Total per IRF	National costs
Data Entry	96[a]	$1,200[b]		$1,200	$1,347,600[c]
Data Entry Audit(d)		$38[e]	1	$38	$42,674[f]
Data Transmissions—Staff time Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.	1	$150[g]		$150	$168,450[h]
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Annual Training:					
Clinical	12	$20–27/hr[i]	1	$240–$324[j]	$269,520–$363,852[k]
Data Entry	12	12.50/hr[l]	1	$150[m]	$168,450[n]
Clinical[o]	2	$20–27/hr.	9	$360–$486	$404,280–$545,778
Total					$2,737,874–$2,973,704

[a] The average total of admissions per year per IRF is approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.

[b] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1,200.

[c] 1,123 × $1,200.

[d] We estimate a 15 minute monthly data entry audit for quality assurance purposes.

[e] $12.50 hr/4 × 12 months=$37.50 per year.

[f] 1,123 × $38.

[g] 1 hr × 12 (mos.) × $12.50/hr.

[h] 1,123 × $150.

[i] Based on the 1998 U.S. Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition,* the median hourly wage for an RN is $20, $23 for an OT, and $27 for a PT. We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training. We expect that the IRF will send one discipline specific clinician to a HCFA sponsored training session and then that individual would train the other IRF clinicians.

[j] 12 hours × $20 to 12 hours × $27.

[k] 1,123 × $240 to 1,123 × $324.

[l] We estimate that the hourly wage for data entry personnel is $12.50 per hour.

[m] 12 hours × $12.50.

[n] 1,123 × $150.

[o] This entry represents the average annual cost of IRF in-house training for the MDS–PAC.

Our data indicates that in 1997 there were 1,123 IRFs. Therefore, we estimate annual ongoing costs for an average-sized IRF, excluding MDS–PAC data collection costs discussed previously, to be approximately $2,438 to $2,648.

d. Conclusion

As discussed in detail above, IRFs will incur costs associated with the MDS–PAC process. Table 7G below is a further analysis of these costs.

TABLE 7G.—MDS–PAC COST PER CASE

[Based on IRFs currently completing a FIM instrument]

	Percent of MDS–PAC items completed	Maximum incremental clinician (physical therapist) cost per IRF (from table 4G)	Total incremental maximum cost per IRF (Col. 2 times Col. 3)	Average maximum incremental cost per case (Col. 4 divided by 320 average admissions per IRF)
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Assessment Type:				
Initial	100.00	$9,424.18	$9,424.18	$29.45
Update	[1] 85.20	9,424.18	8,029.40	25.09
Discharge	[2] 87.50	9,424.18	8,246.16	25.77
Average Estimated Cost to Complete MDS–PAC	.....	.....	25,699.74	80.31
Estimated Maximum MDS–PAC Start-up Cost per IRF [3]	.....	.....	4,673.00	14.60
Total Estimated Maximum first year Cost	.....	.....	30,372.74	94.91

[1] Assumes the time to complete each MDS–PAC item weighted equally at 1.000.

[2] Same as footnote 1.

[3] This amount is based on the maximum costs shown in Table 5G divided by 1,123 IRFs. This amount will decline after the first year of implementation to reflect the ongoing costs shown in Table 6G.

We assessed the relationship between the estimated cost of completing the MDS–PAC with an estimate of the average cost of one RIC. For analysis we used RIC 7: Hip Fractures. This RIC has an estimated average cost of $9,848 (based upon secondary analysis of data from 1996 and 1997 MEDPAR and cost reports). We compared the assumed cost for completing the initial, update and discharge assessments using the MDS–PAC. We found that the average maximum incremental cost per case of completing the MDS–PAC for one year, assuming the completion of three assessments represents approximately 0.008 per cent of the cost of the estimated average cost of RIC 7. We used a single RIC for comparison because there is a large variation of cost across RICs. We believe that the estimated costs of completing the MDS–PAC are well justified when considered within the context of the statutory requirement and the methodology needed to implement the IRF prospective payment system, the probability that the MDS–PAC process will lead to increased quality of care for IRF patients, as well as the potential uses of the automated data by the IRFs themselves, the States, fiscal intermediaries, and HCFA. Our cost estimates may actually overstate anticipated costs, because they do not take into account cost-savings that IRFs may achieve by improving their management information systems, as well as potential improvements in the quality of patients' clinical care resulting from improved care planning under the MDS–PAC assessment process.

C. Alternatives Considered

We propose to use the MDS–PAC as the patient assessment instrument instead of the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used by approximately 56 percent of the IRFs. But these patient assessment instruments are not as precise in assessing patients as the MDS–PAC, because they do not collect as much detailed data as the MDS–PAC. For example, the MDS–PAC provides a better description of a patient's cognitive functioning (the processing of empirical factual concepts) than these other assessment instruments. The MDS–PAC is also better at assessing a patient's mood and behavior patterns, measures of a patient's emotional and psychological status. Nor do these other assessment instruments allow for collecting patient assessment data in sufficient detail to allow us to develop the IRF quality of care monitoring system that we need. In addition, we believe that neither of these other patient assessment instruments permits a comparison of patients across different settings of post-acute care as recommended by MedPAC.

In constructing our proposed assessment schedule we decided not to use the patient assessment schedules associated with the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used to assess patients only upon admission and discharge. We believe that the data provided by our update assessments would yield the type of structured data that we can use to monitor the quality of treatment being furnished. We also propose not to use the FIM items exactly as they are contained in the patient assessment instruments of UDSmr or COS, or the MDS–PAC with the FIM payment items pasted in exactly as contained in the patient assessment instruments of UDSmr or COS. These two approaches were not selected as they would not support HCFA's long-term quality monitoring strategy nor the goal to establish a common core post-acute care assessment instrument. In addition, we propose not to collect only the assessment items that would be used to generate a case-mix group determined payment rate, because these few items do not provide the scope of information needed to monitor access to care, quality of care, and to determine if future adjustments to the payment system are needed.

However, as we discussed earlier in the preamble, the process for arriving at the number of elements on the MDS–PAC was based on a consensus of clinical expert panels, which focused on the scope of elements necessary to support both quality monitoring and payment. Similarly, our proposed assessment schedule, including the number of assessments performed, was designed to meet both payment and quality monitoring objectives of the MDS–PAC. Alternatives to the approaches we have proposed in this rule could include either a reduction in the number of elements on the instrument or in the number of assessments performed while maintaining the MDS–PAC's ability to facilitate both payment and comprehensive quality monitoring. We are specifically requesting comments on these facets of the patient assessment methodology.

In accordance with the provisions of Executive Order 12866 this regulation was reviewed by the Office of Management and Budget.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506 (c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the sections that contain information collection requirements (ICRs).

Section 412.23 Excluded Hospitals: Classifications

- Paragraph (b)(2) requires that, except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, the entity show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more specified conditions.
- Paragraph (b)(8) requires that a hospital seeking classification under this paragraph as a rehabilitation hospital, for the first 12-months cost reporting period that occurs after it becomes a Medicare participating hospital, may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this

section, instead of showing that it has treated this population during its most recent 12-month cost reporting period.

The information collection requirements of these two paragraphs of this section are currently approved under OMB approval number 0938–0358 (Psychiatric Unit Criteria Work Sheet, Rehabilitation Hospital Criteria Work Sheet, Rehabilitation Unit Criteria Work Sheet) through November 30, 2000. The proposed changes to the information collection requirements in these two paragraphs are clarifying changes.

Section 412.116 Method of Payment

Under 412.116 (b), *Periodic interim payments,* a hospital that meets the criteria in § 413.65(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph.

The burden associated with this provision is the time it takes a hospital to write its request for periodic interim payments. We estimate that 34 facilities would request these payments and that it would take each 1 hour to write and mail its request.

Sections 412.606 Patient Assessment and 412.610(c) Assessment Schedule

• Paragraph (a) of § 412.606 requires that at the time each Medicare patient is admitted the facility must have physician orders for the patient's immediate care.

This requirement is subject to the PRA. However, we believe that the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with the requirement are incurred by persons in the normal course of their activities.

• Paragraph (c) of § 412.606, *Comprehensive assessments,* requires that an IRF clinician initially and periodically perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare patient using the MDS–PAC as the patient assessment instrument and that the assessment process must include—

• Direct patient observation and communication with the patient; and

• When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, and the patient's clinical record and other sources.

• Section 412.610(c), *Assessment reference dates,* requires assessments upon admission (Day 4); Day 11, Day 30, and Day 60; upon discharge or when the patient stops receiving part A benefits.

In 1997, there were approxiamtely 359,000 admissions to IRFs and there are 1,123 facilities, averaging 320 admissions annually. We estimate that it would take 85 minutes for the initial assessment and at least 48 minutes for each subsequent assessment.

Under these proposed rules, all Medicare beneficiaries would be assessed two times: upon admission and upon discharge. Sixty-six percent would be assessed on the 11th day as well. Fewer than 9 percent of Medicare beneficiaries in IRFs would also be assessed at 30 days. Fewer than ½ of a percent would require an assessment at 60 days.

Below is a chart showing burden.

Type of assessment	Estimated time for completion (in minutes)	Hours per year per facility (in hours)	Hours per year nationwide (in hours)
Admission (Day 4)	85	453	508,719
Day 11	48	169	189,787
Day 30	48	23	25,829
Day 60	48	1	1,123
Discharge	48	256	287,488
Total/Facility (5 assessment)		902	1,012,946

The total ongoing annual burden for all facilities for five assessments would be 902 hours × 1,123 or 1,012,946 hours.

We are also including training in our burden estimates: 16 hours to train the lead clinician and 12 hours to train the other clinicians (an average of 9). This totals 121,284 nationally for a one-time burden. We also estimate an on-going burden for training of 14 hours per IRF per year (15,722 nationally).

Section 412.608 Patient Rights Regarding MDS–PAC Data Collection.

Under paragraph (a) of this section, before performing an assessment of a Medicare inpatient using the MDS–PAC, an IRF clinician must inform the Medicare inpatient of the following patient rights:

• The right to be informed of the purpose of the MDS–PAC data collection;

• The right to have the MDS–PAC information collected kept confidential and secure;

• The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

• The right to refuse to answer MDS–PAC questions; and

• The right to see, review, and request changes on his or her MDS–PAC assessment.

Under paragraph (b) of this section, the IRF must ensure that the authorized clinician document in the patient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

In accordance with paragraph (c) of this section, the patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

We anticipate adding the burden of disclosure to IRF patients and documenting that disclosure to the burden in § 412.13 on hospitals furnishing a patient rights statements. The hospitals would be able to easily give both statements to patients upon admission, along with other required notifications. The burden for the general patient rights statement has not yet been approved but is under development. We have estimated that it would take each hospital 5 minutes to disclose the general hospital statement to each patient on admission. The disclosure of the IRF patients' rights statement would increase that time by an estimated 2 minutes.

Section 412.610 Assessment Schedule

Paragraph (g), *MDS–PAC record retention,* of this section requires that an IRF maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

We estimate that, for facilities that choose to file a paper copy, it would

take the facility 5 minutes to print out, or copy, each assessment and file it in the patient's record. On average, each facility would need to obtain a copy of and file 882 assessments per year, equaling 74 hours. We cannot estimate how many facilities would choose to file paper copies. However, we are assuming that most facilities would choose to retain the assessments in an electronic format, which would not add to the paperwork burden. We request comments on the accuracy of this assumption concerning how many facilities will comply by retaining an electronic version.

Section 412.612 Coordination of MDS–PAC Data Collection.

Paragraph (b), *Certification,* of this section requires that the authorized clinician who has done at least part of the assessment certify the accuracy and completion date by signing and dating the appropriate lines of section AB of the MDS–PAC.

We estimate that it would take the authorized clinician approximately 10 minutes per assessment to determine to his or her satisfaction that the assessment is complete and to so certify. Eight hundred eighty-two assessments would equal 147 hours per year per facility, and 165,081 hours nationally.

Paragraph (c) of this section requires that any clinical who contributes data for an MDS–PAC item sign and date the appropriate lines of the MDS–PAC.

Under the definition of information in 5 CFR 1320.3(h)(1), ''information'' does not include such items as affidavits, oaths, affirmations, certifications, consents or acknowledgments, provided that they do not entail any burden other than that necessary to identify the respondent, the date, and the respondent's address. We believe that the signatures required by § 412.610(c) are acknowledgments identifying the signers (as persons furnishing a service) and are not information.

Section 412.614 Transmission of MDS–PAC Data

Paragraph (a), *Data format,* of this section requires that each IRF encode and transmit data—

- Using the computer program(s) available from HCFA; or
- Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

In accordance with paragraph (b), *How to transmit data,* of this section, each IRF must—

- Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and
- Transmit data using electronic communications software that provides a direct telephone connection from the IRF to the HCFA MDS–PAC system.

IRFs would have to collect and transmit MDS–PAC data to the HCFA MDS—PAC system. The data may be entered by a IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs would have to allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system.

We estimate that an average IRF with 320 admissions per year will require 3 minutes for data review and entry per assessment for up-front review and another 3 minutes for data entry review for a total of 6 minutes. The burden of transmitting the data is contained in that 6 minutes. The yearly burden would be 96 hours per facility. (This burden also includes recommended 15 minute monthly data entry audit for quality assurance purposes.)

Other Data Transmission Functions

In addition to the burden of managing the data transmission function, IRF staff will have to correct transmission problems and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program.

We estimate that it will require a one-time burden of 5.5 hours per hospital to train the personnel to be able to complete data transmission tasks. With 1,123 facilities, the national burden would be 6177 hours.

Section 412.616 Release of Information Collected Using the MDS–PAC

Under paragraph (b) of this section, a facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and to the extent the facility itself is permitted to do so under § 412.616(a).

The burden associated with this ICR is the time required to include the necessary information in the contract. While this ICR is subject to the PRA, we believe the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 412.618 Interrupted Stay

Paragraph (a) of this section requires that if a patient has an interrupted stay the facility must record interrupted stay data on the MDS–PAC interrupted stay tracking form.

We currently have no data on the incidence of interrupted stays. We estimate, however, that it would take no more than 5 minutes to complete a form. We request comments on the burden that completion of this form might impose.

Submission to OMB

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 412.23, 412.29, 412.116, and 412.606 through 412.618. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: Julie Brown HCFA–1069–P.

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, HCFA Desk Officer.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is proposed to be amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. Section § 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with § 413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of § 412.604.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after April 1, 2001.

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after April 1, 2001, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising the introductory text of paragraph (h)(2).

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified

in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and § 412.20(b), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2):

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in § 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130.

* * * * *

6. In § 412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems specified in § 412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) *Satellite facilities.* * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

7. In § 412.29, the introductory text is revised to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

8. In § 412.116, paragraph (a) is revised to read as follows:

§ 412.116 Method of payment.

(a) *General rule.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before April 1, 2001) are made as described in § 413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after April 1, 2001, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of § 412.604 are made as described in § 412.632.

* * * * *

9. In § 412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* * * *

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system

specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

* * * * *

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

Subparts N and O—[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§ 412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632 is added to read as follows:

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

§ 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 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 April 1, 2001, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities 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 MDS–PAC assessment process that sets the designated endpoint of the common 3 day patient observation period, with most MDS–PAC assessment items usually referring back in time from this endpoint.

Authorized clinician means one of the following clinicians:

(1) An occupational therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(2) A physical therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(3) A physician who is a doctor of medicine or osteopathy and is licensed to practice medicine and surgery by the State in which the function or action is performed.

(4) A registered nurse as defined in § 484.4 of this chapter.

Discharge A Medicare patient in a inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released; or

(2) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized MDS–PAC 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 the period 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 3 consecutive calendar days begin with the day of discharge.

MDS–PAC stands for the Minimum Data Set for Post Acute Care, a patient clinical assessment instrument.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Rural area means an area as defined in § 412.62(f)(1)(iii).

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 an area as defined in § 412.62(f)(1)(ii).

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) 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 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 beneficiaries, HCFA 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.* An inpatient rehabilitation facility must meet 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 patient admitted or discharged on or after April 1, 2001, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606.

(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.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) The applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter, other than physicians' services to individual patients reimbursable on a reasonable cost basis (in accordance with the criteria of § 415.102(a) of this subchapter).

(2) HCFA does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b) of this chapter and services of an anesthetist employed by a physician reimbursable under § 415.102(a) of this subchapter.

(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) *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.

§ 412.606 Patient assessment.

(a) *Admission orders.* At the time that each Medicare patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the MDS–PAC instrument to assess Medicare inpatients who—

(1) Are admitted on or after April 1, 2001; or

(2) Were admitted before April 1, 2001, and are still inpatients as of April 1, 2001.

(c) *Comprehensive assessments.* (1) An inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility must record appropriate and applicable data accurately and completely for each MDS–PAC item.

(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, friends, the patient's clinical record, and other sources.

(4) The authorized clinician, must sign the MDS–PAC attesting to its completion and accuracy.

§ 412.608 Patient rights regarding MDS–PAC data collection.

(a) Before performing an assessment using the MDS–PAC, an authorized clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the MDS–PAC data collection;

(2) The right to have the MDS–PAC information collected be kept confidential and secure;

(3) The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer MDS–PAC questions; and

(5) The right to see, review, and request changes on his or her MDS–PAC assessment.

(b) The inpatient rehabilitation facility must ensure that an authorized clinician documents in the Medicare inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13 of this chapter.

§ 412.610 Assessment schedule.

(a) *General.* For each Medicare inpatient an inpatient rehabilitation facility must submit MDS–PAC assessment data 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 Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the MDS–PAC assessment schedule.

(c) *Assessment reference dates.* With respect to the patient's current hospitalization, an inpatient rehabilitation facility must indicate on the MDS–PAC one of the following assessment reference dates:

(1) *Day 4 MDS–PAC assessment.* For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization, the date that is the 3rd calendar day after the patient started being furnished Medicare-covered Part A services.

(2) *Day 11 MDS–PAC assessment.* For the assessment that covers calendar days 8 through 10 of the patient's current hospitalization, the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

(3) *Day 30 MDS–PAC assessment.* For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization, the date that is the 30th calendar day after the patient

started being furnished Medicare-covered Part A services.

(4) *Day 60 MDS–PAC assessment.* For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization, the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.

(5) *Discontinuation of Medicare-covered Part A services assessment.* For the assessment that is completed when the inpatient is not discharged from the inpatient rehabilitation facility but stops receiving Medicare-covered Part A services, the actual date that the inpatient stops receiving Medicare-covered Part A services.

(6) *Discharge assessment.* For the assessment that is completed when the Medicare inpatient is discharged from the inpatient rehabilitation facility, the actual date of discharge from the inpatient rehabilitation facility.

(d) *Late MDS–PAC assessment reference date.* If the MDS–PAC assessment reference date is entered later than the assessment reference date specified in paragraph (c)(1) of this section, the MDS–PAC assessment reference date is considered late.

(1) If the MDS–PAC assessment reference date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(2) If the MDS–PAC assessment reference date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

(e) *Completion and encoding dates.* (1) The Day 4, Day 11, Day 30, and Day 60 MDS–PAC assessments must be completed 1 calendar day after the MDS–PAC assessment reference date that is recorded on the MDS–PAC.

(2) The discharge MDS–PAC assessment must be completed on the 5th calendar day in the period beginning with the MDS–PAC assessment reference date.

(3) All MDS–PAC assessments must be encoded by the 7th calendar day in the period beginning with the MDS–PAC completion date that is recorded on the MDS–PAC.

(f) *Accuracy of the MDS–PAC data.* The encoded MDS–PAC assessment data must accurately reflect the patient's clinical status at the time of the MDS–PAC assessment.

(g) *MDS–PAC record retention.* An inpatient rehabilitation facility must maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

§ 412.612 Coordination of MDS–PAC data collection.

(a) *Responsibilities of the authorized clinician.* An inpatient rehabilitation facility's authorized clinician who has participated in performing an MDS–PAC patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the patient's MDS–PAC assessment; and

(2) The accuracy of the date inserted in the attestation section of the MDS–PAC.

(b) *Certification.* An inpatient rehabilitation facility's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of the MDS–PAC.

(c) *Signatures.* Any clinician who contributes data for an MDS–PAC item must sign and date the appropriate lines of the MDS–PAC.

(d) *Penalty for falsification.* (1) Under Medicare an individual who knowingly and willfully—

(i) Certifies a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§ 412.614 Transmission of MDS–PAC data.

(a) *Data format.* The inpatient rehabilitation facility must encode and transmit data for each Medicare inpatient—

(1) Using the computerized version of the MDS–PAC available from HCFA; or (2) Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the HCFA MDS–PAC system.

(c) *Transmission dates.* All MDS–PAC assessments must be transmitted to HCFA MDS–PAC system by the 7th calendar day in the period beginning with the last permitted MDS–PAC encoding date.

(d) *Late transmission penalty.* (1) HCFA assesses a penalty when an inpatient rehabilitation facility does not transmit the required MDS–PAC data to the HCFA MDS–PAC system in accordance with the transmission timeframe in paragraph (c) of this section.

(2) If the actual MDS–PAC transmission date is later than the transmission date specified in paragraph (a) of this section the MDS–PAC data is considered late.

(i) If the MDS–PAC transmission date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(ii) If the MDS–PAC transmission date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

§ 412.616 Release of information collected using the MDS–PAC.

(a) *General.* An inpatient rehabilitation facility may release information from the MDS–PAC only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ 412.618 Interrupted stay.

For purposes of the MDS–PAC assessment process, if a Medicare patient has an interrupted stay the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the Day 4 MDS–PAC assessment remains in effect (that is, no new Day 4 MDS–PAC assessment is performed).

(2) The required scheduled MDS–PAC Day 11, Day 30, and Day 60 assessments must be performed.

(3) When the patient is discharged, a discharge MDS–PAC assessment must be performed.

(b) *Recording and encoding of data.* The authorized clinician must record

the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.

(c) *Transmission of data.* The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to the inpatient rehabilitation facility.

(d) *Revised assessment schedule.* (1) If the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission dates for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(2) If the interrupted stay occurs after the Day 4 assessment and before the Day 11 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 11 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(3) If the interrupted stay occurs after the Day 11 and before the Day 30 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 30 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(4) If the interrupted stay occurs after the Day 30 and before the Day 60 assessment then the assessment reference date, completion date, encoding date, and data transmission date for the Day 60 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For the purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from Day 4 assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(b) *Weighting factors.* (1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* HCFA will determine a weighting factor or factors for patients that are discharged and not transferred within a number of days from admission as specified by HCFA.

(3) *Patients who expire.* HCFA will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by HCFA.

(c) *Revision of case-mix group classifications and weighting factors.* HCFA may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following—

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter, and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities HCFA uses—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, used to estimate payments for inpatient operating and capital costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2000.* HCFA determines the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2000 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2000.

(c) *Determining the Federal prospective payment rates*—(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments and other adjustments.

(2) *Update the cost per discharge.* (i) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2001. Based on the updated cost per discharge, HCFA estimates the payments that would have been made to the facility for fiscal year 2001 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(ii) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's fiscal year 2001 cost per discharge determined under paragraph (c)(2)(i) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, HCFA estimates the

payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the budget neutral conversion factor.* The budget neutral conversion factor is computed as follows:

(i) *For fiscal years 2001 and 2002.* Based on the updated costs per discharge and estimated payments for fiscal years 2001 and 2002 determined in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, HCFA computes a budget neutral conversion factor for fiscal years 2001 and 2002, as specified by HCFA, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section including adjustments, described in paragraph (d) of this section, as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the budget neutral conversion factor.* The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* HCFA determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* HCFA adjusts the Federal prospective payment rates for fiscal years 2001 and 2002 so that aggregate payments under the prospective payment system are estimated to equal 98 percent of the amount that would have been made to inpatient rehabilitation facilities under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* HCFA adjusts the budget neutral conversion factor for a given year if HCFA determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate determined under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(2) *Adjustments for low income patients.* HCFA adjusts the Federal prospective payment, on a facility basis, for the proportion of low income patients that receive inpatient rehabilitation services as determined by HCFA.

(3) *Adjustments for rural areas.* HCFA adjusts the Federal prospective payment by a factor, as specified by HCFA, to account for the higher costs per patient in facilities located in rural areas as defined in § 412.602.

(4) *Adjustment for high cost outliers.* HCFA provides for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels, and factors to account for treating low income patients and for rural locations) as specified by HCFA. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount.

(5) *Adjustments related to the MDS–PAC.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made if—

(i) The assessment reference date identified on the MDS–PAC as described in § 412.610(d) is late; and

(ii) The transmission of MDS–PAC data as described in § 412.614(d) is late.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care,; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for non-transfer cases in the case-mix group to which the patient is classified.

(2) HCFA calculates the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for non-transfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the unadjusted payment amount.

(iii) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(ii) of this section.

§ 412.626 Transition period.

(a) *Duration of transition period and proportions of the blended transition rate.* (1) For cost reporting periods beginning on or after April 1, 2001 through fiscal year 2002, inpatient rehabilitation facilities receive a payment comprised of a blend of the adjusted Federal prospective payment, as determined in § 412.624(e) or § 412.624(f) and, a facility-specific payment as determined in paragraph (b) of this section.

(i) For cost reporting periods beginning on or after April 1, 2001 and before fiscal year 2002, payment is based on 66⅔ percent of the facility-specific payment and 33⅓ percent of the adjusted Federal prospective payment.

(ii) For cost reporting periods beginning in fiscal year 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted Federal prospective payment.

(2) For cost reporting periods beginning with fiscal year 2003 and after, payment is based entirely on the adjusted Federal prospective payment.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

§ 412.628 Publication of the Federal prospective payment rates.

HCFA publishes information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, inpatient rehabilitation facilities receive payment under this subpart for inpatient operating costs and capital costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.* (1) *Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP*—(i) *Request by the inpatient rehabilitation facility.* Subject to paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable

cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding paragraph (a)(2)(iii).

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§ 412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before April 1, 2001, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

* * * * *

Subpart E—Payments to Providers

4. In § 413.64 paragraph (h)(2)(i) is revised to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement*—* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 18, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 29, 2000.

Donna E. Shalala,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendix A—Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data file used to develop the proposed IRF prospective payment system. A general description of the process to create this data file is contained in section II of this proposed rule. RAND has performed the following analysis to match UDSmr, COS, and HCFA data files.

Table A shows that for 1996 and 1997, the MEDPAR files had over 12 million records per year. We are interested in a subset of these records: cases paid by Medicare as rehabilitation stays that were exempt from the acute care hospital PPS.

TABLE A.—NUMBER OF MEDPAR CASES AND FACILITIES

Calendar year	No. of cases	No. of facilities
1996	12,231,275	6,339
1997	12,263,463	6,257

Table B shows total 1996 and 1997 rehabilitation stays by type of provider (free-standing rehabilitation facility versus excluded unit of an acute care hospital). This was the ''sampling'' frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining ''complete'' records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would reflect the composition of the frame.

TABLE B.—NUMBER OF REHABILITATION MEDPAR CASES AND FACILITIES

Calendar year/type	No. of cases	No. of facilities
1996:		
Excluded unit	229,193	877
Free-standing	114,933	204
Total	344,126	1,081
1997:		
Excluded unit	240,491	911
Free-standing	118,541	212
Total	359,032	1,123

Note: Free-standing facilities have characters 3–6 of the Medicare provider number in the range 3025–3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a ''provider code'' of T in their MEDPAR records.

Table C shows the number of facilities and the number of UDSmr and COS records for calendar years 1996 and 1997.

TABLE C.—NUMBER OF UDSMR/COS RECORDS AND FACILITIES

Calendar year	Source	No. of records	No. of facilities
1996	UDSmr	225,069	533
	COS	44,478	159
1997	UDSmr	258,915	595
	COS	67,350	164

Matching MEDPAR and UDSmr/COS Facilities

The first step in the matching process is to link MEDPAR facilities to UDSmr/COS facilities. For each of these combinations, RAND counted the number of exact matches of MEDPAR and UDSmr/COS records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our UDSmr/COS datasets is slightly more than half of all IRFs.

TABLE D.—NUMBERS OF UDSMR/COS FACILITIES LINKED TO MEDPAR FACILITIES

Calendar year/source	MEDPAR Unique [1]	MEDPAR Multiple [2]	Non-Rehab [3]	Total
1996:				
UDSmr	501	10	22	533
COS	67	8	84	159
1997:				
UDSmr	557	15	23	595
COS	68	18	78	164

[1] UDSmr/COS IRFs that appear to have a single MEDPAR provider.
[2] UDSmr/COS IRFs that appear to have more than one MEDPAR provider.
[3] UDSmr/COS IRFs that appear to be SNFs or long term care hospitals.

The UDSmr/COS data do not contain the Medicare beneficiary identifier, and therefore it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

(1) Identify match variables;

(2) Recode certain UDSmr/COS variables to be consistent with MEDPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;

(3) Run a match algorithm to link UDSmr/COS and MEDPAR records; and

(4) Choose a single MEDPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility identifier pairings was performed. For free-standing facilities, an attempt was made to match all MEDPAR records to a UDSmr record.

For MEDPAR, in addition to facility identity, 6 variables were used to link the records: Admission date, discharge date, zip code, age at admission, sex, and race. For UDSmr/COS, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payor was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create Additional UDSmr/COS Files

COS's coding of interrupted stays is similar to Medicare's: One record per rehabilitation episode; therefore, these records did not require any additional processing. UDSmr, however, codes multiple stays via a series of ''transfer/return'' dates on a single UDSmr record. To facilitate matching UDSmr and MEDPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records were then given the same chance of matching MEDPAR records as any non-interrupted stay. For both UDSmr and COS files, there were some duplicate cases.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MEDPAR.

TABLE E.—NUMBER OF UDSMR/COS RECORDS AT VARIOUS STAGES OF PROCESSING

Calendar year/source	No. of records		
	Original	After expansion	After duplicate elimination
1996:			
UDSmr	225,069	232,076	231,003
COS	44,478	44,478	44,375
1997:			
UDSmr	258,915	267,444	266,288
COS	67,350	67,350	67,082

Step 3: Match Discharges from MEDPAR and UDSmr/CareData

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect—any variable can be in error. A scoring function is developed, based on Bayes' Theorem, which gives the odds of a match based on how consistent variables tend to be for true matching and non-matching cases. A score of 2.00 or above has a high probability of identifying a match. The match statistics reported below assume that cutoff.

Step 4: Choose a Single MEDPAR Case for Multiple UDSmr/COS Matches

While the matching was unique within a facility/provider pair, some MEDPAR providers were paired with different facilities, as shown in Table F. Also, some UDSmr and COS facilities were the same: 6 overlaps in 1996, 7 in 1997.

TABLE F.—MEDPAR FACILITIES PAIRED WITH MULTIPLE FACILITIES

Source	Calendar year	No. of facilities
UDSmr	1996	5
UDSmr	1997	8
COS	1996	5
COS	1997	10

First, MEDPAR duplicate links were eliminated within each file, and then duplicate links were eliminated between UDSmr and COS files all within the same years. In all cases, the highest scores were kept. Table G provides results for cutoff score 2.0.

TABLE G.—NUMBER OF LINKED RECORDS AFTER DUPLICATION ELIMINATION

Calendar year/source	No. of Records, Cutoff Source ≥2.0			
	Multiple paired providers (a)	Total records	Duplicates eliminated (b)	Overlap eliminated (c)
1996:				
UDSmr	5	163,509	162,850	162,692
COS	5	27,664	27,630	26,197
1997:				
UDSmr	8	185,567	184,431	183,960
COS	10	42,219	41,980	38,722

Note: (a) Number of MEDPAR providers paired with more than one UDSmr/COS facility. (b) Multiple pairings can link the same MEDPAR record to more than one UDSmr/COS case. This step eliminates those multiple links, keeping the link with the highest match score. (c) the same MEDPAR provider might show up in both UDSmr and COS, again allowing the same MEDPAR record to match more than one UDSmr/COS case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: UDSmr, COS, and MEDPAR. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these UDSmr/COS facilities for the eligible RPPS population to be almost 90 percent. This was slightly higher than expected—the Carter, Relles, *et al.* (1997) match rates were about 86 percent.

TABLE H.—MEDPAR MATCH RATES, PROVIDERS WITH A FULL YEAR OF DATA

Source	Calendar year	MEDPAR cases	Matched cases	Percent matched
UDSmr	1996	155,502	136,056	87.5
UDSmr	1997	175,807	156,520	89.0
COS	1996	7,157	6,354	88.8
COS	1997	36,774	33,549	91.2

Note: Tabulations are for patients eligible for IRFPPS.

The UDSmr/COS.com files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Restricting our attention to just these cases, we obtain the percentages shown in Table I.

TABLE I.—UDSMR/COS MATCH RATES FOR MEDICARE AS THE PRIMARY PAYER

Source	Calendar year	UDS/COS cases	Matched cases	Percent matched
UDSmr	1996	160,125	153,926	96.1
UDSmr	1997	179,179	171,885	95.9
COS	1996	28,767	26,857	93.4
COS	1997	44,172	41,168	93.2

Note: UDSmr/COS cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MEDPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in free-standing facilities differed from costs in excluded units of acute care hospitals, we would consider re-weighting the sample of linked cases to adjust our total cost estimates.

Representativeness of Linked MEDPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the UDSmr/COS file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare beneficiaries, and the extent to which UDSmr/COS patients are representative of all Medicare IRFPPS-eligible patients. This analysis reflects the effects of the partial-year sample available for some UDSmr/COS facilities as well as the sampling of MEDPAR facilities. The MEDPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into free-standing rehabilitation facilities (free-standing rehab) and excluded rehabilitation units of acute-care hospitals (excluded units). It presents the number of facilities in the linked MEDPAR sample, along with the total MEDPAR counts of rehabilitation patients at these facilities.

TABLE J.—COMPARISON OF NUMBER OF UDSMR/COS AND MEDPAR REHABILITATION FACILITIES, BY TYPE

Type of facility	1996			1997		
	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS
Number of rehab facilities:						
Free-standing rehab	130	204	64	142	212	67
Excluded unit	435	877	50	489	911	54
Total	565	1,081	42	631	1,123	56
Number of rehab patients:						
Free-standing rehab	86,301	114,933	75	94,327	118,541	80
Excluded unit	130,623	229,193	57	150,787	240,491	63
Total	216,924	344,126	63	245,114	359,032	68

[1] Hospitals with at least one linked MEDPAR/UDSmr/COS rehabilitation record.
[2] Total (matched and unmatched) rehabilitation cases.

As shown in Table J, UDSmr/COS slightly over-represents free-standing rehabilitation facilities and slightly under-represents excluded units. The table also indicates UDSmr/COS's tendency to include larger facilities. In 1997, UDSmr/COS facilities represented 47 percent of the facilities, but served almost 70 percent of all MEDPAR IRF cases. Based on data found in the table, in 1997, UDSmr/COS free-standing facilities had an average of 792 patients, 532 more than other-MEDPAR free-standing facilities, and UDSmr/COS excluded units had an average of 365 patients, 185 more than other-MEDPAR excluded units.

Table K shows the distribution of UDSmr/COS IRFs by size. This shows both that free-standing facilities are larger than excluded units, and that UDSmr/COS IRFs tend to be larger than other MEDPAR facilities within type of facility.

TABLE K.—COMPARISON OF SIZES OF UDSMR/COS AND MEDPAR FACILITIES, BY TYPE OF FACILITY

No. of MEDPAR patients	1996				1997			
	Free-standing		Excluded Unit		Free-standing		Excluded Unit	
	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR
1–100	2	23	30	97	4	24	33	105
101–200	14	9	139	140	14	7	143	126
201–300	14	2	105	102	11	5	123	103
301–400	14	10	59	48	17	9	65	40
401–500	8	8	38	27	12	7	52	29
501–1000	56	16	58	26	59	15	67	18
1001–2000	20	6	6	2	24	3	6	1
2001–3000	1	0	0	0	0	0	0	0
3001–4000	1	0	0	0	1	0	0	0
Total	130	74	435	442	142	70	489	422

Table L shows that there are some UDSmr/COS facilities in each region, although the southeast and mountain States appear to be slightly under represented.

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
AL	7,135	7,839	91	8,338	8,654	96
AK	136	247	55	153	302	51
AR	2,829	6,581	43	3,338	6,973	48
AZ	2,261	3,672	62	2,334	4,084	57
CA	8,108	15,294	53	7,899	15,559	51
CO	1,306	4,757	27	2,786	4,263	65
CT	1,521	2,217	69	2,024	2,290	88
DC	133	1,097	12	104	996	10
DE	1,061	1,399	76	985	1,361	72
FL	17,143	23,021	74	18,734	23,630	79
GA	6,115	9,615	64	7,014	10,716	65

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE—Continued

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
HI	1,087	1,087	100	1,016	1,016	100
IA	1,264	1,264	100	1,404	1,404	100
ID	1,781	1,829	97	1,773	1,807	98
IL	8,044	14,953	54	9,191	14,894	62
IN	5,330	8,943	60	5,349	8,884	60
KS	874	3,224	27	786	3,333	24
KY	3,859	5,198	74	4,083	5,201	79
LA	3,338	9,206	36	5,071	10,061	50
MA	4,532	8,765	52	5,748	8,631	67
MD	667	867	77	574	715	80
ME	130	1,255	10	1,047	1,460	72
MI	13,470	16,523	82	14,090	17,255	82
MN	1,115	2,048	54	1,554	2,112	74
MO	3,349	9,788	34	4,414	10,513	42
MS	1,701	1,968	86	1,747	2,021	86
MT	878	878	100	766	766	100
NC	6,325	7,123	89	7,752	8,771	88
ND	1,564	1,821	86	1,356	1,636	83
NE	1,094	1,195	92	1,008	1,107	91
NH	1,320	2,310	57	1,442	2,505	58
NJ	10,010	11,234	89	10,637	11,083	96
NM	364	1,283	28	452	1,277	35
NV	0	2,230	0	0	2,303	0
NY	7,905	21,431	37	11,618	22,875	51
OH	8,992	11,837	76	10,175	13,888	73
OK	3,238	6,356	51	4,100	6,949	59
OR	824	1,179	70	728	1,184	61
PA	23,437	36,989	63	24,806	35,700	69
RI	1,379	2,247	61	1,517	2,307	66
SC	3,758	4,536	83	4,200	4,878	86
SD	1,684	2,096	80	1,702	2,101	81
TN	7,574	10,731	71	8,477	11,917	71
TX	19,498	33,619	58	22,551	36,616	62
UT	369	858	43	610	984	62
VA	4,924	6,738	73	5,628	7,235	78
VT	446	603	74	412	567	73
WA	3,726	3,753	99	3,584	3,608	99
WI	5,741	6,591	87	6,201	6,690	93
WV	3,480	3,497	100	3,553	3,574	99
WY	105	334	31	283	376	75
Total	216,924	344,126	63	245,114	359,032	68

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched UDSmr/COS sample. Of all the characteristics examined, the UDSmr/COS sample of discharges appears very similar.

