

information, payer information, medical information, medical needs, function modifiers, the FIM™ instrument, discharge information, and quality indicators". The data from some of these categories are used to classify a patient into a CMG. It is the CMG classification code, not the IRF-PAI raw data itself, that is part of the claim data the IRF submits to its FI when the IRF submits data in order to be paid for the services it furnished to the inpatient. We believe that an IRF's clinical staff will initially use the paper version of the IRF-PAI to record its assessment data. Then, in accordance with § 412.610(d), the IRF would use the data that it recorded on the paper version of the IRF-PAI to enter the IRF-PAI data into an electronic version of the document. The electronic version of the IRF-PAI uses the patient assessment data to classify a patient into a CMG. Under the IRF PPS, it is the CMG payment code, along with other information that the IRF submits to the fiscal intermediary (FI), that will determine the payment the IRF receives for the services the IRF furnished to a Medicare Part A fee-for-service beneficiary.

Section 412.614, "Transmission of patient assessment data," specifies that an IRF must transmit to us the IRF-PAI assessment data for each Medicare Part A fee-for-service inpatient. It is the electronic version of the IRF-PAI that enables an IRF to transmit the IRF-PAI data to us. We require that IRF's transmit IRF-PAI data so that we have the IRF-PAI data that are associated with the CMG payment code that the IRF submitted to its FI.

In most cases an IRF will submit claims data, including the patient's CMG, to the FI in order to be paid for the services it furnished to a Medicare Part A fee-for-service inpatient. However, there are situations when the IRF would submit claim data to its FI, but the submission of the claim data is not for the purpose of being paid for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient.

In these situations, Medicare operational procedures that were in effect before implementation of the IRF PPS requires an IRF to send claim data to the FI. The purpose of the IRF sending claim data to the FI in these situations is to enable Medicare to monitor a beneficiary's period of entitlement. For instance, an IRF must still send the FI claim data even if the inpatient's non-Medicare primary payer paid for all of the IRF services the IRF furnished to the Medicare Part A fee-for-service inpatient. Another instance when the IRF must still send the FI

claim data is when any of the services that an inpatient's non-Medicare primary payer did not pay for also do not qualify for payment under the IRF PPS.

We want to relieve the IRF of the burden of transmitting IRF-PAI data to us when the IRF is not requesting that Medicare pay for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient. Accordingly, we are proposing to amend § 412.614 by specifying that § 412.614(a) is a general rule that would read as follows:

(a) *Data format. General rule.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient—

We are also proposing to further amend § 412.614 by adding a new § 412.614(a)(3), which would relieve the IRF of the burden of having to transmit the IRF-PAI data for a Medicare Part A fee-for-service inpatient when Medicare will not be paying the IRF for any of the services the IRF furnished to that inpatient. New § 412.614(a)(3) would read as follows:

Exception to the general rule. When the inpatient rehabilitation facility does not submit claim data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required to, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

E. Proposed Revision of the Definition of Discharge

According to § 412.602, a discharge has occurred when the patient has been formally released from the hospital, or has died in the hospital, or when the patient stops receiving Medicare-covered Part A inpatient rehabilitation services. Our intent in specifying this definition of when a discharge has occurred under the IRF PPS was to try to ensure that Medicare paid an IRF only for furnishing an IRF level of services to the Medicare Part A fee-for-service inpatient. However, in contrast to when a patient is formally released from the IRF or dies, the time when a patient stops receiving Medicare-covered Part A IRF services may be subject to different interpretations resulting in different determinations of when a discharge has occurred. The result of different determinations of when a discharge has occurred is inconsistency in determining the discharge date. This inconsistency

could result in different IRFs furnishing the same services for the same period of time, but being paid differently, because the discharge date determines a patient's length-of-stay, and the patient's length-of-stay is one of the factors that determines the amount of the CMG payment. For example, according to § 412.624(f), a patient's length-of-stay as determined by the inpatient's discharge date may affect the amount of the IRF's CMG payment when a patient is transferred from an IRF to another site of care.

In addition, there may be cases when an IRF believes an inpatient no longer has a medical need for Medicare-covered Part A inpatient rehabilitation services, but the IRF believes that the inpatient has a medical need for a SNF level of services. However, due to circumstances beyond the IRF's control, the IRF is unable to formally release the patient, because the IRF cannot place the patient in a SNF setting. In that situation, according to section 1861(v)(1)(G)(i) of the Act and § 424.13(b), a physician may certify or recertify that the patient needs to continue to be hospitalized in the IRF. The effect of the physician's certification or recertification is that under Medicare the patient is not considered discharged until the patient is formally released from the IRF.

In consideration of what can occur when discharge is defined as being when the inpatient stops receiving Medicare-covered Part A inpatient rehabilitation services, we are proposing to amend § 412.602 by revising the definition of "discharge" by removing the phrase "(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services, unless the patient qualifies for continued hospitalization under § 424.13(b) of this chapter; or". The proposed revised definition would read as follows:

Discharge. A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

- (1) The patient is formally released from the inpatient rehabilitation facility; or
- (2) The patient dies in the inpatient rehabilitation facility.

F. Waiver of the Penalty for Transmitting the IRF-PAI Data Late

Section 412.614(c) "Transmission dates" states that the admission and discharge assessment data must be transmitted together. The discharge assessment is completed after the admission assessment has been completed. Therefore, the date when the IRF-PAI data must be transmitted is