

than the payment rate associated with a case-mix group.

(2) *Medicare Part C (Medicare Advantage) data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for its Medicare Part C (Medicare Advantage) patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its Medicare Part C (Medicare Advantage) data used in the calculations for determining the facility's compliance with the regulations in § 412.23(b)(2).

(e) *Exemption to the consequences for transmitting the IRF-PAI data late.* CMS may waive the consequences of failure to submit complete and timely IRF-PAI data specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(1)(ii) of this section or for waiver of the forfeiture specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

[66 FR 41388, Aug. 7, 2001, as amended at 68 FR 45699, Aug. 1, 2003; 74 FR 39811, Aug. 7, 2009]

§ 412.616 Release of information collected using the patient assessment instrument.

(a) *General.* An inpatient rehabilitation facility may release information from the patient assessment instrument 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 Assessment process for interrupted stays.

For purposes of the patient assessment process, if a Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patient has an interrupted stay, as defined under § 412.602, the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) *Recording and encoding of data.* The clinician must record the interruption of the stay on the patient assessment instrument.

(c) If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 74 FR 39811, Aug. 7, 2009]

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to

§ 412.622

42 CFR Ch. IV (10–1–11 Edition)

classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For 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 admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(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*. We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire*. We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities*. We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors*. We 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 Medi-

care Part A fee-for-service 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, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(3) *IRF coverage criteria*. In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.