TABLE M.—PATIENT CHARACTERISTICS FOR MEDPAR REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Patient characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0–50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51–60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61–70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71–80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81–90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked UDSmr/COS stays with those for other Medicare rehabilitation patients. Average length of stay for UDSmr/COS cases is the same as for non-UDSmr/COS patients. However, for cases in free-standing hospitals, UDSmr/COS stays consume fewer resources: LOS and total charges are about 10 percent less.

TABLE N.—COMPARISON OF RESOURCE USE FOR MEDICARE REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Hospitalization characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
All hospitals:						
Sample size	171,626	172,500	344,126	206,032	153,000	359,032
Length of Stay (days)	16.20	16.20	16.20	15.70	15.70	15.70
Daily therapy charges	$360.00	$351.00	$355.00	$379.00	$368.00	$374.00
Total therapy charges	$5,960.00	$5,829.00	$5,894.00	$6,064.00	$5,924.00	$6,004.00
Total charges	$18,013.00	$18,790.00	$18,403.00	$18,348.00	$19,287.00	$18,748.00
Freestanding hospitals:						
Sample size	65,349	49,584	114,933	82,393	36,148	118,541
Length of Stay (days)	18.0	18.9	18.4	17.8	19.2	18.2
Daily therapy charges	$360.00	$387.00	$371.00	$384.00	$406.00	$391.00
Total therapy charges	$6,652.00	$7,605.00	$7,063.00	$7,002.00	$8,064.00	$7,325.00
Total charges	$19,443.00	$21,214.00	$20,207.00	$20,202.00	$22,541.00	$20,915.00

Note: UDSmr/COS case totals count matched cases, hence differ from Table J which counts matched and unmatched cases.

Appendix B: Variables Suggested for Exclusion from the MDS–PAC Instrument

During the pilot and field testings of versions 7–9 of the MDS–PAC, a number of assessors (Registered Nurses, Physical Therapists, or Occupational Therapists) were asked to rate which items on the MDS–PAC they would suggest dropping. Based on these findings, the MDS–PAC no longer includes 104 items that were originally field tested in Version 8 of the instrument. The table below describes the percentage of assessors by facility type (rehabilitation hospital or skilled nursing facility) who recommended dropping each of the MDS–PAC items displayed in the table. The table is broken down by the type of facility in which the assessor was employed. The items in the table below are the majority of the items that are now in the version of the MDS–PAC found in Appendix BB.

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A1A	First Name	0	8.3
A1B	Middle Initial	0	8.3
A1C	Last Name	0	8.3
A1D	Jr/Sr	0	8.3
A3	Reason for Assessment	5.9	2.0
A5A	Medical Stabilization	5.8	10.0
A5B	Rehab/Functional Improvement	4.7	4.0
A5C	Recuperation	12.8	18.0
A5D	Monitor to Avoid Clinical Complication	9.2	6.0
A5E	Palliative Care	18.6	6.0
A6	Admitted from	6.5	4.8
A7A	Time of Onset of Precipitating Event	15.4	33.3
A7B	Reason Most Recent Acute Care Hospitalization	8.6	10.0
A8A	Primary Payment Source for Stay	2.3	4.0
A8B	Secondary Payment Source for Stay	5.7	8.2
A9	Marital Status	4.7	4.2
AA10	Gender	0	2.0
AA11	Birthdate	0	8.3
AA12A	American Indian/Alaskan Native	12.0	16.7
AA12B	Asian	12.0	16.7
AA12C	Black or African-American	12.0	16.7
AA12D	Native Hawaiian or Other Pacific Islander	12.0	16.7
AA12E	White	12.0	16.7
AA12F	Hispanic or Latino	15.4	16.7
AA13	Date of Reentry	12.9	14.3
A10	Education	10.3	6.0
A11A	Primary Language	1.2	2.0
A11B	Other Language	2.4	2.0
A12	Dominant Hand	9.2	50.0
A13	Mental Health History	12.3	4.9
A14	Conditions Related to MR/DD Status	12.5	25.0
A15A	Legal Guardian	7.5	5.0
A15B	Other Legal Oversight	7.5	5.0
A15C	Durable Power of Attorney/Health	7.5	5.0
A15D	Patient Responsible for Self	7.5	5.0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A16A	Living Will	11.5	2.0
A16B	Do Not Resuscitate	13.8	0
A16C	Do Not Hospitalize	16.1	4.1
A16D	Other Treatment Restrictions	13.8	2.0
A16E	None of the above	12.6	2.0
AA2A	Date of Entry	3.1	0
AA4	Assessment Reference Date	0	0
AA6A	Social Security #	3.4	0
AA6B	Medicare #	0	0
AA7	Medical Record &num	2.3	0
AA8A	State #	6.9	2.0
AA8B	Federal #	4.7	0
AA9	Medicaid #	1.2	0
B1	Comatose	14.8	0
B2A	Short-term Memory Ok	0	2.0
B2B	Long-term Memory Ok	0	2.0
B2C	Situational Memory Ok	8.2	0
B2D	Procedural Memory Ok	5.9	0
B3A	Decisions Regarding Tasks of Daily Life	2.3	0
B3B	Status Compared to 30 Days Ago	6.9	24.5
B4A	Easily Distracted	5.7	0
B4B	Periods of Altered Perception	5.7	2.0
B4C	Episodes of Disorganized Speech	5.7	4.1
B4D	Periods of Restlessness	5.7	2.0
B4E	Periods of Lethargy	6.1	0
B4F	Mental Function Varies over Course of Day	7.4	0
C1	Hearing	3.4	0
C2A	Hearing Aid	4.5	0
C2B	Lip Reading	4.9	0
C2C	Signs/Gestures/Jokes	5.7	0
C2D	Message to Express Needs	4.5	0
C2E	None of the Above	4.5	0
C3A	Expressing Information Content	1.1	22.4
C3B	Status Compared to 30 Days Ago	8.0	2.0
C2	Speech Clarity	0	0
C5A	Verbal Content	0	0
C5B	Status Compared to 30 Days Ago	7.0	22.4
C6A	See in Adequate Light W/Glasses	1.2	0
C6B	More Impaired in Vision	7.4	22.5
D1A	Patient Made Negative Statements	3.8	0
D1B	Persistent Anger W/Self or Others	3.8	0
D1C	Expressions of Unrealistic Fears	11.5	0
D1D	Repetitive Anxious Complaints	7.7	0
D1E	Repetitive Health Complaints	11.5	0
D1F	Sad, Pained, Facial Expressions	7.7	0
D1G	Crying, Tearfulness	3.8	0
D1H	Repetitive Physical Movements	11.5	0
D1IS	Insomnia/change in Sleep Patterns	3.8	0
D1J	W/draw from Activities of Interest	11.5	0
D1K	Reduced Social Interaction	7.7	0
D2	Mood Persistence	4.8	5.0
D3A	Wandering—Freq	3.4	0
D3B	Verbal Abuse Behavior—Freq	4.6	0
D3C	Physical Abuse Behavior—Freq	3.4	2.1
D3D	Social Inappropriate Behavior—Freq	3.4	2.1
D3E	Resists Care—Freq	3.4	0
E10AA	Leg—Joint	4.7	4.2
E10AB	Voluntary Motor Control Leg	5.1	2.6
E10AC	Intact Touch Leg	7.6	10.3
E10BA	Arm-Joint	4.7	4.2
E10BB	Voluntary Motor Control Arm	5.1	2.6
E10BC	Intact Touch Arm	7.6	10.3
E10CA	Trunk & Neck—Joint	7.0	4.2
E10CB	Vol. Motor Control—Trunk & Arm	7.6	2.6
E10CC	Intact Touch Trunk & Arm	8.9	10.3
E1A	Bed Mobility—3 Days	2.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
E1B	Transfer Bed/Chair—3 Days	2.4	2.0
E1C	Locomotion—3 Days	2.4	2.0
E1D	Walk in Corridor—3 Days	4.7	4.1
E1E	Dressing Upper Body—3 Days	2.4	0
E1F	Dressing Lower Body—3 Days	2.4	0
E1G	Eating—3 Days	2.4	0
E1H	Toilet Use—3 Days	2.4	0
E1I	Transfer Toilet—3 Days	2.3	4.1
E1J	Personal Hygiene—3 Days	2.3	0
E1K	Bathing—3 Days	2.4	0
E1L	Transfer Tub/shower—3 Days	4.7	4.1
E3	ADL Areas Now More Impaired	4.0	16.7
E4A	Meal Preparation—Now	4.5	23.4
E4C	Phone Use—Now	10.2	25.5
E4D	Medication Management—Now	4.5	31.9
E4E	Stairs—Now	4.5	23.4
E4F	Car Transfer—Now	5.7	23.4
E5	IADL Areas Now More Impaired	3.8	16.7
E6A	Cane/Crutch	0	0
E6B	Walker	2.3	0
E6C	Wheeled—Not Motorized	2.5	0
E6D	Adaptive Eating Utensil	0	9.1
E6E	Mechanical Lift	3.4	2.2
E6F	Orthotics/Prosthesis	0	18.2
E6G	Postural Support	3.4	2.2
E6H	Slide Board	3.4	2.2
E6I	Other Adaptive Device	2.3	2.2
E6J	None of Above	2.5	2.7
E7A	Hours of Physical Activity—past 24 Hrs	6.5	45.0
E7B	Hours of Physical Activity—30 Days Ago	29.4	50.0
E8A	Distance Walk W/o Sit Down—Consistently	4.6	6.3
E8B	Walking Support Provided	11.1	25.6
E9A	Moved from Seated to Standing	8.0	2.1
E9B	Turned Around Face Opposite Direction	14.8	8.3
F1A	Control of Urinary Bladder	0	0
F1B	Continence Compared to 30 Days Ago	4.5	22.4
F2A	External Catheter	1.1	0
F2B	Indwelling Catheter	2.3	4.1
F2C	Intermittent Cath	2.5	0
F2F	Pads, Briefs	3.7	0
F4	Bowel Continence	1.1	2.0
F5	Bowel Appliances	2.5	0
G2A	Diabetes Mellitus	0	8.3
G2AA	A Multiple Sclerosis	0	8.3
G2AB	Parkinson's Disease	0	8.3
G2AC	Quadriplegia	0	8.3
G2AD	Seizure Disorder	0	8.3
G2AE	Spinal Cord Dysfunction—Nontraumatic	0	8.3
G2AF	Spinal Cord Dysfunction—Traumatic	0	8.3
G2AG	Stroke	0	8.3
G2AH	Anxiety Disorder	0	8.3
G2AI	Depression	0	8.3
G2AJ	Other Psychiatric Disorder	0	8.3
G2AK	Asthma	0	8.3
G2AL	COPD	0	8.3
G2AM	Emphysema	0	8.3
G2AN	Cancer	4.2	8.3
G2AO	Post Surgery—Non Orthopedic	4.2	8.3
G2AP	Renal Failure	0	8.3
G2AQ	None of Above	0	8.3
G2B	Hypothyroidism	0	8.3
G2C	Cardiac Arrhythmias	0	8.3
G2D	Congestive Heart Failure	0	8.3
G2E	Coronary Artery Disease	0	8.3
G2F	Deep Vein Thrombosis	0	8.3
G2G	Hypertension	0	8.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
G2H	Hypotension	0	8.3
G2I	Peripheral Vascular Disease	0	8.3
G2J	Post Acute MI	0	8.3
G2K	Post Heart Surgery	0	8.3
G2L	Pulmonary Embolism	0	8.3
G2M	Pulmonary Failure	0	8.3
G2N	Other Cardiovascular Disease	0	8.3
G2O	Fracture—Hip	0	8.3
G2P	Fracture—Lower Extremity	0	8.3
G2Q	Fracture(s)—Other	0	8.3
G2R	Osteoarthritis	0	8.3
G2S	Osteoporosis	0	8.3
G2T	Rheumatoid Arthritis	0	8.3
G2U	Alzheimer's Disease	0	8.3
G2V	Aphasia or Apraxia	0	8.3
G2W	Cerebral Palsy	0	8.3
G2X	Dementia Other than Alzheimer's	0	8.3
G2Y	Hemiplegia/Hemiparesis	0	8.3
G3A	Antibiotic Resistant Infection	0	2.0
G3B	Cellulitis	0	2.5
G3C	Hepatitis	1.2	2.0
G3D	HIV/AIDS	1.2	2.0
G3E	Pneumonia	0	2.0
G3F	Osteomyelitis	0	2.0
G3G	Septicemia	1.2	2.0
G3H	Staphylococcus Infection	1.2	4.1
G3I	Tuberculosis (Active)	1.2	2.0
G3J	Urinary Tract Infection	0	2.0
G3K	Wound Infection	0	2.0
G3L	None of Above	0	2.0
G4AA	ICD–9–CM Diagnosis Code #1	10.8	4.2
G4AB	ICD–9–CM Code #1	8.4	4.2
G4BA	ICD–9–CM Diagnosis Code #2	10.8	4.2
G4BB	ICD–9–CM Code #2	8.4	4.2
G4CA	ICD–9–CM Diagnosis Code #3	11.0	4.2
G4CB	ICD–9–CM Code #3	8.5	4.2
G4DA	ICD–9–CM Diagnosis Code #4	11.0	4.2
G4DB	ICD–9–CM Code #4	8.5	4.2
G4EA	ICD–9–CM Diagnosis Code #5	12.2	4.2
G4EB	ICD–9–CM Code #5	9.8	4.2
H1	Vital Signs	4.6	12.5
H2A	Dizziness/Vertigo/Lightheaded	1.1	0
H2B	Fell in past 7 Days	1.1	4.1
H2C	Fell in past 8 to 180 Days	7.7	0
H3D	Advanced Cardiac Failure	9.1	10.2
H2E	Chest Pain/Pressure on Exertion	1.1	2.0
H2F	Chest Pain/Pressure at Rest	1.1	2.0
H2G	Edema—Generalized	1.1	2.0
H2H	Edema—Localized	2.3	2.0
H2I	Edema—pitting	3.4	2.1
H2J	Impaired Aerobic Capacity	3.4	2.0
H2K	Constipation	1.1	0
H2L	Dehydrated	3.4	0
H2M	Diarrhea	1.1	0
H2N	Internal Bleeding	3.8	0
H2O	Recurrent Nausea/Vomiting	2.3	0
H2P	Refuse/Inability to Take Liquids Orally	6.8	0
H2R	Fever	4.5	0
H2S	Hemi-neglect	4.5	0
H2T	Cachexia (Severe Malnutrition)	6.8	0
H2U	Morbid Obesity	3.4	0
H2V	End-stage Disease	4.5	0
H2W	None of Above	0	0
H3A	Inability to Lie Flat—Loss of Breath	2.3	0
H3B	Shortness of Breath—Exertion	3.4	0
H3C	Shortness of Breath—Rest	3.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
H3D	Oxygen Saturation	3.4	2.0
H3E	Diff Cough/clearing Airway	3.4	0
H3F	Recurrent Aspiration	2.3	0
H3G	Recurrent Aspiration Infection	4.9	0
H3H	None of Above	3.5	0
H4A	Highest Pressure Ulcer Stage	2.3	0
H4B	# of Current Pressure Ulcers	2.4	0
H4C	Length Multiplied by Width	4.7	12.2
H4D	Exudate Amount	4.7	12.2
H4E	Predominant Tissue	4.7	12.2
H4F	Total Push Score	4.7	10.4
H5A	# of Stasis Ulcers	3.4	0
H5B	# of Surgical Wounds	3.4	0
H5C	Ulcer Resolved/Healed	8.4	6.1
H6A	Burns	2.3	2.0
H6B	Open Lesions Excluding Foot	2.3	0
H6C	Rashes	1.1	0
H6D	Skin Tears or Cuts	1.1	0
H6E	None of Above	1.1	0
I1A	Freq Patient Complains of Pain	0	0
I1B	Intensity of Pain	0	0
I1C	Current Pain Status	7.3	26.8
J1A	Chewing Problem	1.2	0
J1B	Dental Problems	1.2	0
J2	Swallowing	1.2	0
J3A	Height in Inches	5.8	0
J3B	Weight in Pounds	7.0	0
J4A	Weight Loss	8.1	4.2
J4B	Weight Gain	8.2	4.2
J5A	Total Calories	3.5	0
J5B	Fluid Intake	4.6	0
K1A	Total # Physician Visits	21.6	22.4
K1B	# Times Phys/nurse Practitioner Called to Bedside	17.2	40.0
K1C	# Nurse Practitioner Visits	20.7	27.1
K1D	# Phys Asst Visits	20.7	29.2
K1E	# New or Changed Orders	14.9	22.4
K2AA	Diabetic Management	3.5	8.3
K2AB	At Dis—insulin Management	7.7	33.3
K2BA	Injections	7.7	8.3
K2BB	Injections at Discharge	8.3	20.0
K2CA	IV Antibiotics/meds	7.7	8.3
K2CB	At Dis—Iv Antibiotics/meds	7.7	33.3
K2DA	Application of Dressings	7.7	8.3
K2DB	Application of Dressings at Dis.	8.3	20.0
K2EA	Application of Ointments	7.7	8.3
K2EB	At Dis—Application of Ointments	7.7	33.3
K2GA	Nutrition/dehydration Intervention	7.7	8.3
K2GB	At Dis—nutrition/hydration Intervention	7.7	33.3
K2HA	Pressure Relieving Bed/Chair	3.8	8.3
K2HB	At Dis—Pressure Relieving Bed/Chair	7.7	33.3
K2IA	Turning and Repositioning	3.8	8.3
K2IB	At Dis—Turning and Repositioning	7.7	33.3
K2JA	Ulcer Care	7.7	8.3
K2JB	At Discharge—Ulcer Care	7.7	33.3
K2KA	Wound Care—Surgical	7.7	8.3
K2KB	At Dis—Wound Care Surgical	7.7	33.3
K2LA	Bladder Training	3.8	8.3
K2LB	At Dis—Bladder Training	8.3	20.0
K2MA	Scheduled Toileting	3.8	8.3
K2MB	At Dis—Scheduled Toileting	8.3	20.0
K2NA	Bowel Program	3.8	8.3
K2NB	At Dis—Bowel Program	8.3	20.0
K2OA	Cardiac Monitoring/Rehab	11.5	8.3
K2OB	At Dis—Cardiac Monitoring	7.7	33.3
K2PA	Cast(s)	11.5	8.3
K2PB	At Dis—Cast(s)	7.7	33.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K2QA	Continuous Positive Airway Pressure	11.5	8.3
K2QB	At Dis—Continuous Positive Airway Pressure	9.0	33.3
K2RA	Drains	3.8	0
K2RB	At Dis—Drains	7.7	31.7
K2SA	Dialysis	0	0
K2SB	At Dis—Dialysis	4.2	16.7
K2TA	Enteral Tube Feeding	0	0
K2TB	At Dis—Enteral Tube Feeding	6.5	31.7
K2UA	IV Line—Central	3.8	0
K2UB	At Dis—Central Iv Line	7.7	31.7
K2VA	IV Line—Peripheral	3.8	0
K2VB	At Dis—Peripheral Iv Line	7.7	31.7
K2WA	Ng Feeding Tube	0	0
K2WB	At Dis—NG Feeding Tube	6.4	31.7
K2XA	Oxygen	0	0
K2XB	At Dis—Oxygen	6.4	31.7
K2YA	Pain Management—Other than Drugs	7.7	0
K2YB	At Dis—Pain Management	7.7	31.7
K2ZA	Suctioning—Oral	0	0
K2ZB	At Dis—Suctioning—Oral	7.7	31.7
K2AAA	Suctioning—Tracheal	0	0
K2AAB	At Dis—Suctioning Tracheal	7.7	31.7
K2ABA	Tracheostomy Care	0	0
K2ABB	At Dis—Tracheostomy Care	6.4	31.7
K2ACA	Transfusion(s)	7.7	0
K2ACB	At Dis—Transfusion(s)	7.7	31.7
K2ADA	Ventilator or Respirator	7.7	0
K2ADB	At Dis—Vent. Or Resp.	9.0	31.7
K2AEA	Ventilator Weaning	7.7	0
K2AEB	At Dis—Ventilator Weaning	9.0	31.7
K2AFA	Train Family to Assist Patient	3.8	0
K2AFB	At Dis-Train Family to Assist Patient	6.4	31.7
K2AGA	Training in Health Maint	3.8	0
K2AGB	At Dis—Pat Train Skills Required after Discharge	6.4	31.7
K2AHA	Design and Implementation	3.8	0
K2AHB	At Dis—Social Service Design	7.7	31.7
K3AIA	None of Above	0	0
K3AIB	At Dis—None of Above	7.7	31.7
K3A	Range of Motion—Passive	4.5	8.2
K3B	Range of Motion—Active	4.5	8.2
K3C	Splint/Orthotic Assistance	4.5	8.2
K3D	Bed Mobility	4.5	8.2
K3E	Bladder/Bowel	3.4	8.2
K3F	Transfer	4.5	8.2
K3G	Walking	4.5	8.2
K3H	Dressing or Grooming	3.4	8.2
K3I	Eating or Swallowing	3.4	8.2
K3K	Communication	3.4	8.2
K4AA	Speech—Days Ordered	16.0	26.2
K4AB	Speech—Days Delivered	2.4	4.8
K4AC	Speech—Min Delivered	3.7	2.4
K4AD	Post Dis—Speech	4.0	18.0
K4BA	Ot—Days Ordered	17.3	26.2
K4BB	Ot—Days Delivered	2.4	4.8
K4BC	Ot—Min Delivered	2.5	2.4
K4BD	Post Dis—Ot	5.3	18.2
K4CA	Pt—Days Ordered	17.3	26.2
K4CB	Pt—Days Delivered	1.2	4.8
K4CC	Pt—Min Delivered	3.7	2.4
K4CD	Pt—Post Dis—Pt	5.3	18.2
K4DA	Resp. Therapy—Days Ordered	16.0	26.2
K4DB	Resp. Therapy—Days Delievered	2.4	4.8
K4DC	Resp. Therapy—Min. Delivered	3.7	2.4
K4DD	Post Dis—Resp.Therapy	4.0	18.2
K4EA	Psych Therapy—Days Ordered	18.5	26.2
K4EB	Psych Therapy—Days Delivered	3.7	4.8

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K4EC	Psych Therapy—Min Delivered	3.7	2.4
K4ED	Post Dis—Psych Therapy	6.7	18.2
K4FA	Therapeutic Recreation—Days Ordered	18.7	24.2
K3FB	Therapeutic Recreation—Days Delivered	1.3	3.0
K3FC	Therapeutic Recreation—Min Delivered	5.3	0
K3FD	Post Dis—Therapeutic Recreation	6.7	18.2
K5A	Full Bed Rails on Both Sides	5.1	0
K5B	Other Types of Side Rails Used	6.4	4.9
K5C	Trunk Restraint	6.4	0
K5D	Chair Prevents Rising	7.7	2.4
L1A	Bed Mobility/Transfer	6.9	10.2
L1B	Dressing	6.9	10.2
L1C	Eating	6.9	10.2
L1D	Locomotion	6.9	10.2
L1F	Medication Managment	6.8	14.3
L1G	Pain Management	6.8	10.2
L2A	Believe Is Capable of Incr Indep.	5.7	10.4
L2B	Unable to Recognize New Limits	8.0	10.4
L2C	Fails to Initiate/Continue Adls	9.2	10.4
L3A	Functional Status—Last 3 Days	9.2	12.2
L3B	Health Status—Last 3 Days	9.3	12.2
L4	Estimated Length of Stay	2.3	6.0
M1A	Emotional Support	0	8.3
M1B	Intermit Phys Support—less than Daily	0	8.3
M1C	Intermit Phys Support—Daily	0	8.3
M1D	Full Time Physical Support	0	8.3
M1E	All or Most of Nec Transportation	0	9.1
M2A	Family Overwhelmed by Pat. Illness	4.2	16.7
M2B	Family Relationship Require Great Deal of Staff Time	4.2	8.3
M3AA	Type of Residence—Pre	2.3	10.2
M3AB	Type of Residence—Discharge	0	10.0
M3AC	Temp. Type of Residence	5.0	12.5
M3BA	Lived With—Pre	2.5	10.6
M3BB	Live With—Disch	0	10.4
M3BC	Temp Live(d) With	5.3	13.2
N1C	Date Assessment Coord Signed	0	0

BILLING CODE 4120–03–P

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
INTERRUPTED STAY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	**LEGAL NAME OF PATIENT**	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	**ADMISSION DATE**	a. *Date the stay began (date of initial admission)* Month Day Year b. *Date Medicare covered Part A stay began — If different than* ***AA2a*** Month Day Year
6.	**SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]**	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
7.	**MEDICAL RECORD NO.**	
8.	**FACILITY PROVIDER NO.**	a. State No. b. Federal No.
9.	**MEDICAID NO.**	***["+" if pending, "N" if not a Medicaid recipient]***
10.	**GENDER**	1. Male 2. Female
11.	**BIRTHDATE**	Month Day Year
12.	**ETHNICITY/ RACE**	(***CHECK all that apply***) ***ETHNICITY*** Hispanic or Latino ***RACE*** American Indian/Alaskan Native a. Asian b. Black or African American c. Native Hawaiian or other Pacific Islander d. White
13.	**INTERRUPTED STAY**	a. *Date/time departed from the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM b. *Date/time returned to the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM
14.	**CLINICIAN COMPLETING ASSESSMENT**	a. **SIGNATURE OF CLINICIAN ATTESTING TO THE ACCURACY OF THE DATES THE PATIENT DEPARTED FROM AND RETURNED TO THE REHABILITATION UNIT/HOSPITAL** Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*

• Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than **AA2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ASSESSMENT REFERENCE DATE	*Assessment reference date—last day of the 3-day MDS-PAC observation period* Month — Day — Year
5.	DISCHARGE STATUS	a. *Last day of stay* Month — Day — Year b. *If discharged, status at discharge* 0. Rehabilitation program complete for this stay and return not anticipated 1. Patient left, against medical advice, prior to completion of plan of care 2. Acute problem, discharge to acute hospital 3. Patient died
6.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number)
7.	MEDICAL RECORD NO.	
8.	FACILITY PROVIDER NO.	a. State No. b. Federal No.
9.	MEDICAID NO.	*["+" if pending, "N" if not a Medicaid recipient]*
10.	GENDER	1. Male 2. Female
11.	BIRTHDATE	Month — Day — Year
12.	ETHNICITY/ RACE	(*CHECK all that apply*) ***ETHNICITY*** Hispanic or Latino (a.) ***RACE*** American Indian/Alaskan Native (b.) Asian (c.) Black or African American (d.) Native Hawaiian or other Pacific Islander (e.) White (f.)

SECTION AB. ASSESSMENT ATTESTATION

1.	PERSON COMPLETING ASSESSMENT	a. SIGNATURE OF CLINICIAN ATTESTING TO COMPLETION OF ASSESSMENT: Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist g. Date MDS-PAC signed as complete Month — Day — Year

2a. Signatures of staff completing part of the assessment	Credentials	Sections	Date
b.			Date
c.			Date
d.			Date
e.			Date
f.			Date

APPENDIX BB Patient _____ Numeric Identifier _____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
FULL ASSESSMENT FORM (ASSESSMENT, REASSESSMENT, DISCHARGE)

SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY

- **Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated**

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than* ***A2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ADMISSION STATUS	0. First admission to inpatient rehabilitation services 1. Readmission to rehabilitation but not directly from other rehabilitation 2. Readmission directly from other rehabilitation
5.	GOALS FOR STAY	***CODE indicate all that apply:*** 0. No 1. Yes a. Medical stabilization b. Rehabilitation/Functional improvement c. Recuperation d. Monitoring to avoid clinical complication e. Palliative care
6.	ADMITTED FROM (At date of admission—A2)	1. Private home 2. Private apartment 3. Rented room 4. Board and care/group home 5. Assisted living 6. Homeless shelter 7. Transitional living 8. Long term care facility (nursing home) 9. Post acute care SNF 10. Acute care hospital—not rehabilitation unit 11. Rehabilitation unit (in acute hospital) 12. Rehabilitation hospital 13. Long term care hospital 14. Psychiatric hospital/unit 15. MR/DD facility (exclude group home) 16. Other hospital 17. Outpatient surgery center 18. Other
7.	PRECIPITATING EVENT PRIOR TO ADMISSION	a. ***Time of the onset of the precipitating event/problem*** *that directly preceded admission into this facility (time from date of admission—**item A2**)* 0. Within last week 1. Within last 8 to 14 days 2. 15 to 30 days ago 3. 31 to 60 days ago 4. More than 60 days ago b. *Date of admission of most recent acute hospitalization (**within last 90 days**)* Month — Day — Year c. *Reason for most recent acute care hospitalization (**within last 90 days**)* 0. Not hospitalized at any time in **last 90 days** 1. New problem 2. Exacerbation 3. Both
8.	PRIMARY AND SECONDARY PAYMENT SOURCE FOR STAY	0. None - No insurance coverage, no private pay 1. Medicare 2. Medicaid 3. CHAMPUS 4. Department of Veterans Affairs 5. Managed care/HMO—Medicare 6. Managed care/HMO—non-Medicare 7. Private insurance 8. Private pay—self or family 9. Workers' compensation 10. Other payment A Prim B Sec
9.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
10.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9th-11th grade 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
11.	LANGUAGE	a. *Primary Language* 0. English 1. Spanish 2. French 3. Other, specify in **A11b** b. ***If other, specify***
12.	DOMINANT HAND	1. Right 2. Left 3. Unable to determine
13.	MENTAL HEALTH HISTORY	*Patient's RECORD indicates history of mental retardation, mental illness, or developmental disability problem* 0. No 1. Yes
14.	CONDITIONS RELATED TO MR/DD STATUS	1. Not applicable—no MR/DD 2. MR/DD with no organic condition 3. MR/DD with organic condition
15.	RESPONSIBILITY/ LEGAL GUARDIAN	(***CHECK all that apply***) Legal guardian [a.] Other legal oversight [b.] Durable power of attorney/health care proxy [c.] Patient responsible for self [d.] *NONE OF ABOVE* [e.]
16.	ADVANCE DIRECTIVES	(***CHECK all that apply*** *that have supporting* ***documentation***) Living will [a.] Do not resuscitate [b.] Do not hospitalize [c.] Treatment restrictions [d.] *NONE OF ABOVE* [e.]

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*Persistent vegetative state/no discernible consciousness* 0. No 1. Yes (**IF YES, SKIP TO SECTION E**)
2.	MEMORY/ RECALL ABILITY (Over last 3 days)	(***CODE for recall of what was learned or known***) 0. Memory OK 1. Memory problem a. Short-term memory OK—Seems/appears to recall after 5 minutes b. Long-term memory OK—Seems/appears to recall long past c. Situational memory OK—**Both**: recognizes staff names/faces frequently encountered **AND** knows location of places regularly visited (bedroom, dining room, activity room, therapy room) d. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation
3.	COGNITIVE SKILLS FOR DAILY DECISION MAKING (Over last 3 days)	a. *Making decisions regarding tasks of daily life* 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times* 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions b. ***Is now more impaired*** *in decision making than prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today
4.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (Over last 7 days)	(***CODE for behavior in the last 7 days.***) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time***]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from patient's usual functioning (e.g., new onset or worsening) a. **EASILY DISTRACTED**—(e.g., difficulty paying attention; gets sidetracked) b. **PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS**—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. **EPISODES OF DISORGANIZED SPEECH**—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. **PERIODS OF RESTLESSNESS**—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) e. **PERIODS OF LETHARGY**—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. **MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY**—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 3 days)

1.	HEARING	*With hearing appliance, if used* 0. *HEARS ADEQUATELY*—No difficulty in normal conversation, social interaction, TV, phone 1. *MINIMAL DIFFICULTY*—Requires quiet setting to hear well 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to increase volume and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing
2.	MODES OF COMMUNICATION	(***CHECK all used by patient to make needs known***) Hearing aid [a.] Lip reading [b.] Signs/gestures/sounds [c.] Writing messages to express or clarify needs [d.] *NONE OF ABOVE* [e.]
3.	MAKING SELF UNDERSTOOD (Expression)	a. *Expressing information content—however able* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts *BUT* if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to concrete requests 4. *RARELY/NEVER UNDERSTOOD* b. ***Is now more impaired*** *in making self understood by others than was prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today

APPENDIX BB Patient_____ Numeric Identifier_____

4.	SPEECH CLARITY	0. *CLEAR SPEECH*—Distinct, intelligible words 1. *UNCLEAR SPEECH*—Slurred, mumbled words 2. *NO SPEECH*—Absence of spoken words	
5.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	**a.** *Understanding verbal information content (however able) with hearing appliance, if used* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message *BUT* comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message, with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication only 4. *RARELY/NEVER UNDERSTANDS* **b.** *Is* ***now more impaired*** *in understanding others than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	
6.	VISION	**a.** *Ability to see in adequate light and with glasses, if used* 0. *ADEQUATE*—Sees fine detail, including regular print, in newspaper/books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision, eyes do not appear to follow objects BUT may report seeing light or colors only **b.** *Is* ***now more impaired*** *in vision than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	

SECTION D. MOOD AND BEHAVIOR PATTERN

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (Over last 3 days)	(***CODE for indicators observed in last 3 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 3 days 2. Exhibited on each of last 3 days 1. Exhibited on 1-2 of last 3 days	
		VERBAL EXPRESSIONS OF DISTRESS **a. PATIENT MADE NEGATIVE STATEMENTS**—(e.g., "*Nothing matters; Would rather be dead than live this way; What's the use; Let me die*") **b. PERSISTENT ANGER WITH SELF OR OTHERS**—(e.g., easily annoyed, anger at presence in post acute care, anger at care received) **c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—(e.g., fear of being abandoned, left alone, being with others, afraid of nighttime) **d. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS** (non-health related)—(e.g., persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit) **e. REPETITIVE HEALTH COMPLAINTS**—(e.g., persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs) ***SAD, APATHETIC, ANXIOUS APPEARANCE*** **f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS**—(e.g., furrowed brows) **g. CRYING, TEARFULNESS** **h. REPETITIVE PHYSICAL MOVEMENTS**—(e.g., pacing, hand wringing, restlessness, fidgeting, picking) ***SLEEP CYCLE ISSUES*** **i. INSOMNIA/CHANGE IN USUAL SLEEP PATTERNS** ***LOSS OF INTEREST*** **j. WITHDRAWAL FROM ACTIVITIES OF INTEREST**—(e.g., no interest in long standing activities or being with family/friends) **k. REDUCED SOCIAL INTERACTION**—(e.g., less talkative, more isolated)	
2.	MOOD PERSISTENCE (Over last 3 days)	***One or more indicators*** *of depressed, sad or anxious mood* ***were not easily altered by attempts to "cheer up," console, or reassure the patient over last 3 days*** 0. No mood indicators or always easily altered 1. Partially altered or easily altered on only some occasions 2. All aspects of mood not easily altered	
3.	BEHAVIORAL SYMPTOMS (Over last 3 days)	(***CODE*** *for behavioral symptom* ***frequency over the last 3 days***) 0. Behavior not exhibited in last 3 days 1. Behavior of this type occurred on 1 day 2. Behavior of this type occurred on 2 days 3. Behavior of this type occurred daily	
		a. WANDERING—Moved (locomotion) with no rational purpose, seemingly oblivious to needs or safety	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were threatened, screamed at, cursed at	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were hit, shoved, scratched, sexually abused	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings	
		e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position	

SECTION E. FUNCTIONAL STATUS

1.	**3 DAY ADL SELF-PERFORMANCE**—(***CODE for Performance Over All Shifts, for All Episodes, OVER LAST 3 DAYS***) [NOTE - for *Bathing and Tub Transfer*, code for most dependent single episode in this period] 0. *INDEPENDENT*—No help, setup, or supervision —OR— Help, setup, or supervision provided only 1 or 2 times during period (with any task or subtask) 1. *SETUP HELP ONLY*—Article or device provided or placed within reach of patient 3 or more times 2. *SUPERVISION*—Oversight, encouragement or cuing provided 3 or more times during period —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision) 3. *MINIMAL ASSISTANCE* (*LIMITED ASSISTANCE*)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. *MODERATE ASSISTANCE* (*EXTENSIVE ASSISTANCE*)—Patient performed part of activity on own (50% or more of subtasks) *BUT* help of following type(s) provided 3 or more times: — Weight-bearing support (e.g., holding weight of limb, trunk) — Full staff performance of a task (some of time) or discrete subtask 5. *MAXIMAL ASSISTANCE*—Patient involved but completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. *TOTAL ASSISTANCE* (*TOTAL DEPENDENCE*)—Full staff performance of activity during entire period 8. *ACTIVITY DID NOT OCCUR*—During entire period	
		a. BED MOBILITY—How patient moves to and from lying position, turns side to side, and positions body while in bed	
		b. TRANSFER BED/CHAIR—How patient moves between surfaces—to or from: bed, chair, wheelchair, standing position (**EXCLUDE** to/from bath/toilet)	
		c. LOCOMOTION—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how moves once in wheelchair	
		d. WALK IN FACILITY—How patient walks in room, corridor, or other place in facility	
		e. DRESSING UPPER BODY—How patient dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
		f. DRESSING LOWER BODY—How patient dresses and undresses (**street clothes, underwear**) from the waist down, includes protheses, orthotics, belts, pants, skirts, shoes, and fasteners	
		g. EATING—How patient eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
		h. TOILET USE—How patient uses the toilet room (or commode, bedpan, urinal); cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (**EXCLUDE** transfer toilet)	
		i. TRANSFER TOILET—How patient moves on and off toilet or commode	
		j. GROOMING/PERSONAL HYGIENE—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**EXCLUDE** baths and showers)	
		k. BATHING—How patient takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair and TRANSFER). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode***	
		l. TRANSFER TUB/SHOWER—How patient transfers in/out of tub/shower ***Code for most dependent episode***	
2.	ADL ASSIST CODES (Code for most help in last 3 days)	0. Neither code applies 2. 2+ person physical assist 1. Weight bearing support with 1 limb **a.** Bed mobility **b.** Transfer bed/chair **c.** Locomotion **d.** Walk in facility **e.** Dressing upper body **f.** Dressing lower body **g.** Eating **h.** Toilet use **i.** Transfer **j.** Grooming/personal hygiene **k.** Bathing **l.** Transfer tub/shower	
3.	ADL CHANGES	**a.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient is now more limited in self performance than was prior to precipitating event (item* ***A7a****)* **b.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient was independent prior to precipitating event (item* ***A7a****)*	

APPENDIX BB Patient_____ Numeric Identifier_____

4. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (In last 24 hours of 3-day assessment period)

CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—if the patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you consider the patient's capacity (ability) would have been to perform the activity

0. *INDEPENDENT*—Would have required no help, setup, or supervision
1. *SETUP HELP ONLY*—Would have only needed article/device placed within reach; patient could have performed on own
2. *SUPERVISION*—Would have required oversight, encouragement, or cuing
3. *LIMITED ASSISTANCE*—On some occasion(s) could have done on own, other times would have required help
4. *MODERATE ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own
5. *MAXIMAL ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of subtask on own
6. *TOTAL DEPENDENCE*—Full performance by other of activity would have been required at all times (no residual capacity exists)

a. **MEAL PREPARATION**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)

b. **MANAGING FINANCES**—Paying for newspaper or TV service, using cafeteria

c. **PHONE USE**—How telephone calls are made or received (using assistive devices such as large numbers or voice amplification as needed)

d. **MEDICATION MANAGEMENT**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments)

e. **STAIRS**—How moves up and down stairs (e.g., one flight of steps, using hand rails as needed)

f. **CAR TRANSFER**—How moves in and out of a car, opening door, sitting, and rising from seat

5. IADL AREAS NOW MORE LIMITED

***NUMBER** of IADL areas (from **E4** above) in which patient is now more limited in self performance than was prior to precipitating event (item **A7a**)*

0. None
1. Some (1-3 IADL areas)
2. All or most (4-6 IADL areas)

6. DEVICES/ AIDS

(***CHECK all that apply***)

LOCOMOTION DEVICES		Mechanical lift	e.
Cane/Crutch	a.	Orthotics/prosthesis	f.
Walker	b.	Postural support (while sitting)	g.
Wheelchair/scooter	c.	Slide board	h.
OTHER AIDS		Other adaptive devices	i.
Adaptive eating utensil	d.	*NONE OF ABOVE*	j.

