

and be paid 100 percent of the Federal IRF PPS rate. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), however, the transition methodology expired, and payments for all IRFs consist of 100 percent of the Federal IRF PPS.

We established a CMS website that contains useful information regarding the IRF PPS. The website URL is www.cms.hhs.gov/providers/irfpps/default.asp and may be accessed to download or view publications, software, and other information pertinent to the IRF PPS.

C. Operational Overview of the Current IRF PPS

As described in the August 7, 2001 final rule, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument, the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI). All required data must be electronically encoded into the IRF's PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific PAI data elements to classify (or group) the patient into a distinct CMG and account for the existence of any relevant comorbidities. The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS website at www.cms.hhs.gov/providers/irfpps/default.asp).

Once the patient is discharged, the IRF completes the Medicare claim (UB-92 or its equivalent) using the 5-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI). (Claims submitted to Medicare must comply with the electronic claim requirements contained at www.cms.hhs.gov/providers/edi/default.asp, as reported in the Health Insurance Portability and Accountability Act (HIPAA) program claim memoranda issued by CMS and also published at that web site, and as listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in section 3604 of Part 3 of the Medicare Intermediary Manual.) The Medicare FI processes the claim through its software system. This

software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths and then applies the applicable adjustments to account for the IRF's wage index, percentage of LIPs, rural location, and outlier payments.

D. Proposals for FY 2004

In this proposed rule, we are proposing to update the data used to compute the IRF wage indices. In the August 7, 2001 final rule, we used FY 1997 acute care hospital wage data to compute the IRF wage indices for FY 2002. The August 1, 2002 notice that set forth the updated FY 2003 IRF Federal prospective payment rates also used 1997 acute care hospital wage data to compute the FY 2003 IRF wage indices.

In this proposed rule, we are proposing to update the IRF wage indices for FY 2004 by using FY 1999 acute care hospital data. We believe that the FY 1999 acute care hospital data are the best available because they are currently the most recent complete final data. However, any adjustments or updates made under section 1886(j)(6) of the Act must be made in a budget neutral manner. Therefore, in section VI of this proposed rule, we are proposing a methodology to update the wage indices for FY 2004 using 1999 acute care hospital data in a budget neutral manner.

In this proposed rule, we are also proposing to update the underlying data used to compute the IRF market basket index. As explained in Appendix D of the August 7, 2001 final rule, we used 1992 cost report data as the underlying data to develop the excluded hospital with capital market basket that formed the basis of the FY 2002 and FY 2003 IRF market basket index. In section VI of this proposed rule, we are proposing to use 1997 cost report data, the most recent data available, to form the basis of the FY 2004 IRF market basket index.

In section II of this proposed rule, we are proposing to modify or clarify certain criteria for a hospital or a hospital unit to be classified as an IRF. As stated in the August 7, 2001 final rule, we did not change the survey and certification procedures applicable to entities seeking classification as an IRF. Currently, to be paid under the IRF PPS, a hospital or unit of a hospital must first be deemed to be excluded from the diagnosis-related group (DRG)-based acute care hospital PPS under the general requirements in subpart B of

part 412 of the regulations. Second, the excluded hospital or unit must meet the conditions for payment under the IRF PPS at § 412.604 of the regulations.

Lastly, we are proposing, in various sections of this proposed rule, to modify or clarify existing provisions of the IRF PPS. However, we are not proposing refinements to the FY 2002 case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments, due to the lack of available data to make such changes.

II. Requirements and Conditions for Payment Under the IRF PPS

As issued in the August 7, 2001 final rule, § 412.604 “Conditions for payment under the prospective payment system for inpatient rehabilitation facilities” describes the conditions that must be met for an IRF to be paid under the IRF PPS. Section 412.604(a) states the general requirements for payment to be made under the IRF PPS and the effects on Medicare payment if the conditions described therein are not met. Section 412.604(b) states the existing regulatory provisions that must be met for a hospital or unit of a hospital to be excluded from the acute care inpatient hospital PPS and to be classified as an IRF. Section 412.604(c) requires an IRF to complete a patient assessment instrument for each Medicare Part A fee-for-service patient admitted. Section 412.604(d) describes the limitations on IRFs for charging beneficiaries that receive Medicare covered services. Section 412.604(e) describes the requirements associated with furnishing inpatient hospital services directly or under arrangement. Section 412.604(f) states the reporting and recordkeeping requirements that IRFs must meet.

In this section of the proposed rule, we describe proposed changes, if any, to the conditions or underlying requirements of § 412.604.

Section 412.604(a) General Requirements

Under paragraph (a)(2), we propose to change the word “we” to “CMS or its Medicare fiscal intermediary” to read as follows:

“If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary 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