

(i) The right to be informed of the purpose of the collection of the patient assessment data;

(ii) The right to have the patient assessment information collected be kept confidential and secure;

(iii) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(iv) The right to refuse to answer patient assessment questions; and

(v) The right to see, review, and request changes on his or her patient assessment.

(e) The patient rights specified in this section are in addition to the patient rights specified in § 482.13 of this chapter.

It should be noted that when the IRF clinician gives the patient the forms entitled "Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities" and the "Privacy Act Statement—Health Care Records" prior to performing an assessment, these forms do not satisfy the privacy provisions contained in the HIPAA Privacy Rule (65 FR 82462 as modified by 67 FR 53182). For example, these forms do not meet the privacy notice requirements of the HIPAA Privacy Rule (see 45 CFR § 164.520). Health plans and health care providers must meet the notice requirements of the HIPAA Privacy Rule by giving a Notice of Privacy Practices to their patients. The Notice of Privacy Practices describes a health plan or health care provider's uses and disclosures of protected health information and the individual rights that patients have with respect to their protected health information.

C. When the IRF-PAI Must Be Completed

According to § 412.606(b), an IRF must use the IRF-PAI to assess Medicare Part A fee-for-service inpatients. According to § 412.610(c)(1)(i)(A), the admission assessment covers the first 3 calendar days of the inpatient's current IRF Medicare Part A fee-for-service hospitalization. According to § 412.610(c)(1)(i)(B), the admission assessment reference date is the third day of the 3-day admission assessment time period. Section 412.610(c)(1)(i)(C) specifies that the IRF-PAI for the admission assessment "Must be completed on the calendar day that follows the admission assessment reference day."

We are concerned IRFs believe § 412.610(c)(1)(i)(C) means that they

may not start to record data on the IRF-PAI before the calendar day that follows the admission assessment reference day, which is not our intent. The "completion requirement" of the IRF-PAI means when the IRF's staff must have finished recording on the IRF-PAI the assessment data that the IRF's clinical staff obtained during an assessment of the inpatient that was performed during the admission assessment time period. In other words, the date when the IRF-PAI must be completed is a deadline date when the process of recording data on the IRF-PAI must be finished. The IRF's staff is permitted to enter assessment data on the IRF-PAI prior to the deadline date.

How data are recorded on the IRF-PAI is specified in the IRF-PAI item-by-item guide, which is entitled the "IRF-PAI Training Manual Revised 01/16/02." The instructions contained in the IRF-PAI item-by-item guide are, when possible, very similar to the rules for coding the patient assessment instrument that we used as the model for the IRF-PAI. The model for the IRF-PAI was the patient assessment instrument published by Uniform Data System for Medical Rehabilitation (UDSmr). The UDSmr rules for coding their assessment instrument specified that an item's score should reflect the inpatient's lowest level of functioning. Consequently, in order to be consistent with how an inpatient's functional performance was scored on the UDSmr patient assessment instrument, the IRF-PAI item-by-item guide likewise specifies that a patient's assessment must indicate the patient's lowest level of functioning.

During the admission assessment, an IRF clinician records different types of data on the IRF-PAI. We believe that the sources of the data recorded in the categories of the IRF-PAI entitled "Identification Information," "Admission Information," and "Payer Information" makes these data easy and quick to obtain and record. For these categories of data the source of the data may be the patient, the patient's medical record, other patient documents, the patient's family, or a person that has personal knowledge of the patient. In contrast, in order to complete the data for the IRF-PAI categories entitled "Function Modifiers" and "FIM™ Instrument," the clinician observes the patient's functional performance over the admission assessment time period, and makes clinical judgments regarding the patient's performance. Consequently, due to how the data for the Function Modifiers and FIM™ categories are obtained, we believe it is the time span that it takes to assess the

patient's functional performance that will usually determine how long it takes to complete the admission assessment.

Page III-3 of the IRF-PAI manual states that when determining the level of the patient's functional performance the clinician is to "record the lowest (most dependent) score." We believe that in the time span between the patient's admission to and discharge from the IRF, the patient's functional performance improves. We believe that on the patient's admission day and the next few days a patient's functional performance is poor in comparison to functional performance on subsequent days of the patient's current IRF hospitalization. Therefore, during the part of the admission assessment that is the first or second day of the patient's current IRF hospitalization, we believe that a patient's functional performance will usually be scored as indicating the most dependence.

As stated previously, the IRF's clinical staff is permitted to record assessment data on the IRF-PAI at any time during the admission assessment process. Also, as stated previously, we believe it is the scoring of the patient's functional performance that will determine how long it takes to complete the admission assessment. The combination of: (1) Being able to record assessment data at any time during the admission assessment, (2) the requirement that the lowest level of functional performance be recorded, and (3) that the lowest level of functional performance will usually occur on the first or second day of the admission assessment, makes it possible to finish obtaining and recording all the assessment data before the day that follows the admission assessment reference date. However, in accordance with § 412.610(c)(1)(i)(C), an IRF has until the day following the admission assessment reference day to complete the IRF-PAI.

In order to clarify that § 412.610(c)(1)(i)(C) does not prohibit the IRF from recording any or all of the data on the IRF-PAI before the day that follows the admission assessment reference day, we are proposing to amend § 412.610(c)(1)(i)(C) to read as follows: Must be completed by the calendar day that follows the admission assessment reference day.

D. Transmission of IRF-PAI Data

As specified in § 412.606(b), "Patient assessment instrument," an IRF must use the IRF-PAI to assess Medicare Part A fee-for-service inpatients. There are nine categories of IRF-PAI assessment data. The nine categories are entitled "identification information, admission