7. STAMINA

CODE:
0. None
1. Less than 1 hour per day
2. 1 to 2 hours per day
3. 2+ to 3 hours per day
4. 3+ to 4 hours per day
5. More then 4 hours per day

	A Last 24 hours	B Prior
Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping **(A) *in last 24 hours*** *and* **(B) *immediately prior*** *to precipitating event (item **A7a**)*		

8. WALKING AND STAIR CLIMBING (Note time frame)

a. Farthest distance walked without sitting down **Code for most consistent in last 24 hours**
0. 150+ feet
1. 51-149 feet
2. 25-50 feet
3. 10-24 feet
4. Less than 10 feet
8. *ACTIVITY DID NOT OCCUR*

b. Walking support provided **Code for most consistent in last 24 hours**
0. None
1. Setup help only
2. Supervision
3. One person physical assistance
4. Two+ person physical assistance
8. *ACTIVITY DID NOT OCCUR*

8. WALKING AND STAIR CLIMBING (Note time frame) (cont)

c. **Stair climbing—Code for most dependent episode when activity attempted in last 24 hours** [full flight = 12-14 stairs; partial flight = 4-6 stairs] *There are only three possible codes when patient does 4-6 stairs only (code = 2,5,6)*

0. *COMPLETE INDEPENDENCE*—Up and down **full** flight of stairs with NEITHER *physical help* NOR *support device*
1. *MODIFIED INDEPENDENCE*—Up and down **full** flight of stairs with NO *physical help and any of following:*
Use of one or more supportive devices [*support devices* includes the **required** use of hand rails]
OR Use of an appliance (i.e., cane, brace, prosthesis, walker)
OR Excessive time to climb the stairs (3 or more times normal)
2. *SUPERVISION*—Up/down **full** flight of stairs with supervision or cuing -OR- up and down partial flight with NO physical help (device may or may not be used)
3. *MINIMAL ASSISTANCE*—Contact guard/steadying/assistance to go up/down **full** flight of stairs
4. *MODERATE ASSISTANCE*—Some weight bearing help to go up/down **full** flight of stairs, patient does most on own
5. *MAXIMAL ASSISTANCE*—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort -OR- receives physical help on partial flight of stairs
6. *TOTAL ASSISTANCE*—Did not go up/down 4-6 stairs (OR has 2-person assist) OR totally dependent
8. *ACTIVITY DID NOT OCCUR **IN LAST 24 HOURS***

9. BALANCE RELATED TO TRANSITIONS (Code for most dependent in last 24 hours)

CODE:
0. Smooth transition; stabilizes without assistance
1. Transition not smooth, but able to stabilize without assistance
2. Transition not smooth; unable to stabilize without assistance
8. *ACTIVITY DID NOT OCCUR*

a. Moved from seated to standing position

b. Turned around and faced the opposite direction

10. NEURO-MUSCULO-SKELETAL IMPAIRMENT (Code for most limited in last 24 hours)

A. (***CODE** for joint mobility/range of motion at joints listed* **(*code for most impaired joint*)**)
0. No impairment
1. Impairment on one side
2. Impairment on both sides

B. (***CODE** for voluntary motor control (active, coordinated, purposeful movement - **code for most dependent joint***)**)
0. No loss
1. Partial loss one side
2. Partial loss both sides
3. Full loss one side
4. Full loss both sides

C. (***CODE** for Intact touch/sensation on extremity, i.e., tactile sense* **(use same codes as E10B)**)

	A	B	C
a. Leg (hip, knee, ankle, foot)			
b. Arm (shoulder, elbow, wrist, hand)			
c. Trunk and neck			

SECTION F. BLADDER/BOWEL MANAGEMENT

1. BLADDER CONTINENCE (Code for last 7-14 days)

a. *Control of urinary bladder function (if dribbles, volume insufficient to soak through undergarments)*

0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily
5. *FREQUENTLY INCONTINENT*—Tended to be incontinent daily, but some control present (i.e., on day shift)
6. *INCONTINENT*—Has inadequate control of bladder, multiple daily episodes all or almost all of time
8. *DID NOT OCCUR*—No urine output from bladder

b. *Is now more impaired in bladder continence than was prior to precipitating event (item **A7a**)*
0. No or unsure
1. Yes, more impaired today

2. BLADDER APPLIANCE (Code for last 24 hours)

CODE:
0. No
1. Yes

a. External catheter		e. Ostomy	
b. Indwelling catheter		f. Pads, briefs	
c. Intermittent catheterization		g. Urinal, bedpan	
d. Medications for control			

3. BLADDER APPLIANCE SUPPORT (Code for last 24 hours)

0. No appliances **(in item F2)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of sub-tasks involved in using equipment
5. Maximal assistance; patient able to do 25-49% of all sub-tasks involved in using the equipment
6. Total dependence

APPENDIX BB Patient_____ Numeric Identifier_____

4. BOWEL CONTINENCE (Code for last 7-14 days)
0. *CONTINENT*— Complete control, does not use ostomy device
1. *CONTINENT WITH OSTOMY*—Complete control with use of an ostomy device that does not leak stool
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—2-3 times a week
5. *FREQUENTLY INCONTINENT*—4+ times a week but not all of time
6. *INCONTINENT*—All of time
8. *DID NOT OCCUR*— No bowel movement during the entire 14 day assessment period

5. BOWEL APPLIANCES (Code for last 3 days)
CODE: 0. No 1. Yes
a. Bedpan
b. Enema
c. Medication for control
d. Ostomy

6. BOWEL APPLIANCE SUPPORT (Code for last 24 hours)
0. No appliances **(in item F5)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of tasks
5. Maximal assistance; patient able to do 25-49% of all sub-tasks
6. Total dependence

SECTION G. DIAGNOSES

1. IMPAIRMENT GROUP *Refer to manual for coding of impairment group*

2. OTHER DISEASES
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
[If no disease in list, check **G2aq *None of Above*** item]

ENDOCRINE
a. Diabetes mellitus (250.00)
b. Hypothyroidism (244.9)
HEART/CIRCULATION
c. Cardiac arrythmias (427.9)
d. Congestive heart failure (428.0)
e. Coronary artery disease (746.85)
f. Deep vein thrombosis (451.1)
g. Hypertension (401.9)
h. Hypotension (458.9)
i. Peripheral vascular disease (arteries) (443.9)
j. Post acute MI (within 30 days) (410.92)
k. Post heart surgery (e.g., valve, CABG) (V45.81)
l. Pulmonary embolism (415.1)
m. Pulmonary failure (518.8)
n. Other cardiovascular disease (429.2)
MUSCULOSKELETAL
o. Fracture - hip (V43.64)
p. Fracture - lower extremity (812.40)
q. Fracture(s) - other (829.0)
r. Osteoarthritis (715.90)
s. Osteoporosis (733.00)
t. Rheumatoid arthritis (714.0)
NEUROLOGICAL
u. Alzheimer's disease (331.0)
v. Aphasia or Apraxia (784.3,784.69)
w. Cerebral palsy (343.9)
x. Dementia other than Alzheimer's disease (290.0)
y. Hemiplegia/hemiparesis — left side (342.90)
z. Hemiplegia/hemiparesis — right side (342.90)
aa. Multiple sclerosis (340)
ab. Parkinson's disease (332.0)
ac. Quadriplegia (344.00 - 344.09)
ad. Seizure disorder (780.39)
ae. Spinal cord dysfunction—non-traumatic (336.9)
af. Spinal cord dysfunction—traumatic (952.9)
ag. Stroke (CVA) (436)
PSYCHIATRIC/MOOD
ah. Anxiety disorder (300.00)
ai. Depression (311)
aj. Other psychiatric disorder (300.9)
PULMONARY
ak. Asthma (493.9)
al. COPD (496)
am. Emphysema (492.8)
OTHER
an. Cancer (199.1)
ao. Post surgery - non-orthopedic, non-cardiac (V90.9)
ap. Renal failure (586)
aq. *NONE OF ABOVE*

3. INFECTIONS
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
(If no infections, check *NONE OF ABOVE item G3l*)

a. Antibiotic resistant infection (e.g., methicillin resistant staph - (041.11), VRE - (041.9))
b. Cellulitis (682.9)
c. Hepatitis (070.9)
d. HIV/AIDS (042)
e. Pneumonia (486)
f. Osteomyelitis (730.2)
g. Septicemia (038.9)
h. Staphylococcus infection (other than item "G3a") (041.10)
i. Tuberculosis (active) (011.90)
j. Urinary tract infection (599.0)
k. Wound infection (958.3, 998.59,136.9)
l. *NONE OF ABOVE*

4. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9-CM CODES (Any new diagnosis at reassessment or discharge is to be recorded here)
A. ***CODE ICD-9-CM diagnosis code***
B. ***CODE***:
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

	A. ICD-9-CM	B
a.		
b.		
c.		
d.		
e.		

5. COMPLICATIONS/COMORBIDITIES *Code the **ICD-9-CM** diagnostic code. Refer to manual to code comorbidities.*

DIAGNOSIS	ICD-9-CM
a.	
b.	
c.	
d.	

SECTION H. MEDICAL COMPLEXITIES

1. VITAL SIGNS *Vital signs (pulse, BP, respiratory rate, temperature)* ***Score for the most abnormal vital sign***
0. All vital signs were normal/standard (i.e., when compared to standard values)
1. Vital signs abnormal, but not on all days during assessment period
2. Vital signs consistently abnormal (on all days)

2. PROBLEM CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days** unless otherwise noted*)
FALLS/BALANCE
Dizziness/vertigo/light-headedness a.
Fell (since admission or last assessment) b.
Fell in **180 days** prior to admission c.
CARDIAC/PULMONARY
Advanced cardiac failure (ejection fraction < 25%) d.
Chest pain/pressure on exertion e.
Chest pain/pressure at rest f.
Edema - generalized g.
Edema - localized h.
Edema - pitting i.
Impaired aerobic capacity/endurance (tires easily, poor task endurance) j.
FLUID STATUS
Constipation k.
Dehydrated; output exceeds input; or BUN/Creat ratio > 25 l.
Diarrhea m.
Internal bleeding n.
Recurrent nausea/vomiting o.
Refusal/inability to take liquids orally p.
OTHER
Delusions/hallucinations q.
Fever r.
Hemi-neglect (inattention to one side) s.
Cachexia (severe malnutrition) t.
Morbid obesity u.
End-stage disease, life expectancy of **6 or fewer months** v.
NONE OF ABOVE w.

3. RESPIRATORY CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days***)
Inability to lie flat due to shortness of breath a.
Shortness of breath with exertion (e.g., taking a bath) b.
Shortness of breath at rest c.
Oxygen saturation < 90% d.
Difficulty coughing and clearing airway secretions e.
Recurrent aspiration f.
Recurrent respiratory infection g.
NONE OF ABOVE h.

4. PRESSURE ULCERS (Code for last 24 hours)
a. *Highest current pressure ulcer stage*
0. No pressure ulcer **(if no, skip to H5)**
1. Any area of persistent skin redness **(Stage 1)**
2. Partial loss of skin layers **(Stage 2)**
3. Deep craters in the skin **(Stage 3)**
4. Breaks in skin exposing muscle or bone **(Stage 4)**
5. Not stageable (necrotic eschar predominant; no prior staging available)

b. *Number of current pressure ulcers*

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING—calculate three components (**c** through **e**) and code total score in **f**

c. Length multiplied by width (open wound surface area)
0. 0 cm^2
1. <0.3 cm^2
2. 0.3–0.6 cm^2
3. 0.7–1.0 cm^2
4. 1.1–2.0 cm^2
5. 2.1–3.0 cm^2
6. 3.1–4.0 cm^2
7. 4.1–8.0 cm^2
8. 8.1–12.0 cm^2
9. 12.1–24.0 cm^2
10. > 24 cm^2

d. Exudate amount
0. None 1. Light 2. Moderate 3. Heavy

APPENDIX BB Patient_____Numeric Identifier_____

4.	**PRESSURE ULCERS** (Code for last 24 hours) (cont)	**e.** Tissue type 0. Closed/resurfaced: The wound is completely covered with epithelium (new skin) 1. Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface 2. Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance 3. Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous 4. Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges	
		f. TOTAL PUSH SCORE (sum of above three items—**c**, **d**, and **e**)	
5.	**OTHER SKIN INTEGRITY**	**a.** Number of stasis ulcers **in last 24 hours**	
		b. Number of surgical wounds **in last 24 hours**	
		c. Ulcer resolved or healed **in last 90 days** 0. No or never had ulcer 1. Yes	
6.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT** (Code for last 24 hours)	(***CHECK all that apply***)	
		Burns (second or third degree)	a.
		Open lesions other than rashes, cuts (e.g., cancer lesions, ulcers)	b.
		Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)	c.
		Skin tears or cuts (other than surgery)	d.
		NONE OF ABOVE	e.

SECTION I. PAIN STATUS

1.	**PAIN SYMPTOMS** (In last 3 days)	(***CODE the highest level of pain present in the last 3 days, even with treatments*** [Note - At minimum, patient must be asked about frequency and intensity])	
		a. FREQUENCY with which patient complains or shows evidence of pain 0. No pain 2. Daily - single shift 1. Less than daily 3. Daily - multiple shifts	
		b. INTENSITY of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating	
		c. Current pain status as compared to pain status prior to precipitating event (item **A7a**) 0. Same 1. Better 2. Worse 8. UNKNOWN	

SECTION J. ORAL/NUTRITIONAL STATUS (In last 3 days)

1.	**ORAL PROBLEMS**	***CODE***: 0. No 1. Yes	
		a. Chewing problem (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control)	
		b. Dental problems (e.g., ill-fitting or lack of dentures, painful tooth, poor dental hygiene)	
2.	**SWALLOWING**	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE (NPO)*	
3.	**HEIGHT AND WEIGHT**	*Record* ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 3 days****; measure weight consistently in accordance with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (inches) **b.** WT (pounds)	
4.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss	
		b. Weight gain—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned gain 2. Yes, unplanned gain	
5.	**PARENTERAL OR ENTERAL INTAKE**	**a.** The proportion of **total calories** the patient received through parenteral or tube feedings in the **last 3 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%	
		b. The average **fluid intake** per day by IV or tube in **last 3 days** 0. None 3. 1001 to 1500 cc/day 1. to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION K. PROCEDURES/SERVICES (In last 3 days)

1.	**CLINICAL VISITS AND ORDERS**	*Services in* ***last 3 days***	
		a. Total number of physician visits (by attending, consultant, etc.) in which patient was examined and MD notes written	
		b. Number of times **physician or nurse practitioner** called to bedside for emergency—e.g., cardiorespiratory arrest, hemorrhaging, to evaluate change in condition	
		c. Number of **nurse practitioner** visits in which patient examined and notes written	
		d. Number of **physician assistant** visits in which patient examined and notes written	
		e. Number of **new or changed orders**	

2.	**TREATMENTS AND SERVICES**	**A. Over the last 3 days**, code for *treatment frequency* [*either daily* (*code 3*) *or less than daily* (*code 2*) or ordered, not yet implemented (code 1)] **(If no treatments provided or ordered, check *NONE OF ABOVE item K2ai*)** [*Blank*] Did not occur, not ordered 2. Less than daily 1. Ordered, not yet implemented 3. Daily **B.** ***RECORD AT DISCHARGE ASSESSMENT ONLY*** **(A3 = 5)**, *record whether patient will receive service after discharge* [*Blank*] No 1. Yes					
			A	**B**		**A**	**B**
		MEDICATION RELATED			r. Drains (cutaneous drains and other drains)		
		a. Diabetic management			s. Dialysis		
		b. Injections			t. Enteral feeding tube		
		c. IV antibiotics/meds			u. IV line - central		
		SKIN TREATMENT			v. IV line - peripheral		
		d. Application of dressings			w. NG feeding tube		
		e. Application of ointments, topical medications			x. Oxygen		
		f. Debridement (chemical or surgical)			y. Pain management - other than drugs		
		g. Nutrition/hydration intervention to manage skin problems			z. Suctioning - oral/nasopharyngeal		
		h. Pressure relieving bed/chair			aa. Suctioning - tracheal		
		i. Turning and repositioning			ab. Tracheostomy care		
		j. Ulcer care			ac. Transfusion(s)		
		k. Wound care - surgical			ad. Ventilator or respirator		
		MANAGEMENT OF HEALTH PROBLEMS			ae. Ventilator weaning		
		l. Bladder training			**OTHER**		
		m. Scheduled toileting			af. Family training in assistance to patient in health measures or skills required after return to community		
		n. Bowel program			ag. Patient training in health maintenance or skills required after return to community		
		o. Cardiac monitoring/rehabilitation			ah. Design and implementation of discharge plan		
		p. Cast(s)					
		q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)			ai. *NONE OF ABOVE*	ai.	ai.
3.	**NURSING PRACTICE OR RESTORATIVE CARE**	*Record the NUMBER OF DAYS each of the following restorative or practice techniques was* ***provided to the patient for more than or equal to a total of at least 15 minutes per day in the last 3 days*** *(Enter 0 if none or less than 15 min. daily)*					
		a. Range of motion (passive)			f. Transfer		
		b. Range of motion (active)			g. Walking		
		c. Splint/orthotic assistance			h. Dressing or grooming		
		TRAINING AND SKILL PRACTICE IN			i. Eating or swallowing		
		d. Bed mobility			j. Amputation/prosthesis care		
		e. Bladder/bowel			k. Communication		
4.	**THERAPY SERVICES** (By qualified therapist or therapy assistant under direction of therapist)	*Over the* ***last 3 days****, record the number of days and total minutes each of the following therapies was ordered* **[A]** *administered* **[B]** *(for at least 15 minutes a day) (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **A. # of days** treatment ordered during the **last 3 days [MAX=3]** **B. # of days** administered for **15 minutes or more [MAX=3]** **C. total # of minutes** provided in **last 3 days** (or *ordered* if days administered = 0 and days ordered > 0)					
		D. ***RECORD AT DISCHARGE ASSESSMENT*** ***(A3 = 5)****, record whether patient will receive service after discharge* 0. No 1. Yes	**DAYS Ordered**	**DAYS Administered**	**Minutes Delivered**		**Post Discharge**
			A	**B**	**C**		**D**
		a. Speech - language pathology and audiology services					
		b. Occupational therapy					
		c. Physical therapy					
		d. Respiratory therapy					
		e. Psychological therapy (by any licensed mental health professional)					
		f. Therapeutic recreation					

APPENDIX BB Patient_____ Numeric Identifier_____

5.	**DEVICES AND RESTRAINTS**	(*USE THE FOLLOWING* ***CODES FOR LAST 3 DAYS***) 0. Not used 3. Daily use - days only 1. Used less than daily 4. Night and day, but not constant 2. Daily use - night only 5. Constant use for full 24 hours (with periodic release)	
		a. Full bed rails on BOTH open sides of bed	
		b. Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Chair prevents rising	

SECTION L. FUNCTIONAL PROGNOSIS

1.	**FUNCTIONAL IMPROVEMENT GOALS** **(Code for last 24 hours)**	*For* ***all but discharge assessment****—code for clinical staff expectations of patient goals in the areas listed below by time of discharge.* *For* ***discharge assessment****, code for staff expectation of patient functional goal in the post discharge period.* 0. No goal exists 1. Goal-improvement, full recovery to premorbid status anticipated 2. Goal-improvement, partial recovery anticipated 3. Goal-improvement, recovery uncertain 4. Goal-maintenance, prevention of further decline			
		ADLs		**e.** Toileting	
		a. Bed mobility/transfer		**OTHER**	
		b. Dressing		**f.** Medication management	
		c. Eating		**g.** Pain control	
		d. Locomotion		**h.** Managing finances	
2.	**ATTRIBUTES RELEVANT TO REHABILITATION**	*CODE*: 0. No 1. Yes 8. UNKNOWN			
		a. Patient believes he/she is capable of increased independence			
		b. Patient unable to recognize new limitations			
		c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability			
3.	**CHANGE OVER LAST 3 DAYS**	*CODE*: 0. Improved 1. About the same as at admission (or last assessment if this is not an admission assessment) 2. Worse			
		a. Change in overall **functional status** over **last 3 days**			
		b. Change in overall **health status** over **last 3 days**			
4.	**ESTIMATED LENGTH OF STAY FROM DATE OF ADMISSION**	*How long patient is expected to stay in current setting prior to return to community* (***count from date of admission in item A2, including that day***) 0. 1-6 days 4. 91 or more days 1. 7-13 days 5. Discharge to community not expected 2. 14-30 days 6. Expected discharge will be to another health care setting - prior to return to community 3. 31-90 days			

SECTION M. RESOURCES FOR DISCHARGE

1.	**AVAILABLE SOCIAL SUPPORTS** **(Family/close friends)**	*CODE*: 0. No 1. Possibly yes 2. Definitely yes *Presence of one or more family members (or close friends) who are* ***willing and able*** *to provide support after discharge*	
		a. Emotional support	
		b. Intermittent physical support with ADLs or IADLs — less than daily	
		c. Intermittent physical support with ADLs or IADLs — daily	
		d. Full time physical support (as needed) with ADLs or IADLs	
		e. All or most of necessary transportation	
2.	**CAREGIVER STATUS**	*CODE*: 0. No 1. Yes	
		a. Family (or close friend) overwhelmed by patient's illness	
		b. Family relationship(s) require unusual amounts of staff time	

			A Prior to adm	B Perm disch	C Temp disch
3.	**LIVING ARRANGEMENT**	**A.** ***CODE*** *for* ***permanent*** *living arrangement* ***prior to admission*** **B.** ***CODE*** *for* ***permanent*** *arrangement expected* ***at discharge*** *or actual discharge site if this is a discharge assessment* (**A3=5**) **C.** ***CODE*** *for* ***initial*** *arrangement expected at discharge—if different than column* ***M3B*** (otherwise, leave blank) or actual discharge site if this is a discharge assessment (**A3=5**)			
		a. Type of residence 0. UNKNOWN 1. Private home 2. Private apartment 3. Rented room 4. Board and care/assisted living/group home 5. Homeless (with or without shelter) 6. Long-term care facility (nursing home) 7. Post acute care SNF 8. Hospice 9. Acute unit/hospital 10. Other			
		b. Live(d) with 0. UNKNOWN 1. Alone 2. Spouse only 3. Spouse and other(s) 4. Child (not spouse) 5. Other relative(s) (not spouse or children) 6. Friends 7. Group setting 8. Personal care attendant 9. Other			

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Appendix BBB—Item-by-Item Guide to the Minimum Data Set for Post Acute Care (MDS–PAC)

1.1 Required Assessments and Associated Forms

The following rules apply to HCFA's MDS–PAC to be used by rehabilitation hospitals and rehabilitation units in acute care hospitals.

The content of the MDS–PAC patient assessment instrument is recorded on the following required forms:

The Minimum Data Set-Post Acute (MDS–PAC) is designed to be used for admission assessments, reassessments, and discharge assessments. These forms contain Section AA (Identification Information) through M (Resources for Discharge). There are three separate forms which are entitled ''Basic Assessment Tracking Form'', ''Interrupted Stay Tracking Form'', and ''Full Assessment Form''. Whenever an item is on all three forms, there will be no distinguishing notation. However, if an item(s) is (are) to be asked only on a particular form, there will be a statement in the ''coding'' section.

1.2 Overview to the Item-by-Item Guide to MDS–PAC

This Manual is to be used in conjunction with the MDS–PAC forms.

It provides information to facilitate completion of an accurate and uniform patient assessment. Item-by-item instructions focus on:

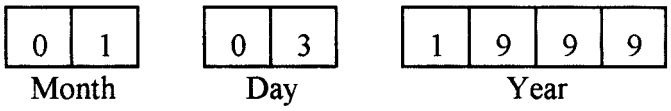
- The intent of items included on the MDS–PAC.
- Supplemental definitions and instructions for completing MDS–PAC items.
- Reminders of which MDS–PAC items require a different observation and information about the patient other than the standard 3-day observation period.
- Sources of information to be consulted in completing specific MDS–PAC items.
- Examples to illustrate MDS–PAC coding responses.

1.3 How Can This Manual Be Used?

Use this manual alongside the MDS–PAC forms, keeping the forms in front of you at all times. The MDS–PAC form itself contains a wealth of information. Learn to rely on it as a resource for many of the definitions and procedural instructions necessary for proper assessment. The amplifying information in this manual should facilitate successful use of the MDS–PAC forms.

Coding Conventions

- Dates—Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 1999 is recorded as:



- The standard no-information code is either a ''circled'' dash or an ''NA''. This code indicates that all available sources of information have been exhausted; that is the information is *not available*, and despite exhaustive probing, it remains unavailable. The use of NA code is very limited. For example, ''NA'' cannot be used in Section E. If an activity has not occurred in the last 3 days, a code of ''8'' must be used.
- NONE OF THE ABOVE is a response item to several items (for example., G3, Infections, box l). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.
- ''Skip'' Patterns—There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to ''skip'' over the next item (or several items) and go on to another (for example, B1, Comatose, directs the assessor to ''skip'' to Section E. if B1 is answered ''1''—Yes''. The intervening items from B2–D3 would not be scored. If B1 was recorded as ''0''—''No'', then the assessor would continue with item B2.).

A useful technique for visually checking the proper use of the ''skip'' pattern instructions is to circle the ''skip'' instructions before going to the next appropriate item.

- The ''8'' code is for use in Section E., Functional Status. The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 3 day period of observation.

The items from the MDS–PAC forms are presented in a sequential basis in this manual. Each item is accompanied by a statement of intent (rationale for assessment), definitions, assessment processes, and coding instructions. Many items are accompanied by patient examples to illustrate coding concepts.

The chart that follows summarizes the recommended approach to assist you in becoming familiar with the MDS–PAC. The initial time investment in this multi-step review process will have a major payback on the quality of your patient assessments using the MDS–PAC.

Carefully review these item-by-item instructions. The time-frame of the assessment, the processes, the coding options and items have been developed to reflect the needs of post-acute patients.

Recommended Approach for Becoming Familiar With the MDS–PAC

(A) First, review the MDS–PAC forms.

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions. Note that the assessment reflects activities over the last 3 days unless otherwise indicated.
- Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?
- Complete the MDS–PAC assessment for a patient at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS–PAC form. Where your review could benefit from additional information, make note of that fact. Where might you secure additional information?

(B) Complete the initial pass through this manual.

- Go on to this step only after first reviewing the MDS–PAC form and trying to complete as many items as possible for a patient known to you.
- As you read this manual, clarify questions that arose as you used the MDS–PAC for the first time to assess a patient. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- Once again, read the instructions that apply to a single section of the MDS–PAC. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same way? It will take time to go through all this material. Do it slowly. Do not rush. Work through the Manual one section at a time.
- Are you surprised by any MDS–PAC definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?
- Do any definitions or instructions differ from what you thought you learned when you reviewed the MDS–PAC form?
- Would you now complete your initial case differently?
- Are there definitions or instructions that differ from current practice patterns in your facility?
- Make notations next to any section(s) of this Manual you have questions about.

In a second pass through this manual, focus on issues that were more difficult or problematic in the first pass.

- Further familiarize yourself with definitions and procedures that differ from current practice patterns or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.
- (D) The third pass through this manual will provide you with another opportunity to review the material in this manual.
- (E) Future use of information in this manual:

• Keep this manual at hand during the assessment process.

• Where necessary, review the intent of each item in question.

• This manual is a source of information. Use it to increase the accuracy of your assessments.

1.4 What Is the Standard Format Used in This Manual?

To facilitate completion of the MDS–PAC assessment and to ensure consistent interpretation of items, this manual presents the following types of information for many (but not all) items:

Intent: Reason(s) for including the item (or set of items) in the MDS–PAC, including discussions of how the information will be used by clinical staff to identify patient problems and develop the plan of care.

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

• Patient interview, observation, and examination.

• Clinical records, facility records, transmittal records (at admission), physician orders, laboratory data, medication records, treatment sheets, flow sheets (for example, vital signs, weights, intake and output), care plans, and any similar documents in the facility record system.

• Discussion with multidisciplinary facility staff—licensed and nonlicensed staff caregivers.

• Discussion with the patient's family, particularly during the admission assessment period, when available.

• Attending physician.

Coding: Proper method of recording each response, with explanations of individual response categories.

1.5 Item-by-Item Instructions for the MDS–PAC Forms

The item-by-item instructions follow the sequence of items on the HCFA MDS–PAC. This will facilitate your use of this guide as a reference tool.

Basic Assessment Tracking Form

Section AA. Identification Information

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

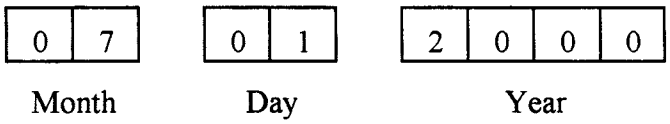
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear on what date the stay for the current precipitating event/problem began, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part A stay began.

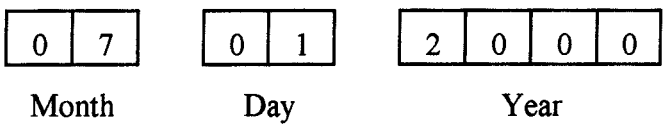
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item AA2A ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date

for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS–PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part-A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date*	MDS–PAC assessment reference date	MDS–PAC must Be completed on:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/1/00	5/1/00	5/5/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Assessment Reference Date

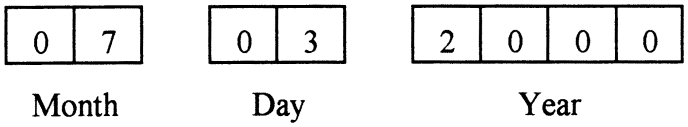
Intent: To establish a common reference point for all staff participating in the patient's assessment. Although staff members may work on completing a patient's MDS–PAC on different days (for example, begin entering demographics on day 1 of admission, and complete functional assessment on day 3), establishment of the assessment reference date ensures the commonality of the assessment period. It starts the ''clock'' so that all assessment items refer to the patient's status, treatment regimen, and resource utilization during the same period of time. Many items require the ''counting'' of the number of treatments, visits, or procedures, making a common temporal reference point crucial for accuracy.

Definition: This is the last day in the MDS–PAC assessment process, that is, the last day of the 3-day MDS–PAC observation period. It is the designated endpoint of the observation period. In order to gain accurate information for the interdisciplinary team, it is essential for everyone to focus on the same time period (that is, for most items, this day and the two that preceded it.) It is from this date that all time references are measured. For a discharge assessment, including an unexpected discharge, see the explanation under ''Process'' below.

For instance, if an item indicates ''in the past 3 days'' this 3 day period is calculated from the last day of the MDS–PAC observation period (that is, the third day and the two days that preceded it.)

Process: Refer to item AA2—''Admission Date''. The date entered in AA2b or if no date is entered in AA2b then the date entered in AA2a must be used to calculate the assessment reference date that must be used for the Day 4, Day 11, Day 30, or Day 60 assessments. The assessment reference date for the discharge assessment is the day when one of either of these two events occurs first: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services. The MDS–PAC discharge assessment process is started only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

Coding: Beginning with the left-most box enter the month, day, and year of the assessment reference date. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example: July 3, 2000, should be entered as follows:



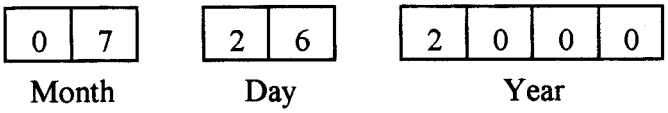
5. Discharge Status

a. Last day of stay.

Intent and Definition: To establish the date when either of these two events occurs first: (1) The individual is discharged as an inpatient from the IRF and physically leaves the facility, or (2) the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services whether or not the patient physically leaves the facility.

Process: Consult the physician's orders. In cases when the patient is discharged ''Against Medical Advice'' (AMA) refer to the documentation in the clinical record progress notes and the physician's orders.

Coding: Beginning with the left-most box enter the month, day, and year of discharge. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example July 26, 2000, should be entered as:



b. If discharged, status at discharge.

Intent: The intent of this item is to determine the patient's status upon discharge.

Definition: This is the patient's clinical and rehabilitation program status at discharge.

Process: Consult with members of the interdisciplinary team. Examine the documentation in the patient's clinical record. Talk to the patient and family if necessary.

Coding

0. Rehabilitation program complete for this stay and return not anticipated.

1. Patient left, against medical advice, prior to completion of plan of care.

2. Acute problem, discharge to acute hospital.

3. Patient died.

6. Social Security and Medicare Numbers

Intent: To record patient identifier numbers.

Process: Review the patient's medical record face sheet (usually at the front of the chart). To ensure accuracy, review a copy of the patient's Social Security (SS) card and Medicare card, if possible. In rare cases, the patient will have neither a Social Security number nor a Medicare number. When this occurs, another type of identification number may be used (for example, a railroad insurance number).

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order.

a. Enter the Social Security number as specified in the medical record or on the Social Security card.

b. Enter the Medicare number as indicated in the medical record. However, if the patient does not have a Medicare number but instead has a comparable railroad insurance number, then enter that number in these boxes and indicate that this is not a Medicare number by placing the letter ''C'' in first box of the ''b'' boxes.

7. Medical Record Number

Definition: A patient's identification number designated by the facility.

Process: Review the patient's medical record ''face sheet'' (usually at the front of the chart) for the medical record number. If the number is missing, obtain the number from the facility's Medical Records Department.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

8. Facility Provider Number

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to health care facilities by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. ''Medicaid only'' facilities have a Federal as well as a State number. The Medicaid Federal number has a ''letter'' in the third box.

Process: Obtain the facility's Medicare and Medicaid numbers from the facility's business office. Once you have these numbers, they apply to all patients of that facility.

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order. Remember, there must be at least one provider number indicated, and there may be two, one for the state, one for the federal.

9. Medicaid Number

Intent: An identifying number for tracking purposes.

Process: Review the patient's medical record face sheet (usually at the front of the chart). Review a copy of the patient's Medicaid card to ensure accuracy, if possible.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

- If the Medicaid application is pending, place a ''+'' in the first box.
- If the patient does not receive Medicaid benefits, place an ''N'' in the first box.

10. Gender

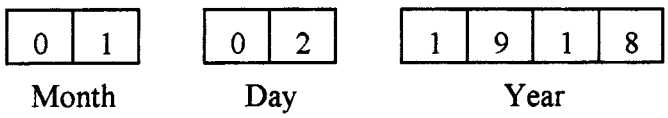
Coding

1. Male.

2. Female.

11. Birthdate

Coding: Beginning with the left-most box enter the month, day, and year of birth. If you do not know the patient's full birthdate you may enter a partial birthdate, but the partial birthdate must at least include the patient's year of birth. If the month or day contains only a single digit, place a ''0'' in the first box. For example: January 2, 1918 should be entered as:



Note: It's not unheard of to mistakenly enter today's date in this location. Make sure you have entered the date of birth.

12. Ethnicity/Race

Intent: The documentation of ethnicity and race per nationally established standards.

Process: Ask the patient and/or family member what best describes their race and ethnic background.

Coding: Check all that apply.

Ethnicity

a. Hispanic or Latino.

Race

b. American Indian/Alaskan Native.
c. Asian.
d. Black or African American.
e. Native Hawaiian or other Pacific Islander.
f. White.

13. Interrupted Stay

Note: This item only appears on the interrupted stay tracking form.

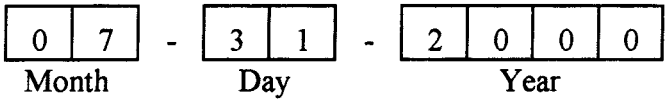
Intent and Definition: To track patients that have an interruption in their stay. An interrupted stay is one in which a patient is discharged from a rehabilitation facility and returns to the same rehabilitation facility in 3 calendar days or less. For purposes of the MDS–PAC assessment process, if a patient has an interrupted stay, then—(1) No new Day 4 MDS–PAC assessment would be performed; and (2) The required scheduled MDS–PAC update assessments must still be performed. Note: A patient that returns to the same rehabilitation facility more than 3 calendar days after being discharged is considered a ''new'' patient in terms of the MDS–PAC assessment schedule process.

In counting the 3 calendar day time period to determine the length of the interrupted stay, the first day of the start of the interrupted stay is counted as ''day 1,'' with midnight of that day serving as the end of that calendar day. The next 2 calendar days that immediately follow would be days two and three. If the patient returns to the rehabilitation facility by midnight of the third calendar day, then it would be determined that the patient had an interrupted stay of 3 calendar days or less.

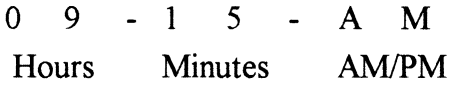
a. Date/time departed from the rehabilitation unit/hospital.

Process: Consult the clinical record, talk to physician and nursing staff.

Coding: If the patient has not had an interrupted stay, the boxes will remain blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in the first box. July 31, 2000, should be entered as follows:



A time of 9:15 am should be entered as follows:

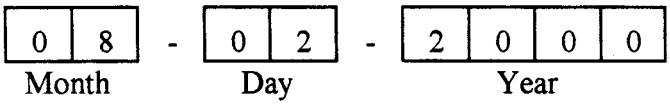


b. Date/time returned to the rehabilitation unit/hospital.

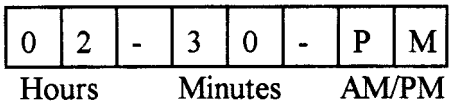
Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

Coding: If patient has not had an interrupted stay, leave the boxes blank. Otherwise, use all the boxes. For a one-digit month or day, place a zero in the first box.

August 2, 2000, should be entered as follows:



A time of 2:30 pm should be entered as follows:



14. Clinician Completing Assessment

Note: This item only appears on the interrupted stay tracking form. This is NOT the same as Section AB ''Assessment Attestation''.

Intent: To ensure that the data recorded on the Interrupted Stay Tracking Form is accurate and submitted to the HCFA MDS–PAC system within 7 calendar days of the date recorded in item AA13b. The date recorded in item AA13b is ''day 1'' when starting to count the 7 calendar days in order to determine the 7 calendar day time period.

Definition: The clinician who signs item AA14a must be a physician, registered nurse, physical therapist, or occupational therapist.

Process: As necessary examine the clinical record, and consult with other members of the interdisciplinary care team to obtain the data needed prior to completing this item.

Coding: After signing your name print your name at AA14b to AA14e. Indicate your credentials in the box at AA14f.

Section AB. Assessment Attestation

1. Person Completing the Assessment

Intent and Definition: A licensed clinician who is a physician, registered nurse, physical therapist, or occupational therapist must sign and certify that—(1) The assessment is complete; and (2) The data recorded for the assessment items are to the best of his or her belief accurately recorded and accurately depict the patient's clinical status.

Process: Examine the MDS–PAC to determine if according to the instructions that the required data for each item has been accurately recorded.

Coding: The physician, registered nurse, physical therapist, or occupational therapist signs his/her name on line AB1a. The date that he or she signed the assessment as complete and accurate is entered in the boxes of AB1g and his/her name must be printed on the line that starts at AB1b. In the box for item AB1f enter the code number that identifies the type of licensed clinician signing item AB1a.

2. Signatures of Staff Completing Part of the Assessment

Intent: Each individual who completes a portion of the assessment must sign and certify to the accuracy of the items he or she has completed.

Coding: On lines AB2a–AB2f each person who has completed any MDS–PAC item signs their name, writes their credentials, indicates what section(s) or item(s) he or she completed, and writes the date of his or her signature.

Section A. Demographic/Admission Information History

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

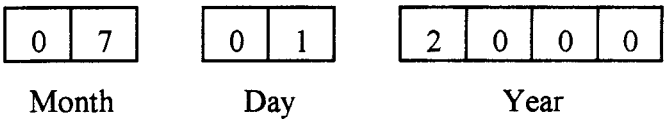
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear what date the stay for the current precipitating event/problem began, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part-A stay began.

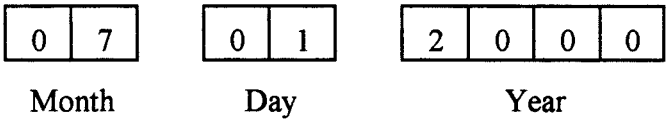
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item A2a ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part-A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part-A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed on:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS—PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	04/05/01	04/06/01	04/12/01	04/18/01
Day 11	Days 8 to 10	04/12/01	04/13/01	04/19/01	04/25/01
Day 30	Days 28 to 30	05/02/01	05/03/01	05/09/01	05/15/01
Day 60	Days 58 to 60	06/01/01	06/02/01	06/08/01	06/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/01/00	5/01/00	5/05/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Admission Status

Intent: The purpose of this item is to determine if the patient has been previously admitted for rehabilitation of this problem.

Process: Talk to the patient and family if necessary. Review the medical record to determine what type of facility this patient has been admitted from.

Coding: Place the number of the most appropriate code in the box.

0. First admission to inpatient rehabilitation services.

1. Readmission to rehabilitation but not directly from other rehabilitation.

2. Readmission directly from other rehabilitation.

5. Goals for Stay

Intent: To document the expected outcomes of the patient's post acute care stay. It is possible and common to have more than one goal for the stay.

Definition: a. Medical stabilization—Patient's condition is unstable and requires frequent medical and nursing monitoring (for example, vital signs; drug levels; laboratory evaluation) and interventions (for example, titrating drug dosages; transfusions) in an effort to achieve a steady state/program of care.

b. Rehabilitation/Functional Improvement—Care is directed towards the attainment of baseline (or prior to the precipitating event) level of function in a selected area or areas, for example, activities of daily living, instrumental activities of daily living, cognitive status, communication status, or psychosocial functioning.

c. Recuperation—Care directed towards recovery from an illness by regaining health or strength. Often includes patient or family caregiver teaching to prepare for different level of care (for example, medication management; energy conservation; ostomy care).

d. Monitoring to avoid clinical complication—For a medically stable patient, care directed at systematic monitoring of the patient's condition through observation (that is, clinical signs and symptoms) and measurement of physical parameters (that is, lab values; respiratory function tests) with the intent of preventing complications associated with the patient's clinical condition.

e. Palliative care—A primary goal of care is to provide comfort and quality of life through the prevention and control of symptoms near the end of life. Palliative care often includes active treatment of associated conditions in an effort to promote a sense of well-being at the end of life (for example, antidepressant drugs/psychotherapy for depression; physical therapy as an adjunct to pain management and prevention of pressure ulcers; nutritional counseling).

Coding: Code each possible goal with one of the following responses, as appropriate:

0. No.

1. Yes.

6. Admitted From (At admission date A2)

Intent: To facilitate care planning by documenting the place from which the patient was admitted to the facility on the date recorded in item A2.

Definition: 1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented room—A rented room in a private house, boarding house, or hotel.

4. Board and care/group home—A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home

health, homemaker, personal care, meal service, transportation, etc.

5. Assisted living—A housing option for older adults who need some assistance with activities of daily living (ADLs) but do not require 24-hour nursing care.

6. Homeless shelter—A community-based shelter for individuals who do not have a place to reside.

7. Transitional living—A community based supervised setting where individuals are taught skills so that they can live independently in the community.

8. Long term care facility (nursing home)—A licensed health facility that provides 24-hour skilled or intermediate nursing care.

9. Post acute care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

10. Acute care hospital (not rehabilitation unit)—A facility licensed as an acute care hospital which focuses primarily on the diagnosis and treatment of acute medical (and in some cases psychiatric) disorders.

11. Rehabilitation unit (in acute care hospital)—A unit within an acute care hospital that focuses on the acute rehabilitation of individuals who have been functionally affected by disease or injury.

12. Rehabilitation hospital—A facility licensed as a rehabilitation hospital that focuses on the physical rehabilitation of individuals who have been functionally affected by disease or injury.

13. Long term care hospital—A facility licensed as a long-term care hospital. Included are hospitals that focus on the management of clinically complex patients, chronic medical needs, chronic disease, etc. (includes chronic disease hospitals, and long term acute care hospitals).

14. Psychiatric hospital/unit—A facility licensed as a psychiatric hospital or unit which focuses on the diagnosis and treatment of psychiatric disorders.

15. MR/DD facility (exclude group home)—A facility which specializes in the management and rehabilitation of individuals with mental retardation or developmental disorders. Examples include mental retardation or developmental disabilities facility (including MR/DD institutions) and intermediate care facilities for the mentally retarded (ICF/MRs).

16. Other hospital—Any other hospital not categorized above (may include in-patient hospice programs).

17. Outpatient surgery center—A stand-alone or hospital-affiliated outpatient surgery center designated to provide perioperative care (no inpatient beds). Includes same-day surgery units.

18. Other—Any other setting not categorized above.

Process: Review the medical record. If unavailable in medical record, ask patient or family.

Coding: Choose only one answer and enter the appropriate code in the box provided.

7. Precipitating Event Prior to Admission

a. Time of onset of the precipitating event or problem that directly preceded admission into this facility (time from admission date—item A2).

Intent: This item seeks to provide the care team with some perspective on the event that caused the admission.

Process: Review medical record for history of the event or problem using admission date to the facility (item A2) as a reference point. If necessary, clarify with patient or family.

Coding: Enter the number that best represents the time period in which the precipitating event occurred. This information is obtained only on admission, but must be coded and submitted to the HCFA MDS–PAC system for each subsequent (for example, the Day 11) assessment.

0. Within last week.

1. Within last 8–14 days.

2. 15–30 days ago.

3. 31–60 days ago.

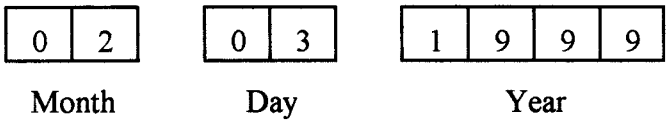
4. More than 60 days ago.

b. Date of admission of most recent acute care hospitalization (within last 90 days).

Intent: This item (in addition to the next) gives perspective on the amount of time the patient spent in the hospital. If there was NO hospitalization in the last 90 days, leave this section blank and move on to item A8.

Process: Review the medical record. Hospital discharge summaries are the most efficient means to gather this information, if available. If unavailable, consult with patient or family.

Code: Enter the date of admission to the hospital in space provided. For a one-digit month or day, place a zero in the first box. For example: February 3, 1999, should be entered as:



c. Reason for most recent acute care hospitalization (within last 90 days).

Definition: Hospitalization—The patient was formally admitted to an acute care hospital by a physician as an inpatient with an overnight stay. This category does not include day surgery or outpatient services.

New problem—A condition that is distinctly different or unrelated to any previously identified disease or condition of the patient.

Exacerbation—Recurrence or aggravation of symptoms or increase in the severity of a previously identified disease or condition.

Process: Review medical record. If necessary, clarify with patient or family.

Coding: Using the following codes, enter the number that best represents the reason the patient was most recently hospitalized.

0. Not Hospitalized at any time in last 90 days.

1. New problem.

2. Exacerbation.

3. Both (New Problem and Exacerbation).

8. Primary and Secondary Payment Sources for Stay (Per diem)

Intent: To document the payment source(s) that covers the daily per diem services for this post acute stay.

Definition: Per diem—Room, board, nursing services and other services included in the routine daily charge.

Process: Consult with the business or billing office to review current payment sources. Do not rely exclusively on information recorded in the patient's medical record (usually the face sheet at the front of the chart) as the patient's clinical condition may trigger different sources of payment during the stay. It's important to capture all methods of payment; usually business offices track such information.

Coding: Using the following list, enter the code which best indicates the primary and secondary payment sources in the appropriate boxes. In Column A, code for the primary payment source for the stay. In Column B, code for the secondary payment source for the stay.

Note: The code for Column B can't be the same as the code in Column A.

0. None—no insurance coverage, no private pay.

1. Medicare.

2. Medicaid.

3. CHAMPUS.

4. Department of Veterans Affairs.

5. Managed Care/HMO—Medicare.

6. Managed Care/HMO—non-Medicare.

7. Private insurance.

8. Private pay—self or family pays, includes private pay by patient or family.

9. Worker's Compensation.

10. Other payment—examples include Commission for the Blind, Alzheimer's Association.

9. Marital Status

Process: Ask patient or family member.

Coding: Choose the code that best describes the patient's current marital status. If the patient is in a ''Common Law'' marriage, enter code ''2'', Married. Common Law marriage—a couple who have been co-habitating and who consider themselves as being married, even though not legally married.

1. Never married.

2. Married.

3. Widowed.
4. Separated.
5. Divorced.

10. Education (Highest Level Completed)

Intent: To record the highest level of education the patient attained. Knowing this information is useful for assessment (for example, interpreting cognitive patterns or language skills), care planning (for example, deciding how to focus a planned recovery program), and planning for patient education in self-care skills.

Definition: The highest level of education attained.

1. No schooling: Patient/family state that patient received no formal schooling at all.
2. 8th grade or less: Patient attended school through 8th grade level or less.
3. 9th–11th grade: Patient completed school at 9th, 10th, or 11th grade.
4. High School: Patient obtained high school diploma—completed school through the twelfth grade or GED.
5. Technical or Trade School: Include schooling in which the patient received a non-degree certificate in any technical occupation or trade (for example, carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).
6. Some College: Includes completion of some college courses at a junior (community) college, associate's degree, or incomplete bachelor's degree.
7. Bachelor's degree: Includes any undergraduate bachelor's level college degree.
8. Graduate Degree: Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

Note: If assessor has been unsuccessful in determining educational information, the assessor may use a ''dash'' symbol to indicate information not available.

Process: Ask the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Code for the best response. For MR/DD patients who have received special education services, code ''2'' (8th grade/less).

11. Language

Definition: (a.) Primary language—The language the patient primarily speaks or understands. If patient is unable to speak at the present time, code for language familiar to patient prior to the precipitating event.

Process: Determine patient's primary language by asking the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Given the choices provided, indicate what the patient identifies as their primary language.

0. English.
1. Spanish.
2. French.
3. Other, specify in A11b.

(b.) If the patient's primary language is other than English, Spanish, or French, enter 3 for Other in item A11a, and print the primary language in item A11b beginning in the left-most box.

12. Dominant Hand

Intent: To document which hand the patient considers to be the ''dominant'' hand. Knowing the patient's ''handedness'' can facilitate rehabilitation and assist in the detection of neurological and functional diagnoses.

Definition: The dominant hand describes what is usually referred to as ''handedness'' and reflects the area of the brain that is most dominant.

Process: Ask patient, family, or therapy staff.

Coding: Indicate which hand the individual has considered to be dominant since childhood. If an individual feels that both hands are equal (ambidextrous), enter code ''3'', unable to determine. Also use code ''3'' if you are unable to obtain this information from the patient, family or medical record.

If Right handed, code ''1''.
If Left handed, code ''2''.
If Unable to determine, code ''3''.

13. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition: Patient has one of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (for example, partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Process: Review the patient's record *only.* For a ''Yes'' response to be entered, there must be written documentation (that is, verbal reports from the patient or patient's family are not sufficient).

Coding: Enter ''0'' for No or ''1'' for Yes.
0. No.
1. Yes.

14. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities)

Intent: To document presence of mental retardation or developmental disabilities with and without organic conditions.

Process: Review the patient's record only. Condition must be documented in the clinical record. Examples of organic conditions related to MR/DD are rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

Coding: If organic condition is present, check if condition is related to MR/DD status present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

1. Not applicable—No MR/DD.
2. MR/DD with no organic condition.
3. MR/DD with organic condition.

15. Responsibility/Legal Guardian

Intent: To record who has responsibility for participating in decisions about the patient's health care, treatment, financial affairs, and legal affairs. Depending on the patient's condition, multiple options may apply. For example, a patient with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a patient may have executed a limited power of attorney to someone responsible only for legal affairs.

Definition: a. Legal guardian—Someone who has been appointed after a court hearing and is authorized to make decisions for the patient, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

b. Other legal oversight—Use this category for any other program in your State whereby someone other than the patient participates in or makes decisions about the patient's health care and treatment.

c. Durable power of attorney/health care—Documentation that someone other than the patient is legally responsible for health care decisions if the patient becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the patient's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the patient at any time.

d. Patient responsible for self—Patient retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the patient is the responsible party.

e. NONE OF THE ABOVE.

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by state law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the patient and the patient's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the patient's record in order for the item to be checked on the MDS–PAC form.

Coding: Check all that apply.

16. Advance Directives

Intent: To document the existence of any legal directives to guide the health care team in making treatment decisions, whether made by the patient him/herself or a legal proxy. This documentation must be in the medical record to be considered current and binding. The absence of pre-existing directives for the patient provides an opportunity for a discussion by the clinical team with the patient and family regarding the patient's wishes. Any discrepancies between the patient's current stated wishes and what is said in legal documents in the patient's file should be resolved immediately.

Definition: a. Living will—A document specifying the patient's preferences regarding measures used to prolong life when there is a terminal prognosis.

b. Do not resuscitate—In the event of respiratory or cardiac failure, the patient, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the patient's respiratory or circulatory function.

c. Do not hospitalize—A document specifying that the patient is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Treatment restrictions—The patient or responsible party (family or legal guardian) does not wish the patient to receive certain medical treatments. Examples include, but are not limited to: blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (for example, reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party. Treatment restrictions could also include:

• *Feeding restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to be fed by artificial means (for example, tube, intravenous nutrition) if unable to be nourished by oral means.

• *Medication restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to receive life-sustaining medications (for example, antibiotics, chemotherapy).

e. NONE OF THE ABOVE.

Process: You will need to familiarize yourself with the legal status of each type of directive in your State. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the patient's wishes until their legal status is determined.

Review the patient's record for documentation of the patient's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some patients at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new patient has ever created an advance directive (for example, ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the patient's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

• The patient (or proxy) should always be involved in the discussion to ensure informed decision-making. If the patient's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS–PAC item only after the preference has been documented.

• If the patient's preference is in areas that require supporting orders by the attending physician (for example, do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS–PAC item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded but patient's or proxy's preference is not indicated, discuss with the patient's physician and check the MDS–PAC item only after documentation confirming that the patient's or proxy's wishes have been entered into the record.

• If your facility has a standard protocol for withholding particular treatments from all patients (for example, no facility staff member may resuscitate or perform CPR on any patient; facility does not use feeding tubes), check the MDS–PAC item only if the advanced directive is the individual preference of the patient (or legal proxy), regardless of the facility's policy or protocol.

Coding: Check all that apply. If none of the directives are verified by documentation in the medical records, check NONE OF ABOVE.

Section B. Cognitive Patterns

Intent: To assess the patient's ability to think coherently, remember and organize thoughts into actions, including daily self-care activities. These items focus on the patient's functional performance, including demonstration of ability to remember recent and past events, to perform key decision making skills. This information can significantly contribute to the development of a post acute plan of care, including the discharge plan.

Questions about cognitive function and memory can be threatening or sensitive for some patients. Some may react defensively or get agitated and emotional if unable to remember or answer the questions. These are not uncommon reactions to ''performance anxiety'' and feelings of being exposed, embarrassed, or frustrated if the patient is aware that he or she cannot respond cogently. It is important to recognize these feelings and to be as supportive as possible.

It is important to establish an environment that enables the patient to function at their optimal level. The first few days of admission to a post acute setting can be overwhelming. Be sure to interview the patient in a private, quiet area (for example, limit distractions and interruptions as much as possible), and not in the presence of other patients or family, unless the patient would prefer that they stay. Using a non-judgmental approach to questioning will help create a needed sense of trust between the assessor and the patient. Clarify and validate your findings with the patient's family or other clinicians as needed. This input is especially important for those patients with limited communication skills or language barriers.

Engage the patient in general conversation to help establish rapport.

• Actively listen and observe for clues to help you structure your assessment. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.

• Be open, supportive, and reassuring during your conversation with the patient (for example, ''Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you'').

If the patient becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting during the three-day observation/assessment period but may be ongoing during the entire assessment period. Say to the agitated patient, for example, ''Let's talk about something else now,'' or ''We don't need to talk about that now. We can do it later''. Observe the patient's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

1. Comatose

Intent: To record whether the patient's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Process: Review medical record for documentation.

Coding: Enter the appropriate number in the box.

If the patient has been diagnosed as comatose or in a persistent vegetative state, code ''1'' (Yes) and Skip to Section E. If the patient is not comatose, or is semi-comatose, code ''0'' (No) and proceed to the next item (B2).

2. Memory/Recall Ability

Intent: To determine a patient's ability to remember recent and past events (that is, short-term, long-term, situational and procedural memory).

Process: a. Short-term memory OK: Ask the patient to describe a recent event that both of you have had the opportunity to remember (you should be able to validate that patient's memory with your knowledge of such events). Examples include what the patient had for breakfast, when the last pain medication dosage was received, (you can validate the patient's recollection with information from the medical record). For persons with verbal communication deficits,

non-verbal responses are acceptable (for example, when asked how many children visited today, they can correctly tap out a response of the appropriate number). If there is no positive indication of memory ability, code ''1'', Memory problem.

b. Long-term memory OK: Engage in conversation about past events that are meaningful to the patient (for example, family, hospitalization, work experience). Ask questions for which you can validate the answers (from your review of the medical record, general knowledge, the patient's family). For patients with limited communication skills, ask family members about their perception of the patient's memory. If the patient demonstrates difficulty remembering key events of long ago, code ''1'', Memory problem.

c. Situational memory OK: This item refers to two abilities that can be demonstrated by the patient within the facility: (1) The patient's ability to recognize the names and faces of staff whom they frequently encounter, AND (2) the patient's ability to remember the location of places regularly visited (for example, bedroom, meal room/dining area, activity room, therapy room). IMPORTANT: For coding purposes, the patient must demonstrate positive abilities in BOTH types of situations to be coded as ''0'', Memory OK. If she/he demonstrates difficulty in one or both areas code as ''1'', Memory problem.

• Recognize staff names and faces—The patient distinguishes staff caregivers from family members, strangers, visitors, and other patients. It is not necessary that the patient remembers all staff members' names, but to recognize them as staff caregivers (that is, nurse, therapist) vs. others.

• Remember the location of places regularly visited—The patient is able to locate or recognize key areas of the facility that they frequent regularly. It is not necessary for the patient to know his/her room number but he/she should be able to find the way to his room, recognize the purposes of particular rooms, etc.

d. Procedural Memory OK: This MDS–PAC item refers to the ability to perform sequential activities. Dressing is an example of such a task as it requires multiple steps to complete the entire task. The patient must be able to perform or remember to perform all or most all of the steps in order to be scored a ''0'' Memory O.K. If the patient demonstrates difficulty in two or more steps, code as ''1'' Memory Problem.

Coding: For each type of memory:

Code ''0'' in the box provided, if memory OK.

Code ''1'' in the box provided, if memory problem is demonstrated.

3. Cognitive Skills for Daily Decision Making

Intent: To record the patient's ability and actual performance in making every day decisions about tasks or activities of daily living. This item is especially important for assessment and care planning for 2 reasons: (1) The information can alert health care providers to new changes (decline or improvement) in the patient's cognitive function, and (2) the information can alert staff to a discrepancy between a patient's capacity for decision-making and their current level of performance, which may indicate that caregivers or family may be inadvertently fostering the patient's dependence. It may have an impact on the course of treatment outcomes and discharge plan.

For persons who have been acutely ill, it is important to determine the patient's ''baseline'' cognitive skills from some point prior to the current admission (Note: this instrument uses a time period prior to the assessment reference date [item AA4]), as well as his/her current skills (Note: the last 3 days, and the time immediately prior to precipitating event), so that the clinician can make a comparison for diagnostic and care planning purposes. Even slight deviations (decline) from baseline may be secondary to a variety of causes including: (1) The outcome of a recent acute event (for example, a primary neurological event such as a CVA; post anesthesia), (2) an evolving acute illness or exacerbation of disease (for example, infection; congestive heart failure; dehydration; drug effects or interactions; depression), or (3) a progression of a chronic neurological condition (for example, Alzheimer's disease; Huntington's disease). Detecting change is the first step in determining whether the change is due to a remediable condition or chronic decline. Likewise, follow-up measurements can provide an indication of success of treatment programs, prognosis for independent living, etc.

(a) Making decisions regarding tasks of daily life.

Process: This assessment should be conducted through conversation with direct care staff, a review of the clinical record (chart), in addition to personally observing and interacting with the patient [Note—this personal interaction can occur in the course of regular ongoing care activities; or it can be a part of a planned MDS–PAC interview/observation where a series of issues are reviewed—cognition, mood, ADLs, activities]. Your inquiry should focus on whether the patient is actively making choices, plans, and decisions, and not whether staff believe the patient might be capable of doing so. Remember, the intent of this item is to record what the patient is doing (performance). Where a health care provider or family member takes decision-making responsibilities away from the patient regarding tasks of everyday living or the patient does not participate in decision-making (which may happen when patients take on the ''sick'' role), consider the patient to have impaired performance in decision making. In this case document how they function now rather than your supposition of their capacity to function. Consult with family and health care providers where necessary to clarify patient decision making.

Coding: Enter the number that most accurately characterizes the patient's cognitive performance in making decisions regarding the tasks of daily life over the last three days.

0. Independent—The patient's decisions in planning and executing daily routines and making decisions were consistent, reasonable, safe, and organized reflecting lifestyle, culture, values.

1. Modified Independence—The patient was organized in daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2. Minimally Impaired—For the most part, the patient was organized in daily routines and made safe decisions, but in specific situations the patient demonstrated poor decision-making skills requiring directions or cues or supervision at those times.

3. Moderately Impaired—The patient demonstrated poor decision making skills that could place his/her safety at risk. The patient needs reminders, cues and supervision in planning, organizing, correcting, and carrying out daily routines. Cues and supervision are required at all times.

4. Severely Impaired—The patient's decision making was severely impaired: the patient never (or rarely) makes decisions.

(b) Is now more impaired in decision making than prior to precipitating event (item A7a).

Intent: To record whether the patient is now more impaired than she/he was at a specified period in time prior to the precipitating event (that is, the current score to item B3a is higher that it would have been prior to the precipitating event).

Process: Through patient interview, family reports, or review of earlier clinical record, compare the patient's current skills in daily decision making with their skills immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

4. Indicators of Delirium—Periodic Disordered Thinking/Awareness

Intent: To assess and record behavioral signs that may indicate that delirium is present. The characteristics of delirium are usually manifested behaviorally, and therefore can be observed. For example, disordered thinking, a typical characteristic of delirium, may be first observed as rambling, irrelevant, or incoherent speech. Other typical behaviors are described in the definitions below.

Many acute conditions (for example, infections; congestive heart failure) and treatment (for example, polypharmacy; anesthesia; anticholinergic drugs) can have a deleterious effect on cognitive performance and the development of delirium, particularly in persons with the following risk factors: over age 80 years, prior history of cognitive impairment, recent hip fractures, complex medical conditions and drug regimens, recent hospitalization, and history or signs/symptoms of depression. The incidence rate of delirium among acute care hospital patients is as high as 41% and often occurs by day 2 through 6 of the hospitalization. Approximately 48–96% of patients continue to have some behavioral and cognitive symptoms by discharge. With the shortening of hospital stays, and the shift towards earlier discharge to post acute environments it is crucial for clinicians to identify and monitor for behavioral

manifestations of delirium for two reasons: (1) to identify new or worsening signs that herald the onset of a treatable acute condition, and (2) to document the progression of changes over time for discharge planning.

Definition: a. Easily distracted—(for example, has difficulty paying attention, does not complete tasks or conversations without getting sidetracked)

b. Periods of altered perception or awareness of surroundings—(for example, moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. Episodes of disorganized speech—(for example, speech is incoherent, nonsensical, irrelevant, rambling from subject to subject; loses train of thought)

d. Periods of restlessness—(for example, fidgeting or picking at skin, clothing, napkins, etc.; frequently changing positions; repetitive physical movements or calling out)

e. Periods of lethargy—(for example, sluggishness, staring into space; difficult to arouse; little body movement)

f. Mental function varies over the course of the day—(for example, alertness and behaviors vary during the course of the day, sometimes better, sometimes worse; sometimes present, sometimes not)

Process: Observe patient and interview staff.

Coding: Code for the patient's behavior in the last seven days regardless of what you believe the cause to be—focus on when the manifested behavior first occurred. Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time.

0. Behavior not present.

1. Behavior present, not of recent onset.

2. Behavior present over last 7 days appears different from the patient's usual functioning (for example, new onset or worsening).

Section C. Communication/Vision Patterns

Intent: To document the patient's sensory function (for example, ability to hear and see with assistive devices, if used, and/or environmental adjustments, if necessary) and ability to understand and communicate with others.

Communication—There are many possible causes for communication problems experienced by elderly and post acute patients. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a patient might have aphasia as well as long standing hearing loss; or he might have dementia with word finding difficulties and a hearing loss. The patient's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions.

Vision—Visual limitations or difficulties may be related to the aging process as well as to diseases common in aged and chronically ill persons (for example, cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases). It is important to identify visual impairment. Some conditions may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the patient's residual visual abilities. In the post acute setting, identifying and addressing visual impairment is an important part of preparing the patient for tasks related to self-care upon potential discharge to a more independent care setting (for example, reading medication and food labels; safely negotiating a living environment; using the stove).

1. Hearing

Intent: To evaluate the patient's ability to hear (with hearing appliance, if used, and/or environmental adjustments, if necessary) during the last 3-day period. Identifying impairments early in the post acute stay can facilitate the development of necessary adaptions for discharge. Often the environment can have an impact on the patient's ability to hear and must be considered in the assessment.

Process: If the patient has an adaptive hearing device/aid/appliance, evaluate hearing ability with the working device in place. Interview the patient (ask about hearing function) and observe for hearing function during your verbal interactions. Use a variety of observations to make your assessment (for example, one-on-one vs. group situations). Always be mindful of environmental factors that may influence your assessment (for example, call bells; vacuum cleaners; suctioning equipment; roommate's conversations; outside noises, etc.). If necessary to clarify exact hearing level, consult with the patient's family, primary caregivers, or speech or hearing specialists.

Be alert to what you have to do to communicate with the patient. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the patient needs to see your face to know what you are saying, or if you have to take the patient to a more quiet area to conduct the interview—all of these are cues that there is a hearing problem, and should be indicated in coding this section.

Coding: Enter the number that corresponds to the most correct response.

0. Hears adequately—The patient hears all normal conversational speech, social interaction, including when using the phone, and watching TV.

1. Minimal difficulty—The patient hears speech at conversational levels but has difficulty hearing when the environment is not quiet or when he/she is in group situations. Background noise affects hearing.

2. Hears in special situations only—The patient is hearing deficient but compensates and hears better when the speaker increases volume, adjusts his voice tone, and/or speaks distinctly; or the patient can hear only when the speaker's face is clearly visible.

3. Highly impaired/absence of useful hearing—The patient hears only some sounds and frequently fails to respond even when speaker adjusts tone and volume, speaks slowly and distinctly, or is positioned face-to-face with the patient. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

2. Modes of Communication

Intent: To record the types of communication techniques (for example, alternative verbal or non-verbal techniques) used by the patient to make his or her needs or wishes known.

Definition: a. Hearing aid—An apparatus used by those with impaired hearing for amplifying sound.

b. Lip reading—Understanding spoken word by means of visualization of the speaker's mouth and lips.

c. Signs/gestures/sounds—This category includes non-verbal expressions used by the patient to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for ''yes'' and once for ''no'' or squeezing another's hand in the same manner.
- Sounds may include grunting, banging, ringing a bell, etc.

d. Writing messages to express or clarify needs—Patient writes notes to communicate with others.

e. NONE OF THE ABOVE.

Process: Interact with the patient and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations. Consult with the direct care staff from all shifts. For patient with limited communication skills, have staff ask patient's family if there are additional effective means of communication.

Coding: Check the boxes for each method used by the patient to communicate his or her needs. If the patient does not use any of the listed items, check NONE OF THE ABOVE.

3. Making Self Understood (Expression)

Intent: To document the patient's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: over the last 3 days, and immediately prior to the precipitating event (A7a).

(a) Expressing information content—however able.

Process: Interact with the patient. Observe and listen to the patient's efforts to communicate with you using the assistive devices/modes of expression they would normally use to communicate. Consult with the primary caregivers (over all shifts), and speech-language pathologist, if possible, who will be able to report on observations of patient's interactions with others in different

settings (for example, one-on-one, groups) and different circumstances (for example, when calm, when agitated) and different times of day. If direct care staff are uncertain and you require further clarification, consult with family members who frequently visit the patient (if such a person is present).

Coding: Enter the number corresponding to the patient's ability to make self understood over the last 3 days.

0. Understood—The patient expresses ideas clearly, without difficulty.

1. Usually Understood—The patient may have difficulty expressing ideas (finding words or finishing thoughts) but is able to make him/herself understood if the listener is patient and gives him/her time to express himself. Little or no prompting required by the listener.

2. Often Understood—The patient has difficulty finding the right words or finishing thoughts, resulting in delayed or incomplete responses. The patient usually requires some prompting/cuing by the listener to complete or clarify the message (make self understood).

3. Sometimes Understood—The patient has limited ability, but expresses simple, concrete requests regarding at least basic needs that would be generally understood (for example, food, drink, sleep, toilet, pain).

4. Rarely or Never Understood—The patient is not able to communicate effectively. At best, this communication is such that it required staff to interpret the meaning of highly individual, patient-specific sounds or body language (for example, indicated presence of pain or need to use the toilet).

(b) Is now more impaired in making self understood by others than was prior to precipitating event (item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to make self understood (last 3 days) with their ability prior to the precipitating event [Item A7a]).

Coding: Enter the number corresponding to the most appropriate response.

0. No, or unsure.

1. Yes, more impaired today.

4. Speech Clarity

Intent: To document the quality/intelligibility of the patient's speech (not the content or appropriateness).

Definition: Speech—the expression of articulate words.

Process: Throughout the course of the assessment the patient will have many opportunities to talk with you. Listen to the clarity of speech. To assess speech quality over the last 3 days also confer with primary caregivers.

Coding: Enter the number corresponding to the response which best describes the clarity and quality of the patient's speech in the last 3 days.

0. Clear speech—utters distinct, intelligible words.

1. Unclear speech—utters slurred or mumbled words.

2. No speech—absence of spoken words.

5. Ability to Understand Others (Comprehension)

Intent: To describe the patient's ability to comprehend information whether communicated to the patient orally, in writing, or in sign language or Braille. This item measures not only the patient's ability to hear messages but also to process and understand language. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: the last 3 days, and immediately prior to a more distant precipitating event (A7a).

(a) Understanding verbal information content (however able) with hearing appliance, if used.

Process: Assess the patient using whatever assistive devices/methods (for example, hearing aids) that the patient would usually use in communicating with others. Interact with the patient. Throughout the assessment process and at other times observe the patient and determine his/her ability to comprehend your questions and statements. Try to observe the patient's interactions with others, in different situations and times of day. Consult with primary staff caregivers (over all shifts), and speech-language pathologist (if present) to clarify patient understanding at different times and in different settings. If direct care staff are uncertain and you require further clarification, consult with family member who frequently visits the patient (if such person is present).

Coding: Enter the number corresponding to the patient's ability to comprehend (understand others) over the last 3 days.

0. Understands—The patient clearly comprehends the speaker's message(s) and demonstrates this understanding through words or actions/behaviors.

1. Usually Understands—The patient may miss some part or intent of the message but comprehends most of it. The patient may have periodic difficulties integrating information but generally demonstrates comprehension, by responding in words or actions. Little or no prompting required.

2. Often Understands—The patient may miss some part or intent of the message. When the messenger(s) (staff or family) rephrase or simplify the message(s) or use gestures, and specifically inquires as to the patient's understanding of what is being communicated, the patient's comprehension is enhanced. This type of prompting occurs often.

3. Sometimes Understands—The patient demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions/cues (for example, one-step commands such as ''close your eyes'')

4. Rarely/Never Understands—The patient demonstrates very limited ability to understand communication. Based on the patient's verbal and nonverbal responses, staff have difficulty determining whether the patient comprehends messages, or the patient can hear sounds but does not understand messages.

(b) Is now more impaired in understanding others than was prior to precipitating event (Item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to understand others (last 3 days) with their ability immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

6. Vision

Intent: To evaluate the patient's ability to see close objects in adequate lighting, using the patient's customary visual appliances for close vision (for example, glasses; contact lenses; magnifying glass). Adequate lighting is defined as the amount of light that is sufficient or comfortable for a person with normal vision.

Process: • Ask the patient about his or her visual abilities for close vision (for example, to see newsprint, menus, greeting cards), use of glasses, contact lenses, etc.

• To validate the patient's reported vision, ask the patient to look at regular-size print in a book or newspaper using whatever visual appliance he or she customarily uses for close vision (for example, glasses, magnifying glass). Then ask the patient to read a few words aloud, starting with larger headlines and ending with the finest, smallest print.

• Be sensitive to the fact that some patients are not literate or are unable to read English. In such cases, ask the patient to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

• If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the patient has any visual ability.

(a) Ability to see in adequate light and with glasses, if used.

Coding: Enter the code that best describes the patient's visual ability given adequate light and use of his/her customary visual aids.

0. Adequate—The patient sees fine detail, including regular print in newspapers/books.

1. Impaired—The patient sees large print, but not regular print in newspapers/books.

2. Moderately Impaired—The patient has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3. Highly Impaired—The patient's ability to identify objects in his or her environment is in question, but eye movements appear to follow objects (for example, people walking by).

Note: Many patients with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such patients appear to ''track'' or follow moving objects in their environment with their eyes. For patients who appear to do this, use code ''3'', Highly Impaired. Even though these are gross measures, with our current limited technology, this is the best general assessment you can do under the circumstances.

4. Severely Impaired—The patient has no vision; reports seeing only light or colors, but eyes do not appear to follow objects (for example, people walking by).

(b) Is now more impaired in vision than was prior to precipitating event (Item A7a).

0. No or unsure.

1. Yes, more impaired today.

Section D. Mood and Behavior Patterns

Mood distress is a serious condition that is associated with significant morbidity and mortality. It may be precipitated by acute illness, loss of independence (whether temporary or permanent), a new diagnosis (possibly terminal), pain, effects of medications, etc. Although changes in mood and behavior can happen to anyone, persons at particular risk for disorders such as depression are those with prior history of mood disorders, mild to moderate cognitive impairment, pain, and unstable health conditions. Many clinicians and patients perceive changes in mood and behavior to be normal, expected reactions to crisis (for example, deteriorating health). Although such reactions are common, it is crucial to identify the particular signs of distress, assess the frequency of their occurrence, and determine whether they are easily altered. Then clinicians can develop an appropriate treatment plan based on the impact of the mood or behavioral indicators on the patient's quality of life and well-being, ability to participate in the post acute treatment and discharge plans, etc.

1. Indicators of Depression, Anxiety, Sad Mood

Intent: To record the frequency of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychic distress may be expressed directly by the patient who is depressed, anxious, or sad. However, direct statements such as ''I'm so depressed'' are often rare; signs must be often ''teased'' out by clinicians through observation and interview. Distress may be more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. Patient made negative statements—for example, ''Nothing matters; Would rather be dead than live this way; What's the use; Let me die.''

b. Persistent anger with self or others—for example, easily annoyed, anger at presence in post acute care, anger at care received.

c. Expressions of what appear to be unrealistic fears—for example, fear of being abandoned, left alone, being with others, afraid of nighttime.

d. Repetitive anxious complaints/concerns (non-health related)—for example, persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit.

e. Repetitive health complaints—for example, persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs.

Distress may also be expressed non-verbally and identified through observation of the patient in the following areas during usual daily routines:

SAD, APATHETIC ANXIOUS APPEARANCE

f. Sad, pained, worried facial expressions—for example, furrowed brows.

g. Crying, tearfulness.

h. Repetitive physical movements—for example, pacing, hand wringing, restlessness, fidgeting, picking.

SLEEP CYCLE ISSUES

Distress can also be manifested in disturbed sleep patterns.

i. Insomnia/change in usual sleep patterns—for example, difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

LOSS OF INTEREST

These items refer to a change in the patient's usual pattern of behavior.

j. Withdrawal from activities of interest—for example, no interest in long standing activities or being with family/friends.

k. Reduced social interaction—for example, less talkative, more isolated.

Process: Initiate a conversation with the patient, being cognizant of earlier statements by (or observations of) the patient. Some patients are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when asked directly how they feel. For patients who verbalize their feelings, ask how long these conditions have been present. Other patients may be unable to articulate their feelings (that is, cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe the patient carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the patient during the three days covered by this assessment. Consult with direct-care staff over all shifts, if possible, or other clinicians who work with the patient, or family who have direct knowledge of the patient's typical and current behavior. Relevant information may also be found in the clinical record, although this can vary.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the patient in the last 3 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 3 days.

1. Exhibited on 1–2 of last 3 days.

2. Exhibited on each of last 3 days.

2. Mood Persistence

Intent: To identify if one or more indicators of depressed, sad or anxious mood [Item D1] were easily altered by attempts to ''cheer up'', console, or reassure the patient over the last three days.

Process: The information on which to base this judgement is gathered as part of the conversations, observation, and record reviews for D1 (the individual indicators of mood state). The key factor here is the need to assess whether (when aggregated across the several mood indicators) the patient cannot be easily consoled, reassured or cheered up.

Coding: One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to cheer up, console, or reassure the patient over last 3 days.

0. No mood indicators or always easily altered.

1. Partially altered or easily altered on only some occasions.

2. All aspects of mood not easily altered.

3. Behavioral Symptoms

Intent: To identify the frequency of behavioral symptoms over the last 3 days that cause distress to the patient, or are distressing or disruptive to other patients or staff members. Such behaviors include those that are potentially harmful to the patient, or disruptive in the environment, even if staff or other patients appear to understand or have adjusted to them (for example, ''Mrs. R. doesn't mean anything by calling out. She does it because she's confused right now.'')

Behavioral symptoms can be associated with an acute illness, a change in medication, or simply a response to or change in the environment. Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care.

Note: Documentation of the patient's behavioral status in the medical record may not be accurate, valid, or complete, and it is not intended to be the only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is determined, subsequent documentation should more accurately reflect the patient's status and response to interventions.

Definition: a. Wandering—Locomotion with no discernible, rational purpose. A wandering patient may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (for example, a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair use.

Do not include pacing back and forth as wandering behavior. If it occurs, it should be documented in Item D1h, ''Repetitive physical movements''.

b. Verbally Abusive Behavioral Symptoms—Other patients or staff were threatened, screamed at, or cursed at.

c. Physically Abusive Behavioral Symptoms—Other patients or staff were hit, shoved, scratched, or sexually abused.

d. Socially Inappropriate/Disruptive Behavioral Symptoms—Includes disruptive sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. Resists care—Resists taking medications/injections, ADL assistance, help with eating, or changes in position. This category does not include instances where the patient has made an informed choice not to follow a course of care (for example, patient has exercised his or her right to refuse treatment, and reacts negatively if staff try to reinstate treatment).

Signs of resistance may be verbal or physical (for example, verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, and their presence should prompt further investigation of their cause (for example, fear of pain, fear of falling, poor comprehension, anger, poor

relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the patient's behavioral symptoms. The coding for this item focuses on the patient's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to record all behavioral symptoms. The fact that staff have become used to the behavior and minimize the patient's presumed intent (''He doesn't really mean to hurt anyone. He's just frightened.'') is not pertinent to this coding. Does the patient manifest the behavioral symptom or not?

Observe the patient and how he/she responds to caregiver attempts to deliver care to him or her. Consult with staff who provide direct care on all three shifts. A symptomatic behavior may be present and might not be seen because it occurs during intimate care on another shift. Therefore, it is especially important to solicit input from direct caregivers (including nurse assistants) who have contact with the patient.

Simply relying on written notes in the patient record is not sufficient. You must be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (for example, staff are working with severely cognitively and functionally impaired patients (for example, in a head trauma unit) and are used to patients' wandering, noisiness, etc.). Focus staff attention on what has been the individual patient's actual behavior over the last three days. Finally, although it may not be complete, review the clinical record for documentation of behaviors you may not have seen, nor staff reported. When such a note is found, review the patient's status with staff. Is the note correct? Is it within the appropriate time frame of the record?

Coding: Behavioral symptom frequency in last 3 days.

Record the frequency of behavioral symptoms manifested by the patient across all three shifts.

Code ''0'' if the described behavioral symptom was not exhibited in last three days. This code applies to patients who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, or a behavior-management program. For example: A ''wandering'' patient who has not wandered in the last three days because he was restricted to bedrest and had a private duty nurse attending to him would be coded ''0''—Behavioral symptom not exhibited in last three days.

Code ''1'' if the described behavioral symptom occurred on 1 day.

Code ''2'' if the described behavioral symptom occurred on 2 days.

Code ''3'' if the described behavioral symptom occurred daily or more frequently (that is, multiple times each day) in the last 3 days.

Section E. Functional Status

Patients in post-acute care settings will have acute (and often chronic) illnesses, and they will be subject to a variety of factors that can severely impact self-sufficiency. For example, cognitive deficits can limit a person's ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete the ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Individualized plans of care can be successfully developed only when the patient's self-performance has been accurately assessed, including the amount and type of support being provided to the patient by others.

For patients in post acute settings, the focus of the admission assessment is twofold: (1) to determine baseline functional performance levels, and (2) to determine if these levels have recently changed. This information will then be used as a basis for developing a plan of care (for example, targeted rehabilitation and other services) with the goal of leading the patient to an expeditious and coordinated discharge to home or a lower level of care.

1. Activities of Daily Living (ADL) Self-Performance Summary (Over Last Three Days)

Intent: To record a summary of the patient's self-care performance in activities of daily living (that is, what the patient actually did for himself or herself or how much verbal or physical help was required by staff members) during the last three days. This requires a review of all ADL activities over this period.

Definition: ADL SELF–PERFORMANCE—Measures what the patient actually did (not what he or she might be capable of doing) within each ADL category over all shifts for all episodes over the last three days according to a performance-based scale.

a. Bed Mobility—How patient moves to and from a lying position, turns side to side, and positions the body while in bed.

b. Transfer—Bed/Chair—How patient moves between surfaces-that is, to/from bed, chair, wheelchair standing position. This definition excludes movement to/from bath or toilet, which is coded under Transfer Toilet (item E1i) and Transfer Tub/Shower (item E1l).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, locomotion is defined as self-sufficiency once in the chair.

d. Walk in Facility—How patient walks in different areas of the facility. For a patient who uses a wheelchair exclusively, this would be coded as ''8'' (Activity did not occur).

e. Dressing Upper Body—How patient dresses and undresses (street clothes, underwear) above the waist. Includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing Lower Body—How patient dresses and undresses (street clothes, underwear) from the waist down. Includes prostheses, orthotics (for example, anti-embolic stockings), belts, pants, skirt, shoes and fasteners.

g. Eating—How patient eats and drinks (regardless of skill). Includes intake or nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet Use—How patient uses the toilet room (or commode, bed pan, urinal), adjusts clothes before and after using toilet, manages perineal hygiene, changes pad, manages ostomy or catheter. (EXCLUDE transfer to toilet which is coded under item E1i, Transfer Toilet).

i. Transfer Toilet—How patient moves on and off toilet or commode or bedpan.

j. Grooming/Personal Hygiene—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup; and washing/drying face and hands (EXCLUDE baths and showers which are coded in item E1k, Bathing).

k. Bathing—How patient takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair and TRANSFER [which is coded in item E1l, Transfer Tub/Shower]). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Note: For this item and item E1l below, you must code for most dependent episode.

l. Transfer Tub/Shower—How patient transfers in/out of tub/shower. Code for most dependent episode.

Process: In order to promote the highest level of functioning among patients, clinical staff must first identify what the patient actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cuing, physical support, etc.)

A patient's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (for example, willing to perform for a nurse assistant he or she likes), medications and changes in underlying functional capacity. The responsibility of the person completing the assessment is to capture the total picture of the patient's ADL self-performance over the 3-day period, 24 hours a day—that is, not only how the evaluating clinician sees the patient, but how the patient performs on other shifts as well.

In order to accomplish this, you will need to know about the multiple episodes of the activity over the last 3-days—for example, how the patient dressed and undressed the upper body yesterday, the day before yesterday, and the day before that. To gather this information, there are two obvious sets of people to talk with—the patient and direct care staff—and when you have these conversations, be sure to plan to discuss all ADLs (get the total picture)—that is, if possible, talk with the patient and direct care staff on all three shifts (including weekends) and review documentation used to communicate with staff across shifts.

Ask questions pertaining to all aspects of the ADL activity definitions. For example,

when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the patient moves to and from a lying position, how the patient turns from side to side, and how the patient positions himself or herself while in bed. A patient can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations, where slight variations are common. Where variations occur, the coding ensures that the patient is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Set up Help only, Supervision, Minimal Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

The following chart provides general guidelines for recording accurate ADL Self-Performance.

Guidelines for Assessing (Item E1) ADL Self-Performance (Last 3 Days)

- The coding options for E1 record the patient's actual level of involvement in self-care and the type and amount of support actually received during the last three days—requiring that you have knowledge of all episodes of each of the ADLs (or as near as possible to all episodes).
- Do not record your assessment of the patient's capacity for involvement in self-care—that is, what you believe the patient might be able to do for himself or herself based on demonstrated skills or physical attributes. An assessment of functional prognosis is covered in Item L1 (Functional Improvement Goals by Discharge).
- Do not record the type and level of assistance that the patient ''should'' be receiving according to the written plan of care. The type and level of assistance actually provided may be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff from all shifts who have cared for the patient over the last three days in discussions regarding the patient's ADL functional performance. Remind staff that the focus is on the last three days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.
- When you are uncertain that the patient could perform the activity as described or conversely where you wonder why the patient is not more independent, observe a regularly scheduled session where this activity is carried out (for example, eating a meal, dressing in the morning). Observation will both help you to validate reported behaviors and will be useful as you go forward to care planning.

Here is a typical conversation between the RN and a nurse assistant regarding a patient's Bed Mobility assessment:

R.N. ''Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?''

N.A. ''She can lay down and sit up by herself, but I help her turn on her side.''

R.N. ''She lays down and sits up without any verbal instructions or physical help?''

N.A. ''No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself.'' se supervision

R.N. ''How do you help her turn side to side?''

N.A. ''She can help turn herself by grabbing onto her siderail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position.''

R.N. ''Do you lift her by yourself or does someone help you?''

N.A. ''I do it by myself.''

R.N. ''How many times during the last three days did you give this type of help?''

N.A. ''Every time she was turned.''

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance (in the last three days) Code of ''4''.

Now review the first two exchanges in the conversation between the RN and the nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the patient's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the patient's actual performance during the last three days. Consider the patient's performance during all shifts, as function may vary. For example, for eating, a patient may receive 3 meals per day and two supplemental feedings. Thus, over 3 days, there would have been 15 feeding episodes. It is this performance experience that forms the basis for scoring item E1g.

0. Independent—No help, or set up or staff oversight/supervision –OR–help, setup or supervision provided only 1 or 2 times during period (with any task or subtask). [See examples of Setup Help in the box following these coding options.]

1. Setup Help Only—Article or device provided or placed within reach of patient 3 or more times. [See examples of Setup Help in the box following these coding options.]

2. Supervision—Oversight, encouragement, or cuing provided 3 or more times during period–OR–Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision).

3. Minimal Assistance (Limited Assistance)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times –OR– Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help).

4. Moderate Assistance (Extensive Assistance)—Patient performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:

- Weight-bearing support (for example, holding weight of one or both lower limbs, trunk).
- Full staff performance of a task (some of time) or discrete subtask.

5. Maximal Assistance—Patient involved but completed less than 50% of subtasks on own (includes 2 + person assist), received weight bearing help or full performance of certain subtasks 3 or more times.

6. Total Assistance (Total Dependence)—Full staff performance of the activity during the entire period.

8. Activity Did Not Occur—During the last three days, the ADL activity was not performed by the patient or staff. In other words, the specific activity did not occur at all.

For example: A patient who was restricted to bed for the entire three day period and was never transferred from the bed would receive a code of ''8'' for Transfer (Item E1b).

However, do not confuse a patient who is totally dependent in an ADL activity (Code 6—Total Dependence) with the activity itself not occurring. For example: A patient who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A patient who is highly involved in giving himself a tube feeding is not totally dependent and should be coded as a ''3.''

Note: Each of these ADL Self-Performance scoring categories is exclusive. There is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided.

There will be times when there is no one type or level of assistance provided to the patient 3 or more times during a three-day period. However the sum total of support of various types will be provided three or more times. In this case, code for the least dependent self-performance category where the patient received that level or more dependent support 3 or more times during the 3 day period. Please review the following example for clarification of this principle.

Examples of Setup Help

- For bed mobility—Handing the patient the bar on a trapeze apparatus.
- For transfer—Giving the patient a transfer board or locking/unlocking the wheels on a wheelchair for a safe transfer.
- For locomotion.

Walking—Handing the patient a walker or cane.

Wheeling—Locking/unlocking the brakes on the wheelchair or adjusting the foot pedals to facilitate foot motion while wheeling.

- For dressing—Retrieving clothes from closet and laying out on the patient's bed; handing the patient a shirt; retrieving a prosthesis or orthotic.
- For eating—Cutting meat and opening containers at meals; giving one food category at a time.
- For toilet use—Handing the patient a bedpan or placing articles necessary for changing ostomy appliance within reach.

• For personal hygiene—Providing a wash basin and grooming articles.

• For bathing—Placing bathing articles at tub side within the patient's reach; handing the patient a towel upon completion of the bath.

2. ADL Assist Codes

Intent: To identify and document the level of weight bearing ADL assistance provided to the patient over the last 3 days.

Definition: a. Bed mobility—How patient moves to and from lying position, turns side to side, and positions body while in bed.

b. Transfer bed/chair—How patient moves between surfaces-to or from: bed, chair, wheelchair, standing position (Exclude to or from bath or toilet).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how the patient moves once in the wheelchair.

d. Walk in facility—How the patient walks in room, corridor, or other place in the facility.

e. Dressing upper body—How the patient dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing lower body—How the patient dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners.

g. Eating—How the patient eats and drinks (regardless of skill) includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet use—How patient uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (Exclude transfer to toilet).

i. Transfer/Toilet—How patient moves on and off toilet or commode

j. Grooming/Personal hygiene—How the patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face, and hands (Excludes baths and showers).

k. Bathing—How patient takes full body bath or shower or sponge bath (Exclude washing of back and hair and transfer). Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.

l. Transfer tub/shower—How the patient transfers in and out of the tub or shower.

Coding: Code for the most help in the last 3 days.

0. Neither code applies.

1. Weight bearing support with 1 limb (arm or leg).

2. 2+ person physical assist.

3. ADL Changes

Intent: In this item the assessor compares the patient's current ADL function to self performance prior to the precipitating event item A7a.

Definition: a. The number of ADL areas (listed under E1) in which the patient is now more impaired in self performance than was prior to the precipitating event (A7a) determines the appropriate coding.

b. The number of ADL areas (from E1 above) in which patient was independent prior to precipitating event (item A7a).

Coding: Place the appropriate number of ADL areas in box a and box b.

4. Instrumental Activities of Daily Living (IADLs)

Intent: The intent of these items is to examine the areas of function that are most commonly associated with independent living.

Process: The patient is to be questioned directly about his or her capacity to perform the usual activities around the home or community in the last 24 hours of a 3-day assessment period. If the patient performed or contributed to the performance of the IADL task during this period (meal preparation, medication management, etc) this performance should be considered when coding. However, be aware that a patient's partial involvement in an activity in the last 24 hours may not necessarily express that patient's full capacity to perform the task.

For example: A patient may have performed part of the medication management with assistance from staff. Staff assistance may have been provided because medication containers are different than what the patient was used to at home. The patient states that within the last 24 hours, he or she could have performed the medication task if he or she had been in his or her own home. In fact, the patient had been independent prior to admission, and there have been no cognitive or functional changes that might cause you to call the patient's judgement into question. The assessor would code E4d as ''0'' Independent.

In talking to the patient, you are both involved in a process of speculation about IADL activities that did not occur at the facility, leading to the assessor's active coding decision.

Definition: a. Meal preparation—How meals are prepared (for example, planning meals, assembling ingredients, cooking, setting out food and utensils.)

b. Managing finances—Paying for newspaper or TV service, using the cafeteria.

c. Phone Use—How telephone calls are made or received (using assistive devices such as large numbers on the telephone, voice amplification as needed.)

d. Medication Management—How medications are managed (for example, remembering to take medications, opening bottles, taking correct dosage of pills, filling syringe, giving injections, applying ointments.)

e. Stairs—How moves up and down stairs (for example, one flight of steps, using handrails as needed.)

f. Car Transfer—How patient moves in and out of a car. Includes opening door, sitting, and rising from seat.

Coding: CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—If patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you would consider the patient's capacity (ability) would have been to perform the activity in the last 24 hours of the 3-day assessment period.

0. Independent—Would have required no help, setup or supervision.

1. Setup Help Only—Would have required help that would have been limited to providing or placing an article/device within reach of the patient; all other tasks would have been performed by the patient on his or her own.

2. Supervision—Would have required oversight, encouragement or cuing.

3. Limited Assistance—On some occasion(s) could have done on own, other times would have required help.

4. Moderate Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own.

5. Maximal Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of all subtasks on own.

6. Total Dependence—Full performance of the activity by other person would have been required at all times (no residual capacity exists).

5. IADL Areas Now More Limited

Intent: In this item the assessor compares the patient's current capacity to perform IADLs to self performance with IADLs prior to the precipitating event (Item A7a).

Process: Compare all the IADL capacity self performance area codes (for Items E4a–f) to the patient's function prior to the precipitating event. Determine the overall number of IADL areas that the patient is now more limited in.

Coding: Code for the most appropriate category.

0. None.

1. Some (1–3 IADL areas).

2. All or most (4–6 IADL areas).

6. Devices/Aids

Intent: To record the type of appliances, aids, or assistive devices the patient used over the last 3 days.

Definition: Locomotion Devices

a. Cane/crutch—A cane is a slender stick held in the hand and used for support during walking. Includes 3 or 4 prong canes. A crutch is a device for aiding a patient with walking. Usually it is a long staff with padded crescent-shaped portion at the top that is placed under the armpit.

b. Walker—A mobile device used to assist a patient with walking. Usually consists of a stable platform made of metal tubing that the patient grasps while taking a step. The patient then moves the walker forward and makes another step. Also check this item in those instances where the patient walks with a wheelchair or Meri-Walker for support. [For Meri-Walkers, if the patient is standing most of the time in the Meri-Walker and using it as a walker, code as a walker—if the patient sits in the Meri-Walker most of the time—code it as a wheelchair.]

c. Wheelchair/scooter—Includes use of a hand-propelled wheelchair as well as motorized chair or scooter, includes wheeling self and being wheeled by others.

Other Aids

d. Adaptive eating utensil—A device that is specially designed to help the patient be independent in eating. Some examples are, built-up spoon, rocker knife, plate guard, special mug.

e. Mechanical lift—A mechanical device such as a Hoyer lift, used to lift a patient.

f. Orthotics/prosthesis—An orthotic is a device added to the upper or lower extremities to stabilize or immobilize present deformity, protect against injury, or assist with function (for example, arm sling, finger splint). A prosthesis is a replacement of a missing body part by an artificial substitute, such as an artificial extremity. A device of a natural function.

g. Postural support (while sitting)—A device (pads, pillows, boards) used to maintain the patient's position while in a chair or wheelchair.

h. Slide Board—A flat surfaced board (usually polished to a smooth finish) used to help a patient transfer from bed to chair or chair to bed.

i. Other Adaptive Devices—Include assistive/adaptive devices such as trapezes, braces.

j. NONE OF THE ABOVE.

Process: Observe, interview patient or staff.

Coding: Check all that apply.

7. Stamina

Intent: Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep patients fit in many ways. Below a certain threshold of activity, functional decline may be accelerated. Activities can include domestic IADLs (for example, light housework), or chosen physical activities (for example, recreation, going out to shop or walk).

It is necessary to understand if the patient is motivated, what the patient's needs may be, what barriers need to be overcome, and whether health education is needed.

Many people are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own life style is for health maintenance. For example, the patient may understand questions on walking and eating, but may not be willing to take corrective action.

Definition: Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping: (A) in last 24 hours and (B) immediately prior to precipitating event (A7a).

Process: Talk to the patient and family members if required. In assessing patient self-involvement, confirm patient stamina estimates. Talk to staff. Determine performance in last 24 hours and prior to precipitating event (Item A7a) and code accordingly.

Coding: Note—Item E7 has two coding columns, Column A and Column B.

0. None.
1. Less than one hour per day.
2. 1 to 2 hours per day.
3. 2+ to 3 hours per day.
4. 3+ to 4 hours per day.
5. More than 4 hours per day.

8. Walking and Stair Climbing

Intent: Walking is a crucial activity when considering a discharge back to the community. The interdisciplinary team members need current information about the patient's walking ability. This knowledge will help the team in devising an accurate service delivery and care plan resulting in an expeditious and coordinated discharge home.

CODE for walking or stair climbing episode that represents the most consistent pattern over the last 24 hours of the 3-day assessment period (includes episodes during therapy, activities, etc.)

Process: Observe the patient and interview staff.

Coding: a. Farthest distance walked without sitting down.

0. 150+ feet.
1. 51–149 feet.
2. 25–50 feet.
3. 10–24 feet.
4. Less than 10 feet.
8. ACTIVITY DID NOT OCCUR.

b. Walking support provided.

0. None.
1. Set up help only.
2. Supervision.
3. One person physical assistance.
4. Two+ person physical assistance.
8. ACTIVITY DID NOT OCCUR.

c. Stair climbing.

Intent: This item gives an indication of the patients stamina as measured by stair-climbing activity.

Process: Talk with the patient and family member if necessary. Consult with therapy staff who have observed or assisted the patient in stair climbing activity in the last 24 hours.

Definition: A full flight of stairs consists of 12–14 stairs (steps). A partial flight of stairs consists of 4 to 6 stairs (steps).

Coding: Code for the most dependent episode of stair climbing activity when the activity attempted in the last 24 hours. Note: There are only three possible codes when the patient does 4–6 stairs (steps) only (code—2, 5, 6).

0. Complete Independence—Up and down full flight of stairs with NEITHER physical help NOR support device.

1. Modified Independence—Up and down full flight of stairs with NO physical help and any of following:

Use of one or more supportive devices (support devices includes the required use of hand rails).

OR Use of an appliance (that is, cane, brace, prosthesis, walker).

OR Excessive time to climb the stairs (3 or more times normal).

2. Supervision—Up/down full flight of stairs with supervision or cuing–OR–up and down partial flight with NO physical help (device may or may not be used).

3. Minimal Assistance—Contact guard/steadying/assistance to go up/down full flight of stairs.

4. Moderate Assistance—Some weight bearing help to go up/down full flights of stairs, patient does most on own.

5. Maximal Assistance—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort–OR–receives physical help on partial flight of stairs.

6. Total Assistance—Did not go up/down 4–6 stairs (OR has 2-person assist) OR totally dependent.

8. Activity did not occur in last 24 hours.

9. Balance Related to Transitions

Intent: Balance is a key component of a patient's ability to transfer from standing to seated position and from seated to standing position. Problems with stability involve provision of support (either staff member or device) to ensure a safe transfer. It is important to assess a person's ability to balance in order that interventions (strength training exercises, safety awareness, restorative nursing, nursing-based rehabilitation) can be implemented to prevent injuries and foster increased independence in the patient.

Process: Over the last 24 hours, assess how the patient: transfers from seated to standing position, or turns and faces the opposite direction. Because this assessment is to be based on the most dependent episode over the last 24 hours, base both on your own observations and reports of staff.

Definition: a. Moved from seated to standing position.

b. (While standing) turned around and faced the opposite direction.

Coding: Code for the most dependent in the last 24 hours.

0. Smooth transition; stabilizes without assistance.

1. Transition not smooth, but able to stabilize without assistance.

2. Transition not smooth, unable to stabilize without assistance.

8. ACTIVITY DID NOT OCCUR.

10. Neuro-musculo-skeletal Impairment

Process: Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new safety pin or wooden ''orange stick'' (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Do not use pins with agitated or restless patients. Abrupt movements can cause injury.
- Ask the patient to close his or her eyes. If the patient cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the patient's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the patient's arms, trunk, and legs. Ask the patient to report if the sensation is ''sharp'' or ''dull.''
- Compare the sensations in symmetrical areas on both sides of the body.
- If the patient is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

• For patients who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (for example, wincing, grimacing, surprise), body motions (for example, pulling the limb away, pushing the examiner) or sounds (for example, ''Ouch!'') to determine if they can feel pain.

Definition: a. Leg (hip, knee, ankle, foot).

b. Arm (shoulder, elbow, wrist, hand).

c. Trunk and neck.

Coding: Code for the most limited in the last 24 hours.

A. Joint mobility/range of motion at joints listed (code for most impaired joint).

0. No impairment.

1. Impairment on one side.

2. Impairment on both sides.

B. Voluntary motor control (active, coordinated, purposeful movement—code for most dependent joint).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

C. Intact touch/sensation on extremity (tactile sense) (Use same codes as E10B).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

Section F. Bowel/Bladder Management

1. Bladder Continence

Intent: To describe the patient's pattern of bladder continence (control) over the last 7–14 days, and to compare current continence status to status prior to the current event which precipitated this post-acute stage. This information is key in care planning for incontinence.

Definition: Bladder Continence—Refers to control of urinary bladder function. This item describes the patient's bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the patient's ability to toilet self—for example, a patient can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The patient's self-performance in toilet use is recorded in Item E1h.

Process: Complete your review in the following order. Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

(1) Review the patient's clinical record and any urinary elimination (bladder) flow sheets (if available).

(2) Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for patients that are struggling to maintain control. Many people with poor control problems will try to hide their problems out of embarrassment or fear of retribution. Others will not report the problem to staff because they mistakenly believe that incontinence is a natural part of aging or certain disease processes and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many patients are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

(3) Validate continence patterns with people who know the patient well (for example, primary family member of a newly admitted patient, or direct care staff).

(4) When the information you have received is inconsistent and particularly if the staff report incontinence that is not reported by the patient, review for physical indications that the patient is in fact incontinent. This could include being present at scheduled toileting intervals, observing clothing, bed clothes, etc.

a. Control of urinary bladder function—(if patient dribbles, volume insufficient to soak through undergarments).

Coding: Choose the response that best reflects the patient's level of bladder continence in the last 7–14 days.

Code for the patient's actual bladder continence pattern—that is, the frequency with which the patient is wet and dry during the 7–14 day assessment period. Do not record the level of control the patient might have achieved under optimal circumstances. For bladder continence the difference between a ''5'' (Frequently Incontinent) and a ''6'' (Incontinent) is determined by the presence (''5'') or absence (''6'') of any bladder control.

0. Continent—Complete control; does not use any type of catheter or other urinary collection device.

1. Continent with Catheter—Complete control with any use of any type of catheter or urinary collection device that does not leak urine.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last 2 weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—Incontinent episodes 2 or more times a week, but not daily.

5. Frequently Incontinent—Tended to be incontinent daily, but some control present (that is, on day shift).

6. Incontinent—Has inadequate control of bladder, multiple daily episodes all or almost all of the time.

8. DID NOT OCCUR—No urine output from bladder.

b. Is now more impaired in bladder incontinence then was prior to precipitating event (item A7a).

Coding: 0. No, or unsure.

1. Yes, more impaired today.

2. Bladder Appliance.

Definition: a. External catheter (condom catheter)—A urinary collection appliance worn over the penis.

b. Indwelling catheter—A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. This item includes catheters inserted through the urethra or via supra-pubic incision.

c. Intermittent catheterization—A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the patient. Catheterization may occur as one-time event (for example, to obtain a sterile specimen) or as part of a bladder emptying program (for example, every shift in a patient with an underactive or a contractile bladder muscle).

d. Medications for control—medications administered to the patient for the purpose of improving control of the bladder.

e. Ostomy—Any type of ostomy of the urinary tract.

f. Pads, briefs—Any type of absorbent disposable or reusable undergarment or item, whether worn by the patient (for example, diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads when a patient is never or rarely incontinent.

g. Urinals, bedpan—A urinal is a container into which a patient urinates. A bedpan is a pan-shaped device placed under a patient for collecting urine (and feces)

Process: Consult with the nursing staff and the patient. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (for example, pads or briefs). If necessary, check the clinical record.

Coding: Code for the last 24 hours.

0. No.

1. Yes.

3. Bladder Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bladder appliances listed in F2.

Coding: Code for the level of bladder appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F2).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50% or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49% of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bladder equipment.

4. Bowel Continence

Process: The assessment for bowel continence should be completed simultaneously with the bladder continence review. This will thus include a review of the patient's clinical record and any bowel records (if available). Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bowel function is a sensitive issue. Be sure to ask about the nature of the problem in a sensitive, straightforward manner.

• Validate continence patterns with people who know the patient well (for example, primary family member of newly admitted patient, direct care staff).

• Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

Coding: Code for bowel continence over the last 7–14 days.

0. Continent—Complete control, does not use ostomy device.

1. Continent with Ostomy—Complete control with use of ostomy device that does not leak stool.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last two weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—2 to 3 times a week.

5. Frequently Incontinent—4+ times a week but not all of the time.

6. Incontinent—All of the time.

8.DID NOT OCCUR—No bowel movement during the entire 14-day assessment period.

5. Bowel Appliances

Definition: a. Bedpan—A bedpan is a pan-shaped device placed under a patient for collecting feces (and urine).

b. Enema—Introduction of solutions into the rectum and colon in order to stimulate bowel activity and to cause emptying of the lower intestine.

c. Medication for control—Medications administered to the patient for the pupose of improving control of the bowels. These medications can include laxatives, stool softeners, stimulants as well as anti-diarrheal preparations.

d. Ostomy—Any type of ostomy of the gastrointestinal tract.

Coding: Code for use of bowel appliances for the last 3 days.

0. No.

1. Yes.

6. Bowel Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bowel appliances listed in F5.

Coding: Code for the level of bowel appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F5).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50 percent or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49 percent of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bowel equipment.

Section G. Diagnoses

1. Impairment Group

Intent: This item identifies the Impairment Group that best describes the primary reason for admission to the rehabilitation program.

Process: Consult with attending physician.

Coding: Each Impairment Group has been assigned a two-digit ID number, a decimal point, and a unique number (from one to four digits) for the subgroups. Code for the major diagnostic category of the patient by selecting the Impairment Group which best describes the condition requiring admission to rehabilitation. Then select a subgroup, if appropriate. Code as specifically as possible.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES

Rehabilitation impairment category	Associated impairment group codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain). 01.2 Right body involvement (left brain). 01.3 Bilateral Involvement. 01.4 No Paresis. 01.9 Other Stroke.
02 Traumatic brain injury (TBI)	02.21 Open Injury. 02.22 Closed Injury.
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic. 02.9 Other Brain.
04 04 Traumatic spinal cord (TSCI)	04.210 Paraplegia, Unspecified. 04.211 Paraplegia, Incomplete. 04.212 Paraplegia, Complete. 04.220 Quadriplegia, Unspecified. 04.2211 Quadriplegia, Incomplete C1–4. 04.2212 Quadriplegia, Incomplete C5–8. 04.2221 Quadriplegia, Complete C1–4. 04.2222 Quadriplegia, Complete C5–8. 04.230 Other traumatic spinal cord dysfunction.
05 Nontraumatic spinal cord (NTSCI)	04.110 Paraplegia, unspecified. 04.111 Paraplegia, incomplete. 04.112 Paraplegia, complete. 04.120 Quadriplegia, unspecified. 04.1211 Quadriplegia, Incomplete C1–4. 04.1212 Quadriplegia, Incomplete C5–8. 04.1221 Quadriplegia, Complete C1–4. 04.1222 Quadriplegia, Complete C5–8. 04.130 Other non-traumatic spinal cord dysfunction.
06 Neurological (Neuro)	03.1 Multiple Sclerosis. 03.2 Parkinsonism. 03.3 Polyneuropathy. 03.5 Cerebral Palsy. 03.8 Neuromuscular Disorders. 03.9 Other Neurologic.
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture. 08.12 Status post bilateral hip fractures. 08.2 Status post femur (shaft) fracture. 08.3 Status post pelvic fracture.
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement. 08.52 Status post bilateral hip replacements. 08.61 Status post unilateral knee replacement. 08.62 Status post bilateral knee replacements. 08.71 Status post knee and hip replacements (same side). 08.72 Status post knee and hip replacements (different sides).
08 Other orthopedic (Ortho)	08.9 Other orthopedic.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES—Continued

Rehabilitation impairment category	Associated impairment group codes
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK). 05.4 Unilateral lower extremity below the knee (BK). 05.5 Bilateral lower extremity above the knee (AK/AK). 05.6 Bilateral lower extremity above/below the knee (AK/BK). 05.7 Bilateral lower extremity below the knee (BK/BK).
11 Amputation, other (AMP–NLE)	05.1 Unilateral upper extremity above the elbow (AE). 05.2 Unilateral upper extremity below the elbow (BE). 05.9 Other amputation.
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis.
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis. 06.9 Other arthritis.
14 Cardiac (Cardiac)	09 Cardiac.
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease. 10.9 Other pulmonary.
16 Pain Syndrome (Pain)	07.1 Neck pain. 07.2 Back pain. 07.3 Extremity pain. 07.9 Other pain.
17 Major multiple trauma, no brain injury or spinal cord injury (MMT–NBSCI).	08.4 Status post major multiple fractures. 14.9 Other multiple trauma.
18 Major multiple trauma, with brain or spinal cord injury (MMT–BSCI).	14.1 Brain and spinal cord injury. 14.2 Brain and multiple fractures/amputation. 14.3 Spinal cord and multiple fractures/amputation.
19 Guillian Barre (FB)	03.4.
20 Miscellaneous (Misc)	*12.1 Spina Bifida. 12.9 Other congenital. 13 Other disabling impairments. 15 Developmental disability. 16 Debility. 17 Infection. 17.2 Neoplasms. 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition. 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition. 17.4 Circulatory disorders. 17.51 Respiratory disorders—Ventilator Dependent. 17.52 Respiratory disorders—Non-ventilator Dependent. 17.6 Terminal care. 17.7 Skin disorders. 17.8 Medical/Surgical complications. 17.9 Other medically complex conditions.
21 Burn (Burns)	11 Burns.

We are in the process of anayzing the effect of moving the few cases within this impairment category to one of the other spinal cord RICs (either 05 or 04 depending upon the ''fit'').

2. Other Diseases

Intent: To document the presence of diseases that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment or discharge plans.

Definition: ENDOCRINE

a. Diabetes Mellitus 250.00—Any of several metabolic disorders characterized by abnormal insulin secretion and elevated blood glucose levels. Category includes insulin-dependent diabetes mellitus (IDDM) as well as other types (for example, non-insulin dependent diabetes mellitus [NIDDM], adult onset diabetes mellitus [AODM], gestational diabetes, and diabetes associated with particular conditions or medications).

b. Hypothyroidism 244.9—Under-activity of the thyroid gland (insufficiency of thyroid hormone) resulting in a decrease in the basal metabolic rate.

HEART/CIRCULATION

c. Cardiac arrhythmias 427.9—A disturbance in the cardiac electrical conduction system resulting in irregularities in heart rate and rhythm.

d. Congestive heart failure 428.0—A dysfunction that occurs when cardiac output is insufficient to meet the person's metabolic demands.

e. Coronary artery disease (CAD) 746.85—A narrowing of one or more of the coronary arteries by atherosclerotic plaque or vascular spasm; results in a decrease in oxygenated blood flow (ischemia) to the heart. Usually associated with angina.

f. Deep vein thrombosis 451.1—A condition in which a blood clot (thrombus) is formed in the deeper/larger veins, usually in the lower extremities.

g. Hypertension 401.9—A persistent elevation of systolic or arterial blood pressure. This category includes primary (essential) and secondary hypertension.

h. Hypotension 458.9—An absolute systolic blood pressure value of less than 90 mm Hg (or a decline of 20 mm Hg or greater in systolic blood pressure from the person's usual baseline, or a decline of 10 mm Hg or greater in diastolic blood pressure from the person's usual baseline). This category also includes orthostatic hypotension (a reduction ≥ 20 mm Hg in systolic blood pressure upon standing).

i. Peripheral vascular disease (arteries) 443.9—A variety of syndromes that result in decreased blood flow in the peripheral arterial vessels, usually of the lower extremities. This category includes arteriosclerosis obliterans, small vessel syndrome, Raynaud's phenomenon, arterial aneurysms (for example, thoracic, abdominal, popliteal), and temporal arteritis. Do not include deep vein thrombosis in this category; if present, use item G2f.

j. Post Acute MI (within 30 days) 410.92—The immediate period following the necrosis of myocardial tissue resulting from obstruction of a coronary artery.

k. Post heart surgery (for example, valve, CABG) V45.81—Cardiovascular surgery such

as percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), valve replacement, percutaneous balloon valvuloplasty.

l. Pulmonary embolism 415.1—Obstruction of one or more of the pulmonary arteries by a thrombus (blood clot).

m. Pulmonary failure 518.8—Failure of the respiratory system to meet oxygenation needs (severe hypoxemia).

n. Other cardiovascular disease 429.2—Any other cardiac diagnosis not coded elsewhere in Section G (for example, valvular heart disease).

MUSCULOSKELETAL

o. Fracture—hip V43.64—Hip fracture (for example, femoral neck; intertrochanteric; subcapital) that has been repaired via surgical arthroplasty or internal fixation. Category also includes fractures treated with traction that may have involved the surgical placement of pins. Also includes surgical hip replacement (for example, total or hemiarthroplasty) following fracture of the hip (for example, femoral neck; intertrochanteric; subcapital fractures, etc). Hips stabilized via open reduction and internal fixation (ORIF) with pins or screws would be included in this item.

p. Fracture—lower extremity 812.40—Any fracture of the lower extremity, other than hip fracture. Includes surgically and non-surgically treated fractures. Category does not include pathological fractures of the lower extremity; if the patient has a diagnosis of pathologic bone fracture of the lower extremity, code item G4.

q. Fracture(s)—other 829.0—Any other fracture type or location not captured in Section G.

r. Osteoarthritis 715.90—A progressive degenerative disease of joint cartilage and bone characterized by joint pain; may be accompanied by joint deformity and limitation of movement.

s. Osteoporosis 733.00—A metabolic bone disorder characterized by a loss of bone density resulting in weakened bones and susceptibility to fractures.

t. Rheumatoid Arthritis 714.0—A progressive degenerative joint disease characterized by recurrent inflammation of synovial tissue and joint deformities.

NEUROLOGICAL

u. Alzheimer's disease 331.0—A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

v. Aphasia or Apraxia (784.3, 784.69)—Symptoms of neurological defects characterized by a difficulty or inability to express thoughts (in speech or writing) or comprehend language (aphasia), or a difficulty/inability to carry out purposeful movements or use objects properly due to a failure to identify them or understand their meaning (apraxia).

w. Cerebral Palsy 343.9—A group of nonprogressive muscular and motor disorders secondary to a neurological defect or trauma at birth.

x. Dementia other than Alzheimer's disease 290.0—Includes diagnosis of organic brain syndrome (OBS) or Chronic Brain Syndrome (CBS), senile dementia, multi-infarct dementia, and dementia related to other neurological diseases other than Alzheimer's Disease (for example., Picks, Creutzfeld-Jacob, Huntington's Disease).

y. Hemiplegia/hemiparesis left side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on left side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

z. Hemiplegia/hemiparesis right side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on right side of body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

aa. Multiple sclerosis 340—A progressive central nervous system disease characterized by demyelination in brain and spinal cord resulting in various neurological symptoms (for example, paresthesias; motor disorders; diplopia or blindness; urinary incontinence); usually involves recurrent exacerbations and remissions.

ab. Parkinson's Disease 332.0—A progressive disease affecting the centers of the brain responsible for control and regulation of movement.

ac. Quadriplegia 344.00–344.09—Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the patient's record.

ad. Seizure Disorder 780.39—Disorder of cerebral function characterized by sudden attacks of altered consciousness, sensory changes, motor activity, or inappropriate behavior. May be focal (localized) or generalized.

ae. Spinal cord dysfunction—non-traumatic 336.9—A non-traumatic disorder affecting the spinal cord (for example, neoplasm; abscess; hematoma; neurologic manifestations of pernicious anemia; spina bifida); may be associated with pain, sensory impairment, abnormal reflexes, motor dysfunction.

af. Spinal cord dysfunction—traumatic 952.9—Alteration of neurological function (for example, motor, sensory, reflexes) secondary to compression or laceration of the spinal cord.

ag. Stroke (CVA) 436—A vascular insult to the brain that may be caused by intracranial bleeding, stenosis, thrombosis, infarcts, or emboli; may result in permanent neurological and physical dysfunction.

PSYCHIATRIC/MOOD

ah. Anxiety Disorder 300.00—A disorder characterized by prominent symptoms of anxiety or phobic avoidance. This category includes generalized anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder, acute distress disorder, and other anxiety disorders (for example, due to general medical condition; substance-induced).

ai. Depression 311—A mood disorder often characterized by a depressed mood (for example, feels sad or empty; appears tearful), decreased ability to think or concentrate, loss of interest or pleasure in usual activities, insomnia or hypersomnia, loss of energy, change in appetite, feelings of hopelessness or worthlessness or guilt. May include thoughts of death or suicide.

aj. Other psychiatric disorders 300.9—Other diagnosed psychiatric disorders not coded elsewhere on this assessment (for example, psychotic disorders, such as anorexia, bulimia; eating disorders).

PULMONARY

ak. Asthma 493.9—Intermittent periods of wheezing and dyspnea as a result of variable and recurring airway obstruction.

al. COPD 496—A group of conditions resulting in generalized airway obstruction (particularly the small airways) associated with varying combinations of asthma, chronic bronchitis, and emphysema. May also be called COLD (chronic obstructive lung disease). This category also includes chronic restrictive lung diseases such as asbestosis.

Note: Do not code asthma or emphysema in this category if either of these are the patient's definitive diagnoses. If asthma only is present, code in item G2ak. If emphysema only is present, code in item G2am.

am. Emphysema 492.8—A specific chronic obstructive pulmonary disease which is characterized by destructive changes in the alveoli which reduce the surface area for gas exchange.

OTHER

an.Cancer 199.1—A diagnosis of a carcinoma characterized by a localized malignant tumor or abnormal cell growth that has not spread to other areas or systems of the body. This category also includes metastatic cancer—a diagnosis of a carcinoma characterized by a malignant tumor or abnormal cell growth that has spread to other areas or systems of the body.

ao. Post surgery-non-orthopedic, non-cardiac V50.9—Status post any surgical procedure not noted in Section G.

ap. Renal Failure 586—Derangement and insufficiency of renal excretory and regulatory function. This category includes acute (ARF) and chronic renal failure (CRF).

aq. NONE OF THE ABOVE

Process: Review patient's current medical record (including current physician treatment orders and nursing care plans), referral information and hospital discharge summary. If the patient was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD–9–CM codes that were current during the hospital stay. If these diagnoses are still present, record them using the appropriate code to categorize the nature of the patient's treatment regimen.

There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, accept statements by the patient that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new patient reports that he or she had a severe depression and was

seeing a private psychiatrist in the community, this information may not have been documented in records accompanying the patient from an acute care hospital to the post acute setting.

Physician involvement in this part of the assessment process would be beneficial. The physician can be asked to review the items in Section G at the time of visit closest to the scheduled MDS–PAC assessment. Use this scheduled visit as an opportunity to ensure that ''active'' diagnoses are noted and ''inactive'' diagnoses are appropriately designated. This is also an important opportunity to share the entire assessment with the physician. It is the responsibility of clinical staff to solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, share this section of the assessment with the physician and ask for his or her input.

Full physician review of the most recent assessment or ongoing input into the assessment currently being completed can be very useful to overall care planning. For the physician, the assessment completed by clinical staff can provide insights that would have otherwise not been possible. For clinical staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional consultation and follow-up.

Record a diagnosis only if the disease is being treated or monitored; or has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, do not place a code for item G2g (hypertension) if one episode occurred several years ago unless the hypertension is either currently being controlled with drug therapy, diet, biofeedback, etc., or is being regularly monitored for recurrence. Likewise gallbladder surgery that occurred 15 years ago would not be recorded in item G2ao (Post surgery—non-orthopedic, non-cardiac) unless it had a relationship to the patient's current health status.

Coding: Record all documented diagnoses in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G2 apply, check NONE OF ABOVE (G2aq). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G2, record the general diagnosis in Section G2 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

3. Infections

Intent: To document the presence of infections that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment and/or discharge plans.

a. Antibiotic resistant infection—any infection in which the bacteria have developed a resistance to the effective actions of an antibiotic (for example, Methicillin resistant staphylococcus aureus [MRSA 041.11], Vancomycin-resistant enterococcus [VRE 041.9]).

b. Cellulitis 682.9—inflammation of cellular or connective tissue, spreading as in erysipelas. The process of inflammation spreading throughout the tissue is called cellulitis.

c. Hepatitis 070.9—an inflammatory process in the liver usually caused by viral infection. This category includes acute and chronic viral hepatitis.

d. HIV/AIDS 042—Code this item only if—(A) there is supporting documentation in the medical record of (1) a positive blood test result for the Human Immunodeficiency Virus (HIV), or (2) a diagnosis of Acquired Immuno-deficiency Syndrome (AIDS), or (3) a diagnosis of AIDS-related complex (ARC); or (B) if the patient (or surrogate decision-maker) informs you of the presence of any of these diagnoses.

e. Pneumonia 486—an acute bacterial or viral infection of the lungs.

f. Osteomyelitis 730.2—an infection of bone, usually caused by bacteria or other pathogens. This category also includes infection of a surgically-implanted prosthesis.

g. Septicemia 038.9—clinical manifestations of bacterial infection of the circulatory system (bacteremia) associated with inadequate tissue perfusion (hypotension, renal failure and risk of death).

h. Staphylococcus infection (other than item ''G3a'' above) 041.10—any infection identified as staphylococcus by culture that is not considered to be resistant to antibiotic treatment.

i. Tuberculosis (active) 011.90—Diagnosis of active tuberculosis as evidenced by symptoms and/or currently receiving drug therapy (for example, isoniazid (INH), ethambutol, rifampin, cycloserine). Includes patients who have converted to PPD positive tuberculin status and are receiving drug treatment.

j. Urinary Tract Infection 599.0—includes chronic and acute symptomatic infection. Code only if there is supporting documentation or significant laboratory findings in the medical record, or the patient is currently being treated or evaluated for a UTI.

k. Wound Infection (958.3, 998.59, 136.9)—Category includes documentation of infection(s) of any type of wound (for example, surgical; traumatic; pressure ulcer) of any part of the body. Note: Report of wound culture may or may not be present in the medical record; diagnosis may be based on presence of drainage, erythema, edema, etc. around wound site.

l. NONE OF THE ABOVE.

Process: Review patient's medical record.

Coding: Record all documented diagnoses of infection(s) in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay. These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (drug therapy; therapeutic rehabilitation services; laboratory monitoring; other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning; respiratory therapy).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G3 apply, check NONE OF ABOVE (G3l). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G3, record the general diagnosis in Section G3 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

For example: If the medical record states that the patient has ''Pneumocystis carinii pneumonia'' record the nature of this diagnosis in item G3e (Pneumonia) and then record the more specific diagnosis and ICD–9–CM code in Section G4.

4. Other Current or More Detailed Diagnoses and ICD–9 Codes

Intent: To identify and document conditions not listed in Items G1, G2 and G3 that have an impact or potential impact on the patient's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, therapeutic rehabilitation, discharge plan or risk of death. Also, to record more specific designations for general disease categories listed in Sections G2 and G3.

Process: Review patient's current medical record, referral information and hospital discharge summary.

Coding: If the patient does not have any other or more detailed diagnoses documented, leave the boxes blank.

Enter the description of the diagnoses on the lines provided. For each diagnosis complete the following:

Write in diagnosis in lines ''a'' through ''e''.

Column A: enter the ICD–9–CM code for the diagnosis in the boxes, AND

Column B: enter the code (from the following codes) that best characterizes the diagnosis.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

Any new diagnosis at reassessment or discharge is to be recorded in G4.

5. Complications/Comorbidities

Intent: To identify and document comorbidities that may effect the patient's functional status or health.

Definition: ''Complications, comorbid conditions, and high-risk medical disorders may occur with any Impairment Group when the occurrence delays or compromises rehabilitation by:

Existing prior to the rehabilitation program.

Occurring or existing during the rehabilitation program.

Causing subject transfer to acute care.

Causing subject death during the rehabilitation program'' (Uniform Data System for Medical Rehabilitation, Guide for the Uniform Data Set for Medical Rehabilitation-Version 5.1, Appendix A: UDSmr Policy Regarding ICD–9 Coding, p. A19.) NOTE: HCFA has excluded from the definition of comorbidities the recording of diagnoses by Rehabilitation Impairment Category. For example, stroke is not a comorbidity for the stroke Rehabilitation Impairment Category, cardiac is not a comorbidity for the cardiac Rehabilitation Impairment Category. The ''Rehabilitation Impairment Categories and Associated Impairment Group Codes'' were discussed previously in this guide.

Process: Review the patient's medical record, referral information, hospital discharge summary, and consult with other clinical staff.

Coding: For the comorbidities to enter in lines G5a thru G5d including the ICD–9–CM codes refer to ''Appendix C: List of Comorbidities'' which is one of the appendixes of this proposed rule. If no comorbid condition exists write in the words ''No comorbid condition'' once and enter ''0000.00'' in the associated boxes.

Section H. Medical Complexities

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Definition: Medical complexities—include a number of indicators which help clinicians and others form a picture of the clinical intensity and level of service the patient receives in the post acute setting.

1. Vital Signs

Intent: To record the status of the patient's vital signs (that is, pulse; blood pressure; respiratory rate; temperature).

Definition: Abnormal vital signs—see ranges in box below.

Process: To interpret whether vital signs are within the range of ''normal'' usually requires an evaluation of several measurements rather than relying on a single value at one point in time. Therefore, review the results from the evaluation of the patient's vital signs over the past three days. In addition to reviewing vital signs, review the patient's clinical record, specifically, vital signs ''flow sheets'', and physician or nursing documentation in the medical record, referral sheet, or discharge summary.

Coding: Code for the ''most abnormal'' set of vital signs over the last 3 days.

0. All vital signs were normal/standard (that is, when compared to standard values).

1. Vital signs abnormal, but not on all days during assessment period.

2. Vital signs consistently abnormal (on all days).

2. Problem Conditions

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Process: Gather information from a variety of sources. Begin by reviewing the discharge referral record and current medical record, including laboratory data, consultation reports, and nursing observations. This will be the primary source of information. Check that it is complete by soliciting input from all members of the interdisciplinary team, including direct care providers (for example, certified nurse assistants). Finally, in your scheduled contact with the patient to assess other areas, interview, observe, and examine the patient to ensure nothing has been overlooked. Remember, you are reviewing problem conditions that have been present in the last 3 days.

Definition: FALLS/BALANCE

a. Dizziness/vertigo/lightheadedness—The patient has experienced the sensation of unsteadiness, that he or she is ''turning'', or that the surroundings are whirling/spinning around; or if the patient complained specifically of dizziness/vertigo/or lightheadedness in the last 3 days.

b. Fell (since admission or last assessment)—Patient/family reports or medical record or discharge summary indicates the patient fell since admission or since last assessment.

c. Fell in 180 days prior to admission—Patient/family reports or medical record or discharge summary indicates the patient fell in the 180 days prior to admission.

CARDIAC/PULMONARY

d. Advanced cardiac failure (ejection fraction <25 percent)—Check if EITHER documented cardiac disease with significant decrease in cardiac output (for example, documented ejection fraction <25 percent) in last 60 days OR diastolic dysfunction, as indicated by repeated episodes of heart failure with a normal ejection fraction).

e. Chest pain/pressure on exertion—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. associated with physical exertion.

f. Chest pain/pressure at rest—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. that starts spontaneously and without physical exertion (at rest).

g. Edema-generalized—Generalized abnormal pooling or accumulation of fluid in tissues throughout the body (not limited to specific site).

h. Edema-localized—Abnormal pooling or accumulation of fluid in specific tissues (for example, pedal edema; lymphedema of upper extremity).

i. Edema-pitting—Abnormal pooling or accumulation of fluid in tissues. Assessed by pressing the patient's skin firmly with the thumb for at least five seconds behind the medial malleolus, dorsum of the foot, or over the shin. If present, a ''thumb print'' will remain over the area of edema.

j. Impaired aerobic capacity/endurance (tires easily, poor task endurance)—A symptom characterized by a limited ability to sustain a period of exercise or exertion due to decreased cardiac or respiratory function (may be as a result of disease or deconditioning).

FLUID STATUS—It is often difficult to recognize when a frail, ill person is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in patients who are unable to recognize or report the common symptoms of fluid variation, are as follows:

k. Constipation—The patient passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

l. Dehydrated: output exceeds input (for example, BUN/creatinine ratio >25)—check this item if the patient's laboratory results reveal a blood urea nitrogen (BUN) to creatinine ratio greater than 25 OR if the patient has 2 or more of the following indicators.

- Patient's fluid intake is less than 2500 ml of fluids daily (water or liquids in beverages, water in food/supplements/parenteral nutrition, IV fluids).
- Patient has clinical signs of dehydration (for example, dry mucous membranes, decrease in skin elasticity).
- Patient's fluid loss exceeds the amount of fluids he or she takes in (for example, loss from vomiting, fever, diarrhea that exceeds fluid replacement)—review the Input and Output record;

m. Diarrhea—Frequent elimination of watery stools from any etiology (for example, diet, viral or bacterial infection).

n. Internal bleeding—Includes gastrointestinal and other types of intestinal bleeding. Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools); any documented bleeding as diagnosed by GI evaluation or any evidence of current bleeding through rectal exam or guaiac testing. Could also include: hematuria (blood in urine); hemoptysis (coughing up blood); or severe epistaxis (nosebleed), etc. present over the last 3 days that did not spontaneously resolve or that occurred more than once.

o. Recurrent nausea/vomiting—Patient reports recurrent (more than one episode) sensations of having to vomit or actual regurgitation of stomach contents; code regardless of etiology (for example, drug side effect or toxicity; influenza; anxiety; obstruction; reaction to particular odors or sights).

p. Refusal/inability to take liquids orally—Patient either rejects intake of fluids (for example, liquids, jello, sorbets, etc.) as a conscious decision or pushes them away, OR has a physical condition that inhibits intake of oral liquids (for example, nausea/vomiting; dysphagia; severe candidiasis of oral mucosa, etc.).

OTHER

q. Delusions/Hallucinations—Delusions are fixed, false beliefs not shared by others that the patient holds even when there is obvious proof or evidence to the contrary (for example, belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the hospital/facility is poisoned).

Hallucinations are false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (for example, hearing voices), visual (for example, seeing people, animals), tactile (for example, feeling bugs crawling over skin), olfactory (for example, smelling fumes), or gustatory (for example, having strange tastes).

r. Fever—Rectal temperatures above 100°Fahrenheit (38°Celsius) are considered significant. Many frail patients have normally low rectal baseline temperatures (for example, 96°). A fever is present when the patient's temperature (°F) is 2.4 degrees greater than the baseline temperature.

s. Hemi-neglect (inattention to one side)—For example, patient denies that their left arm belongs to them, shaves only on one side of face, ignores items to their left.

t. Cachexia (severe malnutrition)—A condition of undernutrition and wasting that may occur in a variety of chronic diseases and malignancies.

u. Morbid Obesity—According to a National Institute of Health consensus panel, a body weight that is double (twice) the ''ideal'' body weight of standard height-weight tables OR 100 pounds (45 g) overweight.

Extremely obese persons are at great risk of serious disorders, including diabetes, hypertension, osteoarthritis, impairment in psychosocial well-being, and death from cardiovascular disease. (Refer to the latest (1983) Metropolitan Life Insurance Company standard height-weight table below to identify ideal/desirable body weights).

HEIGHT AND WEIGHT TABLE FOR WOMEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
4′10″	102–111	109–121	118–131
4′11″	103–113	111–123	120–134
5′0″	104–115	113–126	122–137
5′1″	106–118	115–129	125–140
5′2″	108–121	118–132	128–143
5′3″	111–124	121–135	131–147
5′4″	114–127	124–138	134–151
5′5″	117–130	127–141	137–155
5′6″	120–133	130–144	140–159
5′7″	123–136	133–147	143–163
5′8″	126–139	136–150	146–167
5′9″	129–142	139–153	149–170
5′10″	132–145	142–156	152–173
5′11″	135–148	145–159	155–176
6′0″	138–151	148–162	158–179

HEIGHT AND WEIGHT TABLE FOR MEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
5′2″	128–134	131–141	138–150
5′3″	130–136	133–143	140–153
5′4″	132–138	135–145	142–156
5′5″	134–140	137–148	144–160
5′6″	136–142	139–151	146–164
5′7″	138–145	142–154	149–168
5′8″	140–148	145–157	152–172
5′9″	142–151	148–160	155–176
5′10″	144–154	151–163	158–180
5′11″	146–157	154–166	161–184
6′0″	149–160	157–170	164–188
6′1″	152–164	160–174	168–192
6′2″	155–168	164–178	172–197
6′3″	158–172	167–182	176–202
6′4″	162–176	171–187	181–207

v. End-stage disease, life expectancy of 6 or fewer months—The intent of this item is to heighten staff awareness of the potential terminal nature of the patient's condition so that an appropriate course of care can be developed. In one's best clinical judgement, the patient in the final (end) stage of a disease process (for example, COPD; malignancy; cardiac disease; Alzheimer's disease, etc.) and has only six or fewer months to live. Although it is often difficult to make such a prognosis, this judgement should be substantiated by a physician and the presence of a deteriorating clinical course.

w. NONE OF THE ABOVE—The patient has not experienced any of the above conditions.

Coding: Check all problems present in the last three days, unless other time frames are indicated. If none apply, check NONE OF THE ABOVE.

3. Respiratory Conditions

Intent: To identify and record signs, symptoms or conditions of respiratory distress that could have a direct or indirect affect on the patient's ability to function, participate in rehabilitation and on the patient's plan of care, including discharge. More than one condition may apply.

Definition: a. Inability to lie flat due to shortness of breath—In the last 3 days the patient reported feeling ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, while lying supine; requires more than one pillow or has the head of the bed mechanically raised in order to breathe more comfortably.

b. Shortness of breath with exertion—In the last 3 days the patient has reported becoming ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, even with mild exertion such as taking a bath, transferring from bed to chair, toileting.

c. Shortness of breath at rest—In the last three days the patient reported feeling ''breathless'' or short of breath (dyspneic), or was observed being short of breath, at rest (for example, sitting, talking).

d. Oxygen saturation < 90 percent—In the last 3 days the patient's oxygen saturation level (obtained by oximeter) was less than 90 percent (either while receiving or not receiving oxygen therapy).

e. Difficulty coughing and clearing airway secretions—In the last 3 days the patient reports or has been observed to be unable to cough effectively to expel respiratory secretions (for example, secondary to weakness, pain) or is unable to mobilize secretions or sputum from mouth (for example, secondary to dysphagia or pain) or tracheostomy (for example, secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples might include a post abdominal surgery patient unable to cough due to incisional pain, or a comatose patient that required suctioning to manage secretions.

f. Recurrent aspiration—In the last 3 days a patient with a history of at least one or more episodes of aspiration (inspiration) of fluids/food/secretions, etc. into lungs, exhibits clinical signs and symptoms of another episode. Recurrence often occurs in patients with swallowing difficulties or who receive tube feedings (that is esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

g. Recurrent Respiratory Infection—In the last 3 days patient with a history of respiratory infection (for example., pneumonia; bronchitis) with evidence of a recurrence (for example, prior infection not resolved with medical intervention; infection has been experienced multiple times).

h. NONE OF THE ABOVE—In the last 3 days none of the above conditions were present.

Process: Interview and observe the patient. Review the patient's medical record, including consultation reports by a respiratory therapist and laboratory data such as arterial blood gases (ABG's), as indicated.

Coding: Check all conditions that were present in the last three days. If no conditions apply, check NONE OF THE ABOVE.

4. Pressure Ulcers

Intent: To identify and document the presence, stage and number of pressure ulcers, and, if present, record the characteristics (that is the size, exudate, and predominant tissue) of the ulcer(s).

Definition: Pressure Ulcer—Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed (Agency for Health Care Policy Research, 1992).

Pressure Ulcer Stage—The following pressure ulcer staging definitions are consistent with the recommendations of the Agency for Health Care Policy Research (AHCPR, 1992) and the National Pressure Ulcer Advisory Panel (NPUAP, 1989). A shorter version of these definitions appear on the form as coding options for Items H4a (highest current pressure ulcer stage).

a. Highest current pressure ulcer stage.

0. No pressure ulcer.

1. (Stage 1) Any area of persistent skin redness.

2. (Stage 2) Partial loss of skin layers.

3. (Stage 3) Deep craters in the skin.

4. (Stage 4) Breaks in skin exposing muscle or bone.

5. Not stageable (necrotic eschar predominant, no prior staging available).

PUSH (Pressure Ulcer Healing Scale) Score—A tool to monitor pressure ulcer healing over time. The PUSH Score is measured by assessing wound size, amount of exudate, and characteristics of predominant tissue. The PUSH is used in Items 4c through 4f.

(a) Highest current pressure ulcer stage.

Intent: In conjunction with other items, to facilitate the monitoring of pressure ulcer healing or worsening over time.

Process: Examine the patient for pressure ulcers and determine pressure ulcer stage. Without a full body inspection, an ulcer can be missed. If the patient has more than one ulcer, determine which ulcer has the highest (worst) ulcer stage. This type of information may be found in referral records (including discharge summaries), clinical progress notes, flow sheets, or patient care plans. Review these records to determine the highest ulcer ever achieved for any ulcer the patient currently has.

Coding: Record the highest (worst) current pressure ulcer stage. If the predominant tissue of the ulcer is necrotic eschar, prohibiting accurate staging, code ''5'', Not Stageable (necrotic eschar predominant; no prior staging available). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(b) Number of current pressure ulcers.

Process: Examine the patient for pressure ulcers. Without a full body inspection, an ulcer can be missed. COUNT the number of pressure ulcers.

Coding: Record the number of pressure ulcers, including ulcers that cannot be accurately staged (that is, if the predominant tissue of the ulcer is necrotic eschar). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(c–f) PUSH Scale (Items c through f).

The next four items (c through f) represent the PUSH Scale 3.0 developed by the National Pressure Ulcer Advisory Panel (NPUAP, 1998) to monitor pressure ulcer healing over time. For purposes of this assessment there are three important things to remember for this section:

• The PUSH Scale (items ''c'' through ''f'') can only be calculated for ulcers of Stage 2 and higher OR for ulcers where necrotic eschar is the predominant tissue. If highest pressure ulcer stage is ''0'' or ''1'', enter code of ''0'' in c, d, e, and f.

• Select the LARGEST ulcer. Note: The largest ulcer may not necessarily be the ulcer with the highest ulcer stage.

• Although the PUSH Scale was designed to evaluate the healing of a pressure ulcer, its use in this assessment is to provide a ''snapshot'' of the status for the largest ulcer present at the time of the assessment. When tracked over time, we can know the highest PUSH score that characterizes the patient's pressure ulcer status.

(c) Length multiplied by width (open wound surface area).

Materials: You will need a centimeter ruler to measure the surface area of an open wound. Although it's not necessary, it is also helpful to use a calculator for multiplying ulcer measurements to calculate the total open wound surface area.

Process: • Using a centimeter ruler, measure the greatest length (head to toe) and the greatest width (side to side) of the ulcer margins (for example, the edges of the ''open'' areas). If necrotic eschar is the predominant tissue and the ulcer is not ''open'', measure from edge to edge of the eschar.

• Multiply these two measurements (length x width) to obtain an estimate of the surface area in square centimeters (cm^2). Do not guess! Always use a centimeter ruler and always use the same method each time the ulcer is measured.

Coding: Record the number that corresponds to the largest pressure ulcer's open wound surface area using the following codes:

0. 0 cm^2.
1. <0.3 cm^2.
2. 0.3–0.6 cm^2.
3. 0.7–1.0 cm^2.
4. 1.1–2.0 cm^2.
5. 2.1–3.0 cm^2.
6. 3.1–4.0 cm^2.
7. 4.1–8.0 cm^2.
8. 8.1–12.0 cm^2.
9. 12.1–24.0 cm^2.
10. >24 cm^2.

(d) Exudate amount.

Process: Estimate the amount of exudate (drainage) present after removal of the dressing and before applying any topical agent to the ulcer for the selected (largest) pressure ulcer.

Coding: Record the response that best estimates the amount of exudate (drainage).

0. None.
1. Light.
2. Moderate.
3. Heavy.

(e) Tissue Type.

Process: Inspect the selected (largest) pressure ulcer and note the tissue that occupies the majority of the ulcer bed. Divide the ulcer bed into four imaginary quadrants, each representing about ¼ of the original ulcer surface. Estimate the portion or amount of each tissue type on the ulcer. Determine the predominant tissue type on the ulcer.

Coding: Record the response that describes the most predominant tissue type.

0. Closed/Resurfaced—The wound is completely covered with epithelium (new skin).

1. Epithelial Tissue—For superficial ulcers, new pink or shiny tissue (skin) that grows in

from the edges or as islands on the ulcer surface.

2. Granulation Tissue—Pink or beefy red tissue with a shiny, moist, granular appearance.

3. Slough—Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps/or is mucinous.

4. Necrotic tissue (eschar)—Black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin.

(f) Total PUSH (Pressure Ulcer Healing Scale) Score.

Process: Add up the scores from Items H4c (open wound surface area) + H4d (exudate amount) + H4e (tissue type). This sum represents the total PUSH Score.

Coding: Record the number that represents the Total PUSH Score in the box provided.

5. Other Skin Integrity

(a) Number of stasis ulcers (in the last 24 hours).

Definition: Stasis ulcer—An open lesion, usually of the ankle or lower third of the lower extremities, caused by chronic venous stasis or insufficiency. In the medical record one may also find this type of ulcer referred to as a ''venous ulcer'' or ulcer related to peripheral vascular disease (PVD).

Process: Examine the patient and review the clinical record. COUNT the number of stasis ulcers present in the last 24 hours.

Coding: Record the number of stasis ulcers in the box provided. If there are no stasis ulcers, code a ''0'' in the box.

(b) Number of surgical wounds (in the last 24 hours).

Definition: Surgical wounds—Includes healing and non-healing, open or recently closed (since onset of precipitating event in A7a) surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

Process: Examine the patient's body and COUNT the number of surgical wounds present in the last 24 hours.

Coding: Record the number of surgical wounds in the box provided. If there are no surgical wounds, code a ''0'' in the box.

(c) Ulcer resolved or healed in last 90 days.

Definition: Ulcer—For this item, the term ulcer refers to ANY lesion caused by pressure (that is, pressure ulcer; bedsore; decubitus ulcer) or venous stasis/insufficiency (that is, stasis ulcer).

Process: Review the patient's clinical record over the last 90 days for documentation of the presence of a pressure or stasis ulcer that has been healed (that is, closed/resurfaced; new tissue entirely covers the wound). Validate findings by examining the patient's body.

Coding: Record the most appropriate response to indicate that the patient had an ulcer that was resolved or healed in the last 90 days. If the patient did not have an ulcer that resolved in the last 90 days, use a code of ''0'' in the box. Note: The patient may still have other ulcers in various stages of healing.

0. No, or never had ulcer.

1. Yes.

6. Other Skin Problems or Lesions Present

Intent: To document the presence of skin problems other than ulcers or surgical wounds, and conditions that are risk factors for more serious problems.

Definition: a. Burns (second or third degree)—Includes burns from any cause (for example, heat, electricity, chemicals, radiation, or gases) that affects skin deeper than the epidermis or outermost layer of skin. This category does not include first degree burns (changes in skin color only).

b. Open lesions other than rashes, cuts (for example, cancer lesions, ulcers)—Any open area of the skin unrelated to pressure, venous stasis, surgery, trauma or rashes.

c. Rashes—Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (for example, eczema, heat, drugs, bacteria, fungus, viruses [such as herpes zoster, chicken pox], parasites [such as scabies, lice], contact with irritating substances such as urine or detergents, allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

d. Skin tears or cuts (other than surgery)—Any traumatic break in the skin penetrating to subcutaneous tissue not caused by surgical puncture or incision. Examples include lacerations, punctures wounds, etc.

e. NONE OF THE ABOVE.

Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders.

Process: Ask the patient if he or she has any problem areas. Ask the nurse assistant and examine the patient. Review the patient's record. You are assessing for skin problem areas present over the last 24 hours.

Coding: Check all that apply for the last 24 hours. If there is no evidence of such problems in the last 24 hours, check NONE OF THE ABOVE.

Section I. Pain Symptoms

Intent: The intent of this section is to identify other health conditions that have an impact on the patient's quality of life, health risks, and plan of care, including the discharge plan.

1. Pain Symptoms

Intent: To evaluate and record the presence, frequency and intensity of pain and how it is managed. Pain can impact the patient in many ways, including affecting his or her ability to meet established goals. It is essential that pain is assessed and an effective pain management plan put in place in order to optimize the patient's recovery and quality of life. Items I1a through I1b refer to pain in the last 3 days. In item I1c, how the patient's current perception of pain compares to pain status prior to precipitating event (item A7a). For care planning purposes these items can be used to determine the characteristics of the patient's pain and to monitor his or her response to pain management interventions.

Definition: Pain—pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the patient says it is. If the patient complains of pain, record that pain is present.

Pain assessment may depend on the observation of others (that is, cues), either because the patient does not complain, or is unable to verbalize or describe symptoms.

Process: This evaluation is based solely on the patient's perception of pain, or in cases where the patient has limited ability to communicate, staff's interpretation of behaviors that might indicate pain. Ask the patient to categorize the highest level of pain they have experienced over each time period.

Ask the patient if he or she has experienced any pain or discomfort in the last three days and ask him/her to describe it. If the patient states he or she has pain, take his or her word for it. Pain is a subjective experience.

Observe the patient for indicators of pain. Observation is particularly important in patients who are unable to communicate their experiences of pain. Indicators may include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, lying very still or decreasing usual activities (to prevent pain from occurring).

In severely cognitively impaired patients, the pain experience is particularly difficult to discern. For example, in patients who cannot verbalize that they are feeling pain, discomfort may be manifested by behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, code for the frequency and intensity of symptoms if in your best clinical judgement it is possible that the behavior could be caused by the patient experiencing pain.

Ask nurse assistants and therapists who work with the patient if the patient had complaints or indicators of pain the last three days.

Coding: For each of the following items (I1a through I1b) code for the HIGHEST LEVEL OF PAIN the patient experienced in the last three days, even while receiving treatments.

a. FREQUENCY—Measures how often the patient experiences pain (reports or shows evidence of pain).

Codes: 0. No pain.

1. Pain less than daily.

2. Daily—single shift.

3. Daily—multiple shifts.

b. INTENSITY '' Measures the level of pain as the patient perceives it (described or manifested by the patient). Use the following scale to indicate the level of pain experienced:

Codes: 0. No pain.

1. Mild pain—Although the patient experiences some (''a little'') pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate pain—Patient experiences ''a medium'' amount of pain.

3. Severe pain—Patient experiences intense pain.

4. Times when pain is horrible or excruciating—Worst possible pain the person can imagine.

c. CURRENT PAIN STATUS as compared to pain status prior to precipitating event item (A7a). Patient's experience of pain NOW as compared to pain status prior to precipitating event. Note: If the patient has no pain now and no pain prior to precipitating event (item A7a), code ''0'', same.

Coding: 0. Same.

1. Better.

2. Worse.

8. UNKNOWN—The patient is unable to describe how the pain compares OR there is no available information in the clinical record or via family or professional caregivers.

Section J. Oral/Nutritional Status

1. Oral Problems

Intent: To record any oral or nutritional problems in the last 3 days.

Definition: a. Chewing Problem—Inability to chew regular food easily and without pain or difficulties, regardless of cause (for example, poor mastication, immobile jaw, recent oral surgery, temporomandibular joint pain, decreased sensation/motor control).

b. Dental Problem—Upon exam and interview of the patient, problems with teeth are identified (for example, ill—fitting or lack of dentures, painful tooth, poor dental hygiene).

Process: Examine and interview the patient—this is the crucial part of the process, without this examination, oral problems often go undetected. Review clinical records. Talk to the nurse assistants who have recently helped the patient with his/her ADL's.

Coding: Record the most appropriate response in the box provided. Code ''0'' for No and ''1'' for Yes.

2. Swallowing

Intent: The ability to swallow safely can be affected by many disease processes and functional decline. Alterations in one's ability to swallow can result in choking and aspiration, both of which can cause morbidity and mortality. Often patients with swallowing difficulties require altered consistencies of food and fluids OR may not be able to ingest nutrition by mouth. This item details the diet consistencies and modifications in place to address swallowing difficulties.

Process: Observe patient. Review the patient's clinical record, including MD, dietitian and Speech Language Pathology notes if applicable.

Coding: Using the codes provided, indicate which item best describes the dietary prescriptions to address swallowing difficulties.

0. Normal—Safe and efficient swallowing of all diet consistencies.

1. Requires diet modification to swallow solid foods (mechanical diet or able to ingest specific foods only).

2. Requires modification to swallow solid foods and liquids (puree, thickened liquids).

3. Combined oral and tube feeding [tube feeding (via NGT, GT, JT), and some oral intake]

4. No oral intake (NPO)

3. Height and Weight

Intent: To establish a height and weight in order to monitor nutrition and hydration status over time, to establish a baseline to monitor changes in weight over time.

Process: Base weight on the most recent measure in the last 3 days. Utilize your facility's standard of practice to ensure consistency in measuring weights (for example, in a.m. after voiding, before breakfast, with shoes off and in night clothes).

Coding: Record in ''box a.''—Height in inches and in ''box b''—Weight in pounds.

4. Weight Change

Intent: To assess any presence of weight loss or gain.

Process: Review clinical record, weight records, and dietary notes to assess weight history. Since patient may have only been in your facility a few days, it may be difficult to obtain accurate factual information. Utilize patient and family interview to determine appropriate coding.

a. Weight Loss.

Definition:Weight loss in percentages (for example, 5 percent or more in last 30 days).

Process: New admission '' Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current patient '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned loss.

2. Yes, unplanned loss.

b. Weight Gain.

Definition: Weight gain in percentages (for example, 5 percent or more in last 30 days).

Process: New admissions—Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current weight '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight gain during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned gain.

2. Yes, unplanned gain.

5. Parenteral or Enteral Intake

Intent: To record the proportion of all calories received, and the average fluid intake, through parenteral or tube feeding in the last 3 days.

a. The proportion of total calories the patient received through parenteral or tube feedings in last 3 days.

Definition:Proportion of total calories received—the proportion of all calories ingested during the last 3 days that the patient actually received (not just ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review clinical record, particularly the intake flow sheets. Consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the best response. If the patient took no food or fluids by parenteral or tube feedings, or took just sips of fluid, code ''0'' (None).

0. None.

1. 1 percent to 25 percent.

2. 26 percent to 50 percent.

3. 51 percent to 75 percent.

4. 76 percent to 100 percent.

b. Average fluid intake per day by IV or tube in last 3 days.

Definition: Average fluid intake per day by IV or tube in last 3 days refers to the actual amount of fluid the patient received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last 3 days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the total fluid intake during this time by 3. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the patient received per day by IV or tube in last 3 days.

Codes: 0. None.

1. to 500 cc/day.

2. 501 to 1000 cc/day.

3. 1001 to 1500 cc/day.

4. 1501 to 2000 cc/day.

5. 2001 or more cc/day.

Section K. Procedures/Services

Intent: To document the service, treatments, procedures and devices the patient received over the last 3 days.

1. Clinical Visits and Orders

Intent: To document the number of physician, nurse practitioner, and physician assistant visits in which the patient was examined and notes written, as well as the number of order changes in the last 3 days.

Process: Review the medical record, including physician, nurse practitioner, and physician assistant orders over the last 3 days. See specific processes under each of the following definitions:

Definition: a. Total number of physician visits (by attending, consultant, etc.) in which the patient was examined and MD notes written—This category also includes any primary care or consulting osteopath, podiatrist or dentist. Review the medical record and add up the total number of physician visits the patient had in the last three days. Count only those where the patient was actually seen and examined/assessed by the physician as indicated by physician notes specifically indicating findings/results of the examination. Examination/assessment may be a partial or full exam that occurs at the facility or physician's office/clinic. This category does not include exams conducted in an emergency room.

b. Number of times physician or nurse practitioner called to bedside for emergency (for example, cardiorespiratory arrest, hemorrhaging, to evaluate change in condition)—Once again the physician category also includes bedside visits for emergencies by MD, osteopath, podiatrist, or dentist.

c. Number of nurse practitioner (NP) visits in which patient examined and notes

written—Review the medical record and add up the total number of NP visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by NP notes specifically indicating findings/results of the examination.

d. Number of physician assistant (PA) visits in which patient examined and notes written—Review the medical record and add up the total number of PA visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by PA notes specifically indicating findings/results of the examination.

e. Number of new or changed orders—Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders or renewal orders without changes. Does include orders for lab tests. Review the physician order sheet in the medical record and add up the total amount of new or changed orders by M.D., osteopath, podiatrist, dentist, NP or PA.

Coding: For each clinical visit or order, record how often it was provided to the patient in the last 3 days.

2. Treatments and Services

Intent: To document the following:

- Column A—over the last 3 days, code for treatment frequency [either daily (Code 3) or less than daily (Code 2) or ordered, not yet implemented (Code 1)].
- Column B—Record whether patient will receive service after discharge.

Process: *Column A*—Review patient's plan of care with the primary caregiver, and review the current medical record, referral information and hospital discharge summary. Use the following coding instructions to indicate how often each of these services was provided in the last 3 days. Note: These treatments and services must either be ordered by a physician or performed by a licensed professional and documented appropriately.

Column B—This column is to be completed ONLY at the discharge assessment (Item AA3 = 5). Review the patient's plan of care with the primary caregiver, and review the current medical record. Use the coding instructions for Column B (below) to indicate whether the patient will receive the service/treatment after discharge.

Coding: *Column A*—For each treatment or service indicate how often it was provided to the patient in the last 3 days. If none of these treatments were provided, check NONE OF ABOVE (Item K2aiA, located in the bottom right hand corner of Section K2, Treatments and Services). For any activity that did not occur, or was not ordered, leave the box next to that item blank. Code for most intense treatment on any one day using the following codes:

[Leave blank] if treatment did not occur, not ordered.

Code ''1'' If the treatment was ordered, but has not yet been implemented.

Code ''2'' If the treatment occurred less than daily.

Code ''3'' If the treatment occurred daily.

Column B—For each treatment or service (''a'' through ''ah'') indicate whether the patient will receive it after discharge. Leave ''Blank'' for No, Code ''1'' for Yes. This information is obtained on a Discharge Assessment only.

Definition: MEDICATION RELATED

a. Diabetic management—Involves a variety of activities centered around stabilization of blood sugar, including determining sliding scale insulin dosages, and blood sugar monitoring. In order to use codes 1–3 in Column A, there must be documentation of changes in type of insulin, insulin dosing, or reports/documentation of blood sugar levels.

b. Injections—Subcutaneous, intramuscular, or intradermal injections of any type of medication, antigen, or vaccine. Although antigens and vaccines are considered ''biologicals'' and not medication per se, it is important to track when they are given in order to monitor for systemic reactions. This category does not include intravenous fluids or medications. If the patient received IV medications, record in Item K2c. (If the patient received IV fluids, record in Item J5b).

c. IV antibiotics/medications—Administration of antibiotics or other medications by means of infusion therapy. Includes any drug or biological (for example, contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

SKIN TREATMENT

d. Application of dressing—Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

e. Application of ointments, topical medications—Includes ointments or medications used to treat a skin condition (for example, cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (for example, nitropaste for chest pain).

f. Debridement (chemical or surgical)—Chemical debridement is the process of removing dirt or dead tissue from a wound or burn using chemical agents or dressing change products to promote wound healing. Surgical debridement is the process of surgically removing dirt or dead tissue from a wound or burn to promote wound healing.

g. Nutritional/hydration intervention to manage skin problems—Any nutritional intervention whose purpose is to promote wound healing (for example, high protein drinks, TPN/PPN).

h. Pressure relieving bed/chair—Pressure relieving devices for the bed include air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category. Pressure relieving devices for the chair include gel, air (for example, Roho) or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

i. Turning and repositioning—Includes a continuous, consistent program for changing the patient's position and realigning the body.

j. Ulcer Care—Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

k. Wound care (surgical)—Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of microbial ointments, dressings of any type, suture removal, and warm soaks or heat application.

MANAGEMENT OF HEALTH PROBLEMS

l. Bladder training—A planned program aimed at assessing and treating bladder incontinence.

m. Scheduled toileting—A plan whereby staff members at scheduled times either take the patient to the toilet room, or give the patient a urinal, or remind the patient to go to the toilet. Includes habit training or prompted voiding.

n. Bowel program—A planned program aimed at treating bowel incontinence. A bowel program also includes a program of planned bowel elimination as with patients with spinal cord injury.

o. Cardiac monitoring/Rehabilitation—Cardiac monitoring includes electrical surveillance of heart rates and patterns either through EKG or telemetry. Rehabilitation is a formalized program focusing on regaining function and endurance that has been limited by either a chronic or acute cardiac disease.

p. Cast(s)—A device used to immobilize limbs or joints to promote healing or as a treatment for various musculoskeletal problems.

q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)—Assistive breathing device which provides the patient with a continuous flow of air throughout the breathing cycle.

r. Drains (cutaneous drains and other drains)—A heavy gauged tube used to remove air, fluid, or exudate from a body cavity or wound (exclude chest tubes).

s. Dialysis (includes hemodialysis and peritoneal dialysis)—Hemodialysis is a method for removing unwanted byproducts from the blood of patients with renal insufficiency or failure through the use of a machine (dialyzer). Peritoneal dialysis (CAPD) is a method of removing unwanted by-products from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

t. Enteral Feeding Tube—Any tube inserted into the gastrointestinal tract for the purpose of nutrition, hydration, or medication administration. (This includes, jejunostomy, gastrostomy, and PEG tubes).

u. IV line-Central—A catheter which is placed in the more ''central'' veins such as subclavian, jugular, or superior vena cava, for the purpose of monitoring, and administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infection), and flushes.

v. IV line-peripheral—A catheter which is placed in a peripheral vein (usually hand or arm) for administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infiltration; infection; cellulitis) and flushes.

w. NG feeding tube—A tube inserted through the nose and extending into the stomach.

x. Oxygen—Either the intermittent or continuous use of oxygen to support, promote or maintain vital functions and comfort.

y. Pain management other than drugs—Any documented non-pharmaceutical intervention designed to decrease or alleviate pain. Examples may include (but are not limited to) acupuncture, relaxation therapy, hypnosis, TENS therapy.

z. Suctioning-oral/nasopharyngeal—Removing secretions or other matter from the respiratory system through the mouth or nose.

aa. Suctioning-tracheal—Removing secretions or other matter from the respiratory system through a tracheostomy.

ab. Tracheostomy care—The process of maintaining a clean and functioning tracheostomy, includes assessing the surrounding skin, changing dressing around tracheostomy tube, cleaning and changing inner cannula, monitoring cuff pressures, and securing the tracheostomy tube.

ac. Transfusion(s)—Giving whole blood or blood component (for example, red blood cells) to replace blood loss through injury, surgery, or disease.

ad. Ventilator or respirator—Assures adequate ventilation in patients who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices.

ae. Ventilator weaning—Any patient who was in the process of being weaned off the ventilator or respirator in the last 3 days should be coded under this definition.

OTHER

af. Family training in assistance to patient in health measures or skills required after return to the community—Any documented family teaching to support the patient's discharge home. Examples include, but are not limited to, observing for signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); administering medications; observing for drug side effects or adverse drug reactions; providing ostomy care or dressing changes; coaching strength training exercises; assisting in transferring and locomotion; providing appropriate verbal/physical cues for feeding; how to label closets and drawers so patient can retrieve clothes; application of behavioral management techniques; when to report change or request assistance.

ag. Patient training in health maintenance or skills required after return to community—Any documented patient teaching to support the patient's discharge home. Examples include, but are not limited to, recognizing and reporting signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); self-administration of medications; recognizing and reporting drug side effects or adverse drug reaction; recording adherence to strength training exercises; self-ostomy care; how the Lifeline emergency response system works; how to access help in an emergency.

ah. Design and implementation of discharge plan—Discharge plan developed by the interdisciplinary team; includes making the necessary arrangements and contacts with community services.

ai. NONE OF THE ABOVE—Code if the patient has received NONE of the treatments or services above.

3. Nursing Practice or Restorative Care

Intent: To determine the extent to which the patient receives nursing rehabilitation or restorative services from other than specialized therapy staff (for example, occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the patient's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: Rehabilitation/restorative care—Included are nursing interventions that assist or promote the patient's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item K4. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote patient involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific patients.
- This category does not include exercise groups with more than four patients per supervising helper or caregiver.

Definition: a. Range of motion (passive)—The extent to which, or the limits between which, a part of the body can be passively moved around a fixed point, or joint. Passive range of motion exercise is a program of movements to maintain flexibility and useful motion in the joints of the body.

b. Range of motion (active)—Exercises performed by a patient, with cuing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

c. Splint or orthotic assistance—Assistance can be of 2 types: (1) where staff provide verbal and physical guidance and direction that teaches the patient how to apply, manipulate, and care for an orthotic device or splint, or (2) where staff have a scheduled program of applying and removing a splint or brace, assess the patient's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice—Activities including repetition, physical or verbal cuing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed mobility—Activities used to improve or maintain the patient's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Bladder/Bowel—Activities used to improve or maintain the patient's self-performance in bladder and bowel evacuation (includes ostomy care).

f. Transfer—Activities used to improve or maintain the patient's self-performance in moving between surfaces or planes either with or without assistive devices.

g. Walking—Activities used to improve or maintain the patient's self-performance in walking, with or without assistive devices.

h. Dressing or grooming—Activities used to improve or maintain the patient's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

i. Eating or swallowing—Activities used to improve or maintain the patient's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the patient's ability to ingest nutrition and hydration by mouth.

j. Amputation/prosthesis care—Activities used to improve or maintain the patient's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (for example, leg stump or eye socket).

k. Communication—Activities used to improve or maintain the patient's self-performance in using newly acquired functional communication skills or assisting the patient in using residual communication skills and adaptive devices.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding: For the last three days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during each day (24-hour period). The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero ''0'' if none, or if the service was provided for less than 15 minutes per day in the last 3 days.

4. Therapy Services

This item involves therapies that occurred after admission to the facility and meet the following criteria: (1) were ordered by a physician, (2) were performed by a qualified therapist (that is, one who meets state credentialing requirements) OR (3) were performed by therapy assistant under the direction of the therapist.

The therapy treatment may occur either inside or outside the facility. Includes only therapies based on a therapist's assessment and treatment plan that is documented in the patient's clinical record.

Intent: To record the (A) total number of days treatment was ordered in the last 3 days, (B) number of days administered (for 15 minutes or more), (C) total number of minutes each of the following therapies was provided in the last 3 days (or ordered if days administered =0 and days ordered >0), and (D) whether the patient will receive the service after discharge. Note: In order for therapy minutes to be recorded in the most precise 15 minute increment, either the physician's order or the therapist's plan of care must indicate minutes of therapy ordered by the physician or recommended in the therapist's plan of care.

Definition: a. Speech-language pathology, audiology services—Services that are provided by a qualified speech-language pathologist.

b. Occupational therapy—Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified occupational therapist.

c. Physical therapy—Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified physical therapist.

d. Respiratory therapy—Included are coughing, deep breathing, administration of heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (that is, trained nurse, respiratory therapist). This item does not include use of hand-held medication dispensers. Count only the time that the qualified professional spends with the patient. For high intensity respiratory patients who receive 24° respiratory care, have a discussion with the therapist to get an estimate of the actual amount of time spent at the bedside providing care.

e. Psychological therapy by any licensed mental health professional—Therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

f. Therapeutic recreation—Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

Process: Review the patient's clinical record and consult with each of the qualified therapists.

Coding: For Boxes (Columns) A, B and C count only post-admission therapies (given in or outside the facility).

Column A: Days ordered—In the first column, enter the number (#) of days the treatment was ordered during the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column B: Days administered—In the second column, enter the number (#) of days the therapy was administered for at least 15 minutes or more in the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column C: Minutes delivered—In the third column, enter the total number (#) of minutes the particular therapy was provided in the last 3 days. The time should include only the actual treatment time (not time waiting, writing reports, or conducting an evaluation). Enter total number of minutes ordered if days administered (K4B) = 0 and days ordered (K4A) > 0. Enter ''0'' if the therapy was not ordered or administered. [Note—Enter cumulative time over all 3 days even when total time on a day (or days) was less than 15 minutes].

Column D: Post Discharge Therapy—Code at discharge assessment only (A3=5). Record whether the patient will receive the therapy service after discharge. Code ''0'' for No, or ''1'' for Yes. This information is obtained on a Discharge Assessment only.

5. Devices and Restraints

Intent: To record the frequency, over the last three days, with which the patient was restrained by any of the devices listed below at any time during the day or night.

Definition: This category includes the use of any device (for example, physical or mechanical device, material, or equipment attached or adjacent to the patient's body) that the patient cannot easily remove and that restricts freedom of movement or normal access to his or her body. If device is used as an ''enabler,'' you still must code device in this item.

a. Full bed rails—Full rails may be one or more rails along both sides of the patient's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the patient from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). A veil screen (used in pediatric units) or veil bed is included in this category.

b. Other types of side rails used (for example, one-side half rail, one-side full rail, two-sided half rails).

c. Trunk restraint—Includes any device or equipment or material that the patient cannot easily remove (for example, vest or waist restraint).

d. Chair prevents rising—Any type of chair with locked lap board or chair that places patient in a recumbent position that restricts rising or a chair that is soft and low to the floor (for example, bean bag chair). Includes ''comfort cushions'' (for example, lap buddy), ''merry walkers.''

Process: Check the patient's clinical records and restraint device flow sheets. Consult nursing staff. Observe the patient.

Coding: For each device type, enter the code that best describes the pattern of restraint or device use for the last 3 days:

0. Not used in last three days

1. Used, but used less than daily in last three days

2. Daily use—night only in the last three days

3. Daily use—days only in the last three days

4. Night and day use, but not constant use in the last three days

5. Constant use for full 24 hours (with periodic release) during the last three days

Section L. Functional Prognosis

Intent: A major goal of post acute care is to rehabilitate the patient to a level of function and health that enables return to the patient's previous living arrangement or, if not appropriate, to the most independent living arrangement possible. Developing plans of care to achieve this goal and prepare for post-discharge needs requires (1) establishing individualized goals in specific areas of function and health, (2) estimating the degree to which the patient will improve, (3) evaluating the patient's and family's individual needs, values, motivation for participation in rehabilitation, and (4) estimating the rate of patient change (and goal achievement) and length of stay. This section asks the interdisciplinary team to take this information and make some predictions on rehabilitation prognosis. These predictions are essential in planning services needed during the stay as well as upon discharge.

1. Functional Improvement Goals

Intent: This section looks at some key functional areas, and asks staff to make a prediction whether the patient will meet these goals in the indicated time frame.

Definition: ADLs

a. Bed mobility/transfer—Goals that involve how patient moves to and from a lying position, turns side to side, and positions body while in bed. Also includes goals involving how patient moves between surfaces—to or from: bed, chair, wheelchair.

b. Dressing—Goals that involve how the patient dresses and undresses (street clothes and underwear) including prostheses, orthotics, fasteners, pullovers, belts, pants, skirts, and shoes.

c. Eating—Goals centering on how the patient eats and drinks (regardless of skill). This includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

d. Locomotion—Goals involving how the patient moves between locations in his/her room and adjacent corridor on the same floor.

If patient uses a wheelchair, the goals would involve how the patient moves once the patient is in the wheelchair.

e. Toileting—Goals that involve how the patient uses the toilet room (or commode, urinal, bedpan), cleanses himself/herself after toilet use or incontinent episode(s), changes pads, manages ostomy or catheter, and adjusts clothes. This item does include goals centering on transfers on and off the toilet or commode.

OTHER

f. Medication Management—Goals involving how the patient manages medications (remembering to take medications, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments).

g. Pain Control—Goals involving the control (cessation or mitigation) of pain by the patient. Pain control goals could involve both pharmacologic and non-pharmacologic interventions.

h. Managing Finances—In the inpatient environment this includes goals involving financial activities such as paying for the newspaper, paying for TV service. When considering home discharge, this item involves paying bills, managing checking account, or bank account.

Process: Using your best clinical judgment, code each of these functional areas using the scale described below. A review of the physician orders, notes and plans of care would be essential in this process to confirm what goals have been established.

Coding: Choose the response that best reflects the clinical staff's prognosis for goal attainment in each of the specified areas in the last 24 hours. Code for the most aggressive goal in each area. For admission assessment and reassessment, code for clinical staff expectations of patient goals in the areas listed below by time of discharge. For discharge assessments, code for staff expectation of patient functional goal in the post discharge period.

0. No goal exists—There is currently no goal in the patient's plan of care that aims to improve or maintain the patient's current functional performance or health (in the area specified) in the area indicated.

1. Goal—improvement, full recovery to premorbid status anticipated—Goals for improvement in the area specified have been set, and clinical staff project that the patient will improve to the level of function or health (in the area specified) that he or she experienced prior to the precipitating event (Item A7a).

2. Goal—improvement, partial recovery anticipated—Goals for improvement in the specified area have been set, but given the patient's current status and availability of services within the expected length of stay, clinical staff project that the patient will not improve to the level of function or health (in the area specified) he or she experienced prior to the precipitating event (Item A7a).

3. Goal—improvement, recovery uncertain—Goals for improvement in the specified area have been set, but given the patient's current health, functional or emotional status, clinical staff are unable to determine if the patient will partially or fully return to the level of function or health (in the specified area) he or she experienced prior to the precipitating event (Item A7a).

4. Goal—maintenance, prevention of further decline—Goals for maintenance (preservation) of function or health in the specified area have been set, and clinical staff project that the patient will meet maintenance goals as evidenced by NO further deterioration in function or health (in the area specified).

2. Attributes Relevant to Rehabilitation

Intent: The intent of this section is to measure the patient's and his or her family's motivation to participate in the rehabilitation program and goals. This is essential to establish the patient and the patient's support system's participation in the established plan of care. When conflicts arise, the plan of care needs to be modified to reflect efforts to resolve these conflicts. For example, if the patient is in the post-acute setting for rehabilitation after a stroke, but is ''refusing rehabilitation,'' this issue becomes the primary issue to deal with rather than the fact that the patient's mobility is limited.

Definition: a. Patient believes he/she is capable of increased independence—The patient states that he/she has the capacity to improve or be more independent (albeit with therapeutic support) or demonstrates this belief by actively participating in rehabilitative programming.

b. Patient unable to recognize new limitations—The patient lacks insight into the level of his/her altered function; may use poor judgement, thereby placing self at safety risk; may resist participation in therapeutic programming aimed at improving function or compensating for deficits.

c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability—The patient refrains from participating in self-care in one or more ADL areas in which he/she has shown self-care abilities.

Process: Interview the patient. Get a sense of what his/her goals are from this post-acute admission. Also discuss what the patient's family or support person's perceptions are. Observe the patient's behavior and participation in plan of care. Are there differences in the Care Plan goals established by the team and the patient's and family's goals?

Coding: Indicate ''0'' for No, ''1'' for Yes, or ''8'' for Unknown in the box corresponding to each item, indicating that they have been observed, verbalized or documented in the last 3 days.

3. Change Over the Last 3 Days

Intent: To evaluate and predict the rate in which the patient will progress toward his or her established goals.

Process: Obtain information via review of the medical record, staff and patient interview.

Definition: a. Change in overall functional status over last 3 days.

b. Change in overall health status over last 3 days.

Coding: From the following codes, choose the response that best reflects your best clinical judgement of the patient's rate of overall functional and health status change over the last 3 days.

0. Improved.

1. About the same as at admission (or last assessment if this is not an admission assessment).

2. Worse.

4. Estimated Length of Stay From Date of Admission

Intent: It is essential to put a time frame around established goals in the plan of care. The guiding time frame in this process is the anticipated length of stay. This is established based on a number of factors including but not limited to, diagnosis, functional ability and prognosis, medical complications, support systems, patient motivation, and anticipated living arrangement and payor source. All this information must be taken into consideration when making a prediction.

Process: Use a chart review, patient/support system interview, or obtain interdisciplinary clinical input to code for the anticipated length of stay.

Coding: Starting from (and including) the date entered in AA2b or if AA2b is blank AA2a (Admission Date), using your best clinical judgement, determine the patient's expected length of stay in the current setting prior to returning to a community setting. Choose the response that best reflects the anticipated time frame.

0. 1–6 days.

1. 7–13 days.

2. 14—30 days.

3. 31—90 days.

4. 91 or more days.

5. Discharge to community not expected—It is anticipated that the patient will never return to the community, even if they are transferred to another facility. This category also includes patients who are expected to die during this admission.

6. Expected discharge will be to another health care setting prior to return to community—Examples include transfer to nursing facility with eventual discharge to the community.

Section M. Resources for Discharge

Intent: In this section some key elements related to discharge planning are addressed. Before formulating a discharge plan, the resources available to support the patient's discharge home should be evaluated based on the patient's current needs. In conjunction with previous sections of the assessment, these items lay the ground work for developing a realistic discharge/transition plan.

1. Available Social Supports

Intent: To identify the availability of family or friends to provide support during the post-acute phase and after discharge.

Process: Information should be obtained through patient/family interview and through medical record review. Determine if there is any indication that family or close friends are present and available. Privately employed caregivers would not be coded in this item.

Definition: a. Emotional Support—The provision of encouragement, comfort, attentive listening.

b. Intermittent physical support with ADLs or IADLs—less than daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing

housework, shopping etc, on a less than daily basis.

c. Intermittent physical support with ADLs or IADLs—daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis (for example, once a day), but not full time.

d. Full time physical support (as needed) with ADLs or IADLs—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis full time.

e. All or most of necessary transportation—Includes providing transportation by driving patient in a car (or other motorized vehicle) OR accompanying patient using bus, subway, or other public transportation.

Coding: Ask if one or more family members/close friends are willing and able to provide support after discharge. Enter the most appropriate response next to the type of support. Enter ''0'' for No, ''1'' for Possibly yes, and ''2'' for Definitely Yes.

2. Caregiver Status

Intent: The following items identify issues with the patient's family or informal caregivers in preparation for discharge. Often, when a family member needs post-acute care, the entire family is affected. It is important to determine how the caregiver(s) is coping, whether he/she requires additional supports, or if he/she is willing and able to provide the patient with extended care in their home.

Process: Interview the patient and family/caregiver, as well as staff who are closely involved with the patient's care. Review medical record, including Social Service notes.

Coding: Enter a ''0'' for ''No'', and a ''1'' for ''Yes'' in the box next to each statement that applies to the patient and their care givers/family.

0. No.

1. Yes.

a. Family (or close friend) overwhelmed by patient's illness.

b. Family relationship(s) require unusual amounts of staff time.

3. Living Arrangement

Intent: The intent of this item is to establish the permanent living arrangement both prior to admission [A] and that which is expected after discharge [B]. If the initial arrangement expected at discharge is different than column M3B—code in column C for Temporary Discharge arrangement (A3 = 5).

Process: Obtain information through patient and family interview. Medical record review may also be helpful.

Definition: a. Type of residence.

0. Unknown.

1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented Room—A rented room either part of a private house or a boarding room establishment.

4. Board and Care/assisted living/group home—An alternative housing option which integrates shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

5. Homeless (with or without shelter)—Person does not have a residence—lives out on streets, woods, etc. or uses a community based shelter for individuals who do not have a residential address.

6. Long Term Care Facility (nursing home)—A residence that provides 24-hour skilled or intermediate nursing care.

7. Post Acute Care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

8. Hospice—An interdisciplinary program of palliative care and support services that addresses the physical, social, spiritual, and financial needs of terminally ill patients and their families.

9. Acute unit/hospital—A facility licensed as an acute care hospital or unit. Patients in acute care may receive comprehensive and complex diagnostic services, treatments, and surgery.

10. Other—Any other setting not categorized above.

b. Live(d) with.

0. Unknown.

1. Alone—Living with a pet is coded as living alone.

2. Spouse only—If patient is living as married (common law marriage) with another person, use this code.

3. Spouse and others—husband or wife, and other family members, friends, boarders.

4. Child—Lives with child, no spouse present.

5. Other relative(s)—Not spouse or children.

6. Friends.

7. Group setting—An alternative housing option which integrates a shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

8. Personal Care Attendant—A health care worker either hired by an agency or the patient himself. This worker is trained to provide the patient with help in ADL's and other types of assistance.

9. Other—Any other living arrangement not categorized above.

Process: Review the medical record. Consult the patient and family. This is meant to measure permanent placement. If a patient is going to be discharged to a skilled nursing facility for a short period of time, and then discharged back to their home, the permanent living arrangement would be either 1 or 2 depending on home service arrangements.

Coding: a. Type of residence—

- In Column A—indicate the type of residence where the patient permanently resided prior to admission.
- In Column B—indicate the type of residence where the patient is expected to permanently reside after discharge.
- In Column C—indicate the type of residence where the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

b. Lived with—

- In Column A—indicate with whom the patient permanently resided prior to admission.
- In Column B—indicate with whom the patient is expected to permanently reside after discharge.
- In Column C—indicate with whom the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

Appendix C: List of Comorbidities

ICD9 code No.	Abbreviated code title
011	Pulmonary tuberculosis*
011.0	TB of lung, infiltrative
011.00	TB lung infiltr-unspec
011.01	TB lung infiltr-no exam
011.02	TB lung infiltr-exm unkn
011.03	TB lung infiltr-micro DX
011.04	TB lung infiltr-cult DX
011.05	TB lung infiltr-histo DX
011.06	TB lung infiltr-oth test
011.1	TB of lung, nodular
011.10	TB lung nodular-unspec
011.11	TB lung nodular-no exam
011.12	TB lung nodul-exam unkn
011.13	TB lung nodular-micro DX
011.14	TB lung nodular-cult DX
011.15	TB lung nodular-histo DX
011.16	TB lung nodular-oth test
011.2	TB of lung w cavitation
011.20	TB lung w cavity-unspec
011.21	TB lung w cavity-no exam
011.22	TB lung cavity-exam unkn
011.23	TB lung w cavit-micro DX
011.24	TB lung w cavity-cult DX
011.25	TB lung w cavit-histo DX
011.26	TB lung w cavit-oth test
011.3	Tuberculosis of bronchus
011.30	TB of bronchus-unspec
011.31	TB of bronchus-no exam
011.32	TB of bronchus-exam unkn
011.33	TB of bronchus-micro DX
011.34	TB of bronchus-cult DX
011.35	TB of bronchus-histo DX
011.36	TB of bronchus-oth test
011.4	TB fibrosis of lung
011.40	TB lung fibrosis-unspec
011.41	TB lung fibrosis-no exam
011.42	TB lung fibros-exam unkn
011.43	TB lung fibros-micro DX
011.44	TB lung fibrosis-cult DX
011.45	TB lung fibros-histo DX
011.46	TB lung fibros-oth test
011.5	TB bronchiectasis
011.50	TB bronchiectasis-unspec
011.51	TB bronchiect-no exam
011.52	TB bronchiect-exam unkn
011.53	TB bronchiect-micro DX
011.54	TB bronchiect-cult DX
011.55	TB bronchiect-histo DX
011.56	TB bronchiect-oth test
011.6	Tuberculous pneumonia
011.60	TB pneumonia-unspec

ICD9 code No.	Abbreviated code title
011.61	TB pneumonia-no exam
011.62	TB pneumonia-exam unkn
011.63	TB pneumonia-micro DX
011.64	TB pneumonia-cult DX
011.65	TB pneumonia-histo DX
011.66	TB pneumonia-oth test
011.7	Tuberculous pneumothorax
011.70	TB pneumothorax-unspec
011.71	TB pneumothorax-no exam
011.72	TB pneumothorx-exam unkn
011.73	TB pneumothorax-micro DX
011.74	TB pneumothorax-cult DX
011.75	TB pneumothorax-histo DX
011.76	TB pneumothorax-oth test
011.8	Pulmonary TB nec
011.80	Pulmonary TB nec-unspec
011.81	Pulmonary TB nec-no exam
011.82	Pulmon TB nec-exam unkn
011.83	Pulmon TB nec-micro DX
011.84	Pulmon TB nec-cult DX
011.85	Pulmon TB nec-histo DX
011.86	Pulmon TB nec-oth test
011.9	Pulmonary TB nos
011.90	Pulmonary TB nos-unspec
011.91	Pulmonary TB nos-no exam
011.92	Pulmon TB nos-exam unkn
011.93	Pulmon TB nos-micro DX
011.94	Pulmon TB nos-cult DX
011.95	Pulmon TB nos-histo DX
011.96	Pulmon TB nos-oth test
012	Other respiratory TB*
012.0	Tuberculous pleurisy
012.00	TB pleurisy-unspec
012.01	TB pleurisy-no exam
012.2	TB pleurisy-exam unkn
012.3	TB pleurisy-micro DX
012.04	TB pleurisy-cult DX
012.5	TB pleurisy-histolog DX
012.6	TB pleurisy-oth test
012.1	TB thoracic lymph nodes
012.10	TB thoracic nodes-unspec
012.11	TB thorax node-no exam
012.12	TB thorax node-exam unkn
012.13	TB thorax node-micro DX
012.14	TB thorax node-cult DX
012.15	TB thorax node-histo DX
012.16	TB thorax node-oth test
012.2	Isolated trach/bronch TB
012.20	Isol tracheal TB-unspec
012.21	Isol tracheal TB-no exam
012.22	Isol trach TB-exam unkn
012.23	Isolat trach TB-micro DX
012.24	Isol tracheal TB-cult DX
012.25	Isolat trach TB-histo DX
012.26	Isolat trach TB-oth test
012.3	Tuberculous laryngitis
012.30	TB laryngitis-unspec
012.31	TB laryngitis-no exam
012.32	TB laryngitis-exam unkn
012.33	TB laryngitis-micro DX
012.34	TB laryngitis-cult DX
012.35	TB laryngitis-histo DX
012.36	TB laryngitis-oth test
012.8	Respiratory TB nec
012.80	Resp TB nec-unspec
012.81	Resp TB nec-no exam
012.82	Resp TB nec-exam unkn
012.83	Resp TB nec-micro DX
012.84	Resp TB nec-cult DX
012.85	Resp TB nec-histo DX
012.86	Resp TB nec-oth test
013	CNS tuberculosis*
013.0	Tuberculous meningitis
013.00	TB meningitis-unspec
013.01	TB meningitis-no exam
013.02	TB meningitis-exam unkn
013.03	TB meningitis-micro DX
013.04	TB meningitis-cult DX
013.05	TB meningitis-histo DX
013.06	TB meningitis-oth test
013.1	Tuberculoma of Meninges
013.10	Tubrclma meninges-unspec
013.11	Tubrclma mening-no exam
013.12	Tubrclma menin-exam unkn
013.13	Tubrclma mening-micro DX
013.14	Tubrclma mening-cult DX
013.15	Tubrclma mening-histo DX
013.16	Tubrclma mening-oth test
013.2	Tuberculoma of brain
013.20	Tuberculoma brain-unspec
013.21	Tubrcloma brain-no exam
013.22	Tubrclma brain-exam unkn
013.23	Tubrcloma brain-micro DX
013.24	Tubrcloma brain-cult DX
013.25	Tubrcloma brain-histo DX
013.26	Tubrcloma brain-oth test
013.3	TB abscess of brain
013.30	TB brain abscess-unspec
013.31	TB brain abscess-no exam
013.32	TB brain absc-exam unkn
013.33	TB brain absc-micro DX
013.34	TB brain abscess-cult DX
013.35	TB brain absc-histo DX
013.36	TB brain absc-oth test
013.4	Tuberculoma spinal cord
013.40	Tubrclma sp cord-unspec
013.41	Tubrclma sp cord-no exam
013.42	Tubrclma sp cd-exam unkn
013.43	Tubrclma sp crd-micro DX
013.44	Tubrclma sp cord-cult DX
013.45	Tubrclma sp crd-histo DX
013.46	Tubrclma sp crd-oth test
013.5	TB abscess spinal cord
013.50	TB sp crd abscess-unspec
013.51	TB sp crd absc-no exam
013.52	TB sp crd absc-exam unkn
013.53	TB sp crd absc-micro DX
013.54	TB sp crd absc-cult DX
013.55	TB sp crd absc-histo DX
013.56	TB sp crd absc-oth test
013.6	TB encephalitis/myelitis
013.60	TB encephalitis-unspec
013.61	TB encephalitis-no exam
013.62	TB encephalit-exam unkn
013.63	TB encephalitis-micro DX
013.64	TB encephalitis-cult DX
013.65	TB encephalitis-histo DX
013.66	TB encephalitis-oth test
013.8	CNS tuberculosis nec
013.80	CNS tb nec-unspec
013.81	CNS tb nec-no exam
013.82	CNS tb nec-exam unkn
013.83	CNS tb nec-micro DX
013.84	CNS tb nec-cult DX
013.85	CNS tb nec-histo DX
013.86	CNS tb nec-oth test
013.9	CNS tuberculosis nos
013.90	CNS tb nos-unspec
013.91	CNS tb nos-no exam
013.92	CNS tb nos-exam unkn
013.93	CNS tb nos-micro DX
013.94	CNS tb nos-cult DX
013.95	CNS tb nos-histo DX
013.96	CNS tb nos-oth test
014	Intestinal tb*
014.0	tuberculous peritonitis
014.00	TB peritonitis-unspec
014.01	TB peritonitis-no exam
014.02	TB peritonitis-exam unkn
014.03	TB peritonitis-micro DX
014.04	TB peritonitis-cult DX
014.05	TB peritonitis-histo DX
014.06	TB peritonitis-oth test
014.8	Intestinal tb nec
014.80	Intestinal tb nec-unspec
014.81	Intestin tb nec-no exam
014.82	Intest tb nec-exam unkn
014.83	Intestin tb nec-micro DX
014.84	Intestin tb nec-cult DX
014.85	Intestin tb nec-histo DX
014.86	Intestin tb nec-oth test
015	TB of bone and joint*
015.0	TB of vertebral column
015.00	TB of vertebra-unspec
015.01	TB of vertebra-no exam
015.02	TB of vertebra-exam unkn
015.03	TB of vertebra-micro DX
015.04	TB of vertebra-cult DX
015.05	TB of vertebra-histo DX
015.06	TB of vertebra-oth test
015.1	TB of hip
015.10	TB of hip-unspec
015.11	TB of hip-no exam
015.12	TB of hip-exam unkn
015.13	TB of hip-micro DX
015.14	TB of hip-cult DX
015.15	TB of hip-histo DX
015.16	TB of hip-oth test
015.2	TB of knee
015.20	TB of knee-unspec
015.21	TB of knee-no exam
015.22	TB of knee-exam unkn
015.23	TB of knee-micro DX
015.24	TB of knee-cult DX
015.25	TB of knee-histo DX
015.26	TB of knee-oth test
015.5	TB of limb bones
015.50	TB of limb bones-unspec
015.51	TB limb bones-no exam
015.52	TB limb bones-exam unkn
015.53	TB limb bones-micro EX
015.54	TB limb bones-cult DX
015.55	TB limb bones-histo DX
015.56	TB Limb bones-oth test
015.6	TB of mastoid
015.60	TB of mastoid-unspec
015.61	TB of mastoid-no exam
015.62	TB of mastoid-exam unkn
015.63	TB of mastoid-micro DX
015.64	TB of mastoid-cult DX
015.65	TB of mastoid-histo DX
015.66	TB of mastoid-oth test
015.7	TB of bone nec
015.70	TB of bone nec-unspec
015.71	TB of bone nec-no exam
015.72	TB of bone nec-exam unkn
015.73	TB of bone nec-micro DX
015.74	TB of bone nec-cult DX
015.75	TB of bone nec-histo DX
015.76	TB of bone nec-oth test
015.8	TB of joint nec
015.80	TB of joint nec-unspec
015.81	TB of joint nec-no exam
015.82	TB joint nec-exam unkn
015.83	TB of joint nec-micro DX
015.84	TB of joint nec-cult DX
015.85	TB of joint nec-histo DX
015.86	TB of joint nec-oth test
015.9	TB of bone & joint nos

ICD9 code No.	Abbreviated code title
015.90	TB bone/joint nos-unspec
015.91	TB bone/jt nos-no exam
015.92	TB bone/jt nos-exam unkn
015.93	TB bone/jt nos-micro DX
015.94	TB bone/jt nos-cult DX
015.95	TB bone/jt nos-histo DX
015.96	TB bone/jt nos-oth test
016	Genitourinary TB*
016.0	TB of kidney
016.00	TB of kidney-unspec
016.01	TB of kidney-no exam
016.02	TB of kidney-exam unkn
016.03	TB of kidney-micro DX
016.04	TB of kidney-cult DX
016.05	TB of kidney-histo DX
016.06	TB of kidney-oth Test
016.1	TB of bladder*
106.10	TB of bladder-unspec
016.11	TB of bladder-no exam
016.12	TB of bladder-exam unkn
016.13	TB of bladder-micro DX
016.14	TB of bladder-cult DX
016.15	TB of bladder-histo DX
016.16	TB of bladder-oth test
106.2	TB of ureter
016.20	TB of ureter-unspec
016.21	TB of ureter-no exam
016.22	TB of ureter-exam unkn
016.23	TB of ureter-micro DX
016.24	TB of ureter-cult DX
016.25	TB of ureter-histo DX
016.26	TB of ureter-oth test
016.3	TB of urinary organ nec
016.30	TB urinary nec-unspec
016.31	TB urinary nec-no exam
016.32	TB urinary nec-exam unkn
016.33	TB urinary nec-micro DX
016.34	TB urinary nec-cult DX
016.35	TB urinary nec-histo DX
016.36	TB urinary nec-oth test
016.4	TB of epididymis
016.40	TB epididymis-unspec
016.41	TB epididymis-no exam
016.42	TB epididymis-exam unkn
016.43	TB epididymis-micro DX
016.44	TB epididymis-cult DX
016.45	TB epididymis-histo DX
016.46	TB epididymis-oth test
016.5	TB male genital org nec
016.50	TB male genit nec-unspec
016.51	TB male gen nec-no exam
016.52	TB male gen nec-ex unkn
016.53	TB male gen nec-micro DX
016.54	TB male gen nec-cult DX
016.55	TB male gen nec-histo DX
016.56	TB male gen nec-oth test
016.6	TB of ovary and tube
016.60	TB ovary & tube-unspec
016.61	TB ovary & tube-no exam
016.62	TB ovary/tube-exam unkn
016.63	TB ovary & tube-micro DX
016.64	TB ovary & tube-cult DX
016.65	TB ovary & tube-histo DX
016.66	TB ovary & tube-oth test
016.7	TB female genit org nec
016.70	TB female gen nec-unspec
016.71	TB fem gen nec-no exam
016.72	TB fem gen nec-exam unkn
016.73	TB fem gen nec-micro DX
016.74	TB fem gen nec-cult DX
016.75	TB fem gen nec-histo DX
016.76	TB fem gen nec-oth test
016.9	Genitourinary TB nos
016.90	GU TB nos-unspec
016.91	GU TB nos-no exam
016.92	GU TB nos-exam unkn
016.93	GU TB nos-micro DX
016.94	GU TB nos-cult DX
016.95	GU TB nos-histo DX
016.96	GU TB nos-oth test
017	Tuberculosis nec*
017.0	TB skin & subcutaneous
017.00	TB skin/subcutan-unspec
017.01	TB skin/subcut-no exam
017.02	TB skin/subcut-exam unkn
017.03	TB skin/subcut-micro DX
017.04	TB skin/subcut-cult DX
017.05	TB skin/subcut-histo DX
017.06	TB skin/subcut-oth Test
017.1	Erythema nodosum in TB
017.10	Erythema nodos TB-unspec
017.11	Erythem nodos TB-no exam
017.12	Erythem nod TB-exam unkn
017.13	Erythem nod TB-micro DX
017.14	Erythem nodos TB-cult DX
017.15	Erythem nod TB-histo DX
017.16	Erythem nod TB-oth test
017.2	TB of periph lymph node
017.20	TB periph lymph-unspec
017.21	TB periph lymph-no exam
017.22	TB periph lymph-exam unk
017.23	TB periph lymph-micro DX
017.24	TB periph lymph-cult DX
017.25	TB periph lymph-histo DX
017.26	TB periph lymph-oth test
017.3	TB of eye
017.30	TB of eye-unspec
017.31	TB of eye-no exam
017.32	TB of eye-exam unkn
017.33	TB of eye-micro DX
017.34	TB of eye-cult DX
017.35	TB of eye-histo DX
017.36	TB of eye-oth test
107.4	TB of ear
017.40	TB of ear-unspec
017.41	TB of ear-no exam
017.42	TB of ear-exam unkn
017.43	TB of ear-micro DX
017.44	TB of ear-cult DX
017.45	TB of ear-histo DX
017.46	TB of ear-oth test
017.5	TB of thyroid gland
017.50	TB of thyroid-unspec
017.51	TB of thyroid-no exam
017.52	TB of thyroid-exam unkn
017.53	TB of thyroid-micro DX
017.54	TB of thyroid-cult DX
017.55	TB of thyroid-histo DX
017.56	TB of thyroid-oth test
017.6	TB of adrenal gland
017.60	TB of adrenal-unspec
017.61	TB of adrenal-no exam
017.62	TB of adrenal-exam unkn
017.63	TB of adrenal-micro DX
017.64	TB of adrenal-cult DX
017.65	TB of adrenal-histo DX
017.66	TB of adrenal-oth test
017.7	TB of spleen
017.70	TB of spleen-unspec
017.71	TB of spleen-no exam
017.72	TB of spleen-exam unkn
017.73	TB of spleen-micro DX
017.74	TB of spleen-cult DX
017.75	TB of spleen-histo DX
017.76	TB of spleen-oth test
017.8	TB of esophagus
017.80	TB esophagus-unspec
017.81	TB esophagus-no exam
017.82	TB esophagus-exam unkn
017.83	TB esophagus-micro DX
017.84	TB esophagus-cult DX
017.85	TB esophagus-histo DX
017.86	TB esophagus-oth test
017.9	TB of organ nec
017.90	TB of organ nec-unspec
017.91	TB of organ nec-no exam
017.92	TB organ nec-exam unkn
017.93	TB of organ nec-micro DX
017.94	TB of organ nec-cult DX
017.95	TB of organ nec-histo DX
017.96	TB of organ nec-oth test
018	Miliary tuberculosis*
018.0	Acute miliary TB
018.00	Acute miliary TB-unspec
018.01	Acute miliary TB-no exam
018.02	AC miliary TB-exam unkn
018.03	AC miliary TB-micro DX
018.04	Acute miliary TB-cult DX
018.05	AC miliary TB-histo DX
018.06	AC miliary TB-oth test
018.8	Miliary TB nec
018.80	Miliary TB nec-unspec
018.81	Miliary TB nec-no exam
018.82	Miliary TB nec-exam unkn
018.83	Miliary TB nec-micro DX
018.84	Miliary TB nec-cult DX
018.85	Miliary TB nec-histo DX
018.86	Miliary TB nec-oth test
018.9	Miliary tuberculosis nos
018.90	Miliary TB nos-unspec
018.91	Miliary TB nos-no exam
018.92	Miliary TB nos-exam unkn
018.93	Miliary TB nos-micro DX
018.94	Miliary TB nos-cult DX
018.95	Miliary TB nos-histo DX
018.96	Miliary TB nos-oth test
027.0	Listeriosis
027.1	Erysipelothrix infection
027.2	Pasteurellosis
027.8	Zoonotic bact dis nec
027.9	Zoonotic bact dis nos
036.0	Meningococcal meningitis
036.2	Meningococcemia
036.3	Meningococc adrenal synd
036.40	Meningococc carditis nos
036.42	Meningococc endocarditis
036.43	Meningococc myocarditis
037	Tetanus
038.0	Streptococcal septicemia
038.1	Staphylococc septicemia
038.10	Staphylcocc septicem nos
038.11	Staph aureus septicemia
038.19	Staphylcocc septicem nec
038.2	Pneumococcal septicemia
038.3	Anaerobic septicemia
038.4	Gram-neg septicemia nec
038.40	Gram-neg septicemia nos
038.41	H. influenae septicemia
038.42	E coli septicemia
038.43	Pseudomonas septicemia
038.44	Serratia septicemia
038.49	Gram-neg septicemia nec
038.8	Septicemia nec
038.9	Septicemia nos
042	Human immuno virus dis
052.0	Postvaricella encephalit
052.1	Varicella pneumonitis
053.0	Herpes zoster meningitis
054.3	Herpetic encephalitis

ICD9 code No.	Abbreviated code title
054.5	Herpetic septicemia
054.72	H Simplex meningitis
054.79	H Simplex Complicat nec
055.0	Postmeasles Encephalitis
055.1	Postmeasles Pneumonia
070.20	Hpt B acte coma wo dlta
070.21	Hpt B acte coma w dlta
070.22	Hpt B chrn coma wo dlta
070.23	Hpt B chrn coma w dlta
070.41	Hpt C acute w hepat coma
070.42	Hpt DLT wo b w hpt coma
070.43	Hpt E w hepat coma
070.44	Chrnc hpt C w hepat coma
070.49	Oth vrl hepat w hpt coma
070.06	Viral hepat nos w coma
072.1	Mumps meningitis
072.2	Mumps encephalitis
072.3	Mumps pancreatitis
079.5	Retrovirus
090.42	Congen syph meningitis
093.20	Syphil endocarditis nos
093.82	Syphilitic myocarditis
094.2	Syphilitic meningitis
094.87	Syph rupt cereb aneurysm
098.89	Gonococcal inf site nec
112.4	Candidiasis of lung
112.5	Disseminated candidiasis
112.81	Candidal endocarditis
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115	Histoplasmosis*
115.1	Histoplasma capsulatum
115.00	Histoplasma capsulat nos
115.01	Histoplasm capsul mening
115.02	Histoplasm capsul retina
115.03	Histoplasm caps pericard
115.04	Histoplasm caps endocard
115.05	Histoplasm caps pneumon
115.09	Histoplasma capsulat nec
115.1	Histoplasma duboisii
115.10	Histoplasma duboisii nos
115.11	Histoplasm dubois mening
115.12	Histoplasm dubois retina
115.13	Histoplasm dub pericard
115.14	Histoplasm dub endocard
115.15	Histoplasm dub pneumonia
115.19	Histoplasma duboisii nec
115.9	Histoplasmosis, unspec
115.90	Histoplasmosis nos
115.91	Histoplasmosis meningit
115.92	Histoplasmosis retinitis
115.93	Histoplasmosis pericard
115.94	Histoplasmosis endocard
115.95	Histoplasmosis pneumonia
115.99	Histoplasmosis nec
130.0	Toxoplasm meningoenceph
130.3	Toxoplasma myocarditis
130.4	Toxoplasma pneumonitis
136.3	Pneumocystosis
204.00	Act lym leuk w/o rmsion
205.00	Act myl leuk w/o rmsion
206.00	Act mono leuk w/o rmsion
207.00	Act erth/erylk w/o rmson
208.00	Act leuk uns cl w/o rmsn
260	Kwashiorkor
261	Nutritional marasmus
262	Oth severe malnutrition
277.00	Cystic fibros w/o ileus
277.01	Cystic fibrosis w ileus
286.0	Cong factor viii diord
286.1	Cong factor ix disorder
286.6	Defibrination syndrome
320.0	Hemophilus meningitis
320.1	Pneumococcal meningitis
320.2	Streptococcal meningitis
320.3	Staphylococc meningitis
320.7	Mening in oth bact dis
320.81	Anaerobic meningitis
320.82	Mningts gram-neg bct nec
320.89	Meningitis oth spcf bact
320.9	Bacterial meningitis nos
321.0	Cryptococcal meningitis
321.1	Mening in oth fungal dis
321.4	Meningit d/t sarcoidosis
321.8	Mening in oth nonbac dis
324.0	Intracranial abscess
324.1	Intraspinal abscess
324.9	CNS abscess nos
345.11	Gen CNV epil w intr epil
345.3	Grand mal status
348.1	Anoxic brain damage
376.01	Orbital cellulitis
376.02	Orbital periostitis
376.03	Orbital osteomyelitis
398.0	Rheumatic myocarditis
403.01	Mal hyp ren w renal fail
404.01	Mal hyper hrt/ren w chf
404.03	Mal hyp hrt/ren w chf&rf
410.01	Ami anterolateral, init
410.11	Ami anterior wall, init
410.21	Ami inferolateral, init
410.31	Ami inferopost, initial
410.41	Ami inferior wall, init
410.51	Ami lateral nec, initial
410.61	True post infarct, init
410.71	Subendo infarct, initial
410.81	Ami nec, initial
410.91	Ami nos, initial
415.1	Pulmon embolism/infarct
415.11	Iatrogen pulm emb/infarc
415.19	Pulm embol/infarct nec
421.0	AC/subac bact endocard
421.1	AC endocardit in oth dis
421.9	AC/subac endocardit nos
422.0	AC myocardit in oth dis
422.90	Acute myocarditis nos
422.91	Idiopathic myocarditis
422.92	Septic myocarditis
422.93	Toxic myocarditis
422.99	Acute myocarditis nec
427.41	Ventricular fibrillation
427.5	Cardiac arrest
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0	Nontraum extradural hem
432.1	Subdural hemorrhage
433.01	OCL bslr art w infrct
433.11	OCL crtd art w infrct
433.21	OCL vrtb art w infrct
433.31	OCL mlt bi art w infrct
433.81	OCL spcf art w infrct
433.91	OCL art nos w infrct
434.01	CRBL thrmbs w infrct
434.11	CRBL emblsm w infrct
434.91	CRBL art ocl nos w infrc
436	CVA
440.23	ATH ext ntv art ulcrtion
440.24	ATH ext ntv art gngrene
441.0	Dissecting aneurysm
441.00	DSCT of aorta unsp site
441.01	DSCT of thoracic aorta
441.02	DSCT of abdominal aorta
441.03	DSCT of thoracoabd aorta
441.1	RUPTUR thoracic aneurysm
441.3	RUPT abd aortic aneurysm
441.5	RUPT aortic aneurysm nos
441.6	Thoracoabd aneurysm rupt
446.3	Lethal midline granuloma
451.89	Thrombophlebitis nec
452	Portal vein thrombosis
453	OTH venous thrombosis*
453.0	BUDD-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Vena cava thrombosis
453.3	Renal vein thrombosis
464.11	AC tracheitis w obstruct
464.21	AC laryngotrach w obstr
464.31	AC epiglottitis w obstr
466.1	Acute bronchiolitis
480.0	Adenoviral pneumonia
480.1	RESP syncyt viral pneum
480.2	Parinfluenza viral pneum
480.8	Viral pneumonia nec
480.9	Viral pneumonia nos
481	Pneumococcal pneumonia
482	Oth bacterial pneumonia*
482.0	K. pneumoniae pneumonia
482.1	Pseudomonal pneumonia
482.2	H.influenzae pneumonia
482.3	Streptococcal pneumonia
482.30	Streptococcal pneumn nos
482.31	Pneumonia strptococcus A
482.32	Pneumonia strptococcus B
482.39	Pneumonia oth strep
482.4	Staphylococcal pneumonia
482.40	Staphylococcal pneu nos
482.41	Staph aureus pneumonia
482.49	Staph pneumonia nec
482.8	Bacterial pneumonia nec
482.81	Pneumonia anaerobes
482.82	Pneumonia e coli
482.83	Pneumo oth grm-neg bact
482.84	Legionnaires' disease
482.89	Pneumonia oth spcf bact
482.9	Bacterial pneumonia nos
483	Pneumonia: organism nec*
483.0	Pneu mycplsm pneumoniae
483.1	Pneumonia d/t chlamydia
483.8	Pneumon oth spec orgnsm
484	Pneum in oth infec dis*
484.1	Pneum w cytomeg incl dis
484.3	Pneumonia in whoop cough
484.5	Pneumonia in anthrax
484.6	Pneum in aspergillosis
484.7	Pneum in oth sys mycoses
484.8	Pneum in infect dis nec
485	Bronchopneumonia org nos
486	Pneumonia, organism nos
487	Influenza*
487.0	Influenza with pneumonia
506.0	Fum/vapor bronc/pneumon
506.1	Fum/vapor ac pulm edema
507.0	Food/vomit pneumonitis
507.1	Oil/essence pneumonitis
507.8	Solid/liq pneumonit nec
510.0	Empyema with fistula
510.9	Empyema w/o fistula
511.1	Bact pleur/effus not tb
513.0	Abscess of lung
513.1	Abscess of mediastinum
514	Pulm congest/hypostasis
515	Postinflam pulm fibrosis
518.3	Pulmonary eosinophilia
518.5	Post traum pulm insuffic
518.81	Acute respiratry failure
519.2	Mediastinitis
528.3	Cellulitis/abscess mouth
530.4	Perforation of esophagus
530.82	Esophageal hemorrhage

ICD9 code No.	Abbreviated code title
531.00	AC stomach ulcer w hem
531.01	AC stomac ulc w hem-obst
531.10	AC stomach ulcer w perf
531.11	AC stom ulc w perf-obst
531.20	AC stomac ulc w hem/perf
531.21	AC stom ulc hem/perf-obs
531.40	CHR stomach ulc w hem
531.41	CHR stom ulc w hem-obstr
531.50	CHR stomach ulcer w perf
531.51	CHR stom ulc w perf-obst
531.60	CHR stomach ulc hem/perf
531.61	CHR stom ulc hem/perf-ob
532.00	AC duodenal ulcer w hem
532.01	AC duoden ulc w hem-obst
532.10	AC duodenal ulcer w perf
532.11	AC duoden ulc perf-obstr
532.20	AC duoden ulc w hem/perf
532.21	AC duod ulc hem/perf-obs
532.40	CHR duoden ulcer w hem
532.41	CHR duoden ulc hem-obstr
532.50	CHR duoden ulcer w perf
532.51	CHR duoden ulc perf-obst
532.60	CHR duoden ulc hem/perf
532.61	CHR duod ulc hem/perf-ob
533.00	AC peptic ulcer w hemorr
533.01	AC peptic ulc w hem-obst
533.10	AC peptic ulcer w perfor
533.11	AC peptic ulc w perf-obs
533.20	AC peptic ulc w hem/perf
533.21	AC pept ulc hem/perf-obs
533.40	CHR peptic ulcer w hem
533.41	CHR peptic ulc w hem-obs
533.50	CHR peptic ulcer w perf
533.51	CHR peptic ulc perf-obst
533.60	CHR pept ulc w hem/perf
533.61	CHR pept ulc hem/perf-ob
534.00	AC marginal ulcer w hem
534.01	AC margin ulc w hem-obst
534.10	AC marginal ulcer w perf
534.11	AC margin ulc w perf-obs
534.20	AC margin ulc w hem/perf
534.21	AC marg ulc hem/perf-obs
534.40	CHR marginal ulcer w hem
534.41	CHR margin ulc w hem-obs
534.50	CHR marginal ulc w perf
534.51	CHR margin ulc perf-obst
534.60	CHR margin ulc hem/perf
534.61	CHR marg ulc hem/perf-ob
535.01	Acute gastritis w hmrhg
535.11	ATRPH gastritis w hmrhg
535.21	GSTR Mcsl Hyprt w hmrg
535.31	ALCHL Gstritis w hmrhg
535.41	OTH SPF Gastrt w hmrhg
535.51	GSTR/DDNTS NOS w hmrhg
535.61	Duodenitis w hmrhg
537.4	Gastric/Duodenal fistula
537.83	Angio Stm/dudn w hmrhg
540.0	AC Append w peritonitis
557.0	AC VASC insuff intestine
562.02	DVRTCLO SML Int w hmrhg
562.03	DVRTCLI SML Int w hmrhg
562.12	DVRTCLO colon w hmrhg
562.13	DVRTCLI colon w hmrhg
567.0	Peritonitis in infec dis
567.1	Pneumococcal peritonitis
567.2	Suppurat peritonitis nec
567.8	Peritonitis nec
567.9	Peritonitis nos
569.60	Colstomy/enter comp nos
569.61	Colosty/enterost infectn
569.69	Colstmy/enteros comp nec
569.83	Perforation of intestine
569.85	Angio intes w hmrhg
570	Acute necrosis of liver
572.0	Abscess of liver
572.4	Hepatorenal syndrome
573.4	Hepatic infarction
575.4	Perforation gallbladder
576.3	Perforation of bile duct
577.2	Pancreat cyst/pseudocyst
579.3	Intest postop nonabsorb
580.0	AC proliferat nephritis
580.4	AC rapidly progr nephrit
580.81	AC nephritis in oth dis
580.89	Acute nephritis nec
580.9	Acute nephritis nos
583.4	Rapidly prog nephrit nos
584.5	Lower nephron nephrosis
584.6	AC renal fail, cort necr
584.7	AC ren fail, medull necr
584.8	AC renal failure nec
584.9	Acute renal failure nos
590.2	Renal/perirenal abscess
596.6	Bladder rupt, nontraum
659.30	Septicemia in labor-unsp
659.31	Septicem in labor-deliv
665.00	Prelabor rupt uter-unsp
665.01	Prelabor rupt uterus-del
665.03	Prelab rupt uter-antepar
665.10	Rupture uterus nos-unsp
665.11	Rupture uterus nos-deliv
669.10	Obstetric shock-unspec
669.11	Obstetric shock-deliver
669.12	Obstet shock-deliv w p/p
669.13	Obstetric shock-antepar
669.14	Obstetric shock-postpart
669.30	AC ren fail w deliv-unsp
669.32	AC ren fail-deliv w p/p
669.34	AC renal failure-postpar
673.00	OB air embolism-unspec
673.01	OB air embolism-deliver
673.02	OB air embol-deliv w p/p
673.03	OB air embolism-antepart
673.04	OB air embolism-postpart
673.10	Amniotic embolism-unspec
673.11	Amniotic embolism-deliv
673.12	Amniot embol-deliv w p/p
673.13	Amniotic embol-antepart
673.14	Amniotic embol-postpart
673.20	OB pulm embol nos-unspec
673.22	Pulm embol nos-del w p/p
673.23	Pulm embol nos-antepart
673.24	Pulm embol nos-postpart
673.30	OB pyemic embol-unspec
673.31	OB pyemic embol-deliver
673.32	OB pyem embol-del w p/p
673.33	OB pyemic embol-antepart
673.34	OB pyemic embol-postpart
673.80	OB pulmon embol nec-unsp
673.81	Pulmon embol nec-deliver
673.82	Pulm embol nec-del w p/p
673.83	Pulmon embol nec-antepar
673.84	Pulmon embol nec-postpar
674.00	Puerp cerebvasc dis-unsp
682	Other cellulitis/abscess*
682.0	Cellulitis of face
682.1	Cellulitis of neck
682.22	Cellulitis of trunk
682.3	Cellulitis of arm
682.4	Cellulitis of hand
682.5	Cellulitis of buttock
682.6	Cellulitis of leg
682.7	Cellulitis of foot
682.8	Cellulitis, site nec
765.01	Extreme immatur <500G
765.02	Extreme immatur 500–749G
765.03	Extreme immatur 750–999G
781.7	Tetany
785.51	Cardiogenic shock
785.59	Shock w/o trauma nec
799.1	Respiratory arrest
958.0	Air embolism
958.1	Fat embolism
958.5	Traumatic anuria
996.02	Malfunc prosth hrt valve
996.61	React-cardiac dev/graft
996.62	React-oth vasc dev/graft
996.63	React-nerv sys dev/graft
996.64	React-indwell urin cath
996.66	React-inter joint prost
996.67	React-oth int ortho dev
996.69	React-int pros devic nec
997.62	Infection amputat stump
998.0	Postoperative shock
998.3	Postop wound disruption
998.5	Postoperative infection
998.6	Persist postop fistula
999.1	Air embol comp med care
V440	Tracheostomy status
V451	Renal dialysis status
V461	Dependence on respirator

*Denotes this is a category rather than a code.

Appendix D—The IRF Market Basket

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor (for purposes of setting prospective payment system rates) based on a market basket index. The proposed market basket includes both operating and capital costs of rehabilitation facilities (that is, freestanding rehabilitation hospitals and rehabilitation hospital units). The index currently used for operating costs for rehabilitation facilities is the excluded hospital market basket. This market basket is based on 1992 cost report data and includes Medicare participating rehabilitation, long term care, psychiatric, cancer, and children's hospitals. Since freestanding rehabilitation hospitals are a component of the excluded hospital market basket, this index most closely reflects the cost shares of rehabilitation facilities. Because the excluded hospital market basket only includes operating costs, we are proposing to use the excluded hospital market basket with the addition of a capital portion to the index. We provide a brief explanation of the methodology used to develop our proposed index for rehabilitation facilities. We refer to this index as the excluded hospital (with capital) market basket. In the following discussion we describe: the methodology used to determine the operating portion of the market basket, the methodology used to determine the capital portion of the market basket, and additional analyses that help support the extent to which rehabilitation cost shares are reflected in the market basket that we are proposing.

The operating portion of the excluded hospital market basket consists of major cost categories and their respective weights. The major cost categories include wages, benefits, drugs, and a residual. The weights for the major cost categories are developed from the Medicare cost reports for FY 1992. The cost

report data used includes those hospitals excluded from the inpatient hospital prospective payment system where the Medicare average length of stay is within 15 percent (higher or lower) of the total facility average length of stay. Limiting the sample in this way provides a more accurate reflection of the structure of costs for Medicare. The detailed cost categories are derived from the Asset and Expenditure Survey, 1992 Census of Service Industries, by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce. This is used in conjunction with the 1992 Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. A more detailed description of the development of this index can be found in our final rule, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; published in the **Federal Register** at 62 FR 45965–45996, on August 29, 1997.

As previously stated, the market basket we are proposing needs to reflect both operating and capital costs. Capital costs include depreciation, interest, and other capital-related costs. The cost categories for the capital portion of the market basket that we are proposing is developed in a similar manner as those for the inpatient hospital prospective payment system capital input price index, which is explained in the August 30, 1996 **Federal Register**. We calculated weights for capital costs, using the same set of Medicare cost reports used to develop the operating share for excluded hospitals. The resulting capital weight for the 1992 base year is 9.080 percent.

Because capital is consumed over time, depreciation and interest costs in the current year reflect both current and previous capital purchases. We use vintage weighting of current and previous capital price changes to capture this effect. Vintage weighting, which is explained in the August 30, 1996 **Federal Register** (61 FR 46197 through 46203), is the process of weighting price changes for individual years in proportion to that year's share of total purchases still being consumed.

In order to vintage weight the capital portion of the index as described above, the average useful life of both assets and debt instruments (for example, a loan, bond, or promissory note) needs to be developed. For depreciation expenses, the useful life of fixed and movable assets is calculated from the Medicare cost reports for excluded hospitals, including freestanding rehabilitation hospitals. The average useful life for fixed assets is 21 years and the average useful life for movable assets is 13 years. For interest expenses, we use the same useful life of debt instruments used in the hospital prospective payment system capital input price index. We believe that this useful life is appropriate, because it reflects the average useful life of hospital issuances of commercial and municipal bonds from all hospitals, including rehabilitation facilities. The average useful life of interest expense is determined to be 22 years. After the useful life is determined, a set of weights is calculated by determining the average proportion of depreciation or interest expense incurred during any given year during the useful life. This information is developed using the Medicare cost reports. These calculations are the same as those described for the inpatient hospital prospective payment system capital input price index in the August 30, 1996 **Federal Register**. The price proxies for each of the capital cost categories are the same as those used for the inpatient hospital prospective payment system capital input price index. The cost categories, price proxies, and base-year fiscal year 1992 weights for the excluded hospital (with capital) market basket are presented in Table 1. The vintage weights for the index are presented in Table 2.

TABLE 1.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) STRUCTURE AND WEIGHTS

Cost category	Price/wage variable	Weights (%) Base-year: 1992
TOTAL		100.000
Compensation		57.935
Wages and Salaries	HCFA Prospective payment system Occupational	47.417
Employee Benefits	HCFA Prospective payment system	10.519
Professional fees: Non-Medical	ECI—Compensation: Prof. & Tech	1.908
Utilities		1.523
Electricity	WPI—Commercial Electric Power	0.916
Fuel Oil, Coal, etc	WPI—Commercial Natural Gas	0.365
Water and Sewerage	CPI–U—Water & Sewage	0.243
Professional Liability Insurance	HCFA—Prof. Liab. Prem	0.983
All Other Products and Services		28.572
All Other Products		22.027
Pharmaceuticals	WPI—Prescription Drugs	2.791
Food: Direct Purchase	WPI—Processed Foods	2.155
Food: Contract Service	CPI–U—Food Away fr. Home	0.998
Chemicals	WPI—Industrial Chemicals	3.413
Medical Instruments	WPI—Med. Inst. & Equip	2.868
Photographic Supplies	WPI—Photo Supplies	0.364
Rubber and Plastics	WPI—Rub. & Plast. Products	4.423
Paper Products	WPI—Convert. Paper and Paperboard	1.984
Apparel	WPI—Apparel	0.809
Machinery and Equipment	WPI—Mach. & Equipment	0.193
Miscellaneous Products	WPI—Finished Goods	2.029
All Other Services		6.544
Telephone	CPI–U—Telephone Services	0.574
Postage	CPI–U—Postage	0.268
All Other: Labor Intensive	ECI—Compensation: Service Workers	4.945
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757
Capital-Related Costs		9.080
Depreciation		5.611
Fixed Assets	Boeckh-Institutional Construction: 21 year useful life	3.570
Movable Equipment	WPI—Machinery & Equipment: 13 year useful life	2.041
Interest Costs		3.212
Non-profit	Avg. Yield Municipal Bonds: 22 year useful life	2.730
For-profit	Avg, Yield AAA Bonds: 22 year useful life	0.482
Other Capital-Related Costs	CPI–U—Residential Rent	0.257

*The wage and benefit proxies are a blend of 10 employment cost indices (ECI). A detailed discussion of the price proxies can be found in the August 30, 1996 FEDERAL REGISTER final rule.

TABLE 2.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) VINTAGE WEIGHTS

Year	Fixed assets (21 year weights)	Movable assets (13 year weights)	Interest: capital-related (22 year weights)
1	0.0201	0.0454	0.0071
2	0.0225	0.0505	0.0082
3	0.0225	0.0562	0.0100
4	0.0285	0.0620	0.0119
5	0.0301	0.0660	0.0139
6	0.0321	0.0710	0.0161
7	0.0336	0.0764	0.0185
8	0.0353	0.0804	0.0207
9	0.0391	0.0860	0.0244
10	0.0431	0.0923	0.0291
11	0.0474	0.0987	0.0350
12	0.0513	0.1047	0.0409
13	0.0538	0.1104	0.0474
14	0.0561	.....	0.0525
15	0.0600	.....	0.0590
16	0.0628	.....	0.0670
17	0.0658	.....	0.0742
18	0.0695	.....	0.0809
19	0.0720	.....	0.0875
20	0.0748	.....	0.0931
21	0.0769	.....	0.0993
22	.....	.....	0.1034
Total	1.0000	1.0000	1.0000

We further analyzed the extent to which the weights in the excluded hospital (with capital) market basket that we are proposing reflects the cost weights in rehabilitation hospitals; particularly since more than 50 percent of excluded hospitals are psychiatric hospitals. For this purpose, we conducted an analysis comparing the cost weights of rehabilitation hospitals to the cost weights for excluded hospitals. We analyzed the variations of major costs, such as wages, drugs, and capital for rehabilitation and excluded hospitals. This analysis showed that while these weights differed slightly between rehabilitation hospitals and excluded hospitals, the difference is very small. When these weights are substituted into the market basket structure for sensitivity analysis, the effect is never more than 0.2 percentage points in any given year. This difference is less than the 0.25 percentage point criteria that determines whether a forecast error adjustment under the inpatient hospital prospective payment system is warranted. We conducted this analysis in both the base year (FY 1992), and for the most recent set of cost reports (FY 1997) to determine if the difference in weights changed over time. Again, the differences were very small. Based on this analysis, we concluded that using the excluded hospital (with capital) market basket for the IRF prospective payment system will provide a reasonable measure of the price changes facing rehabilitation hospitals. We request comments on any other data sources that may be available to provide detailed cost category information on rehabilitation hospitals, or on data sources for cost categories in rehabilitation units.

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