

§ 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.

*Transmission of IRF-PAI Data*  
(§ 412.614)

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.

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 IRFs 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. 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 IRF must encode and transmit data for each Medicare Part A fee-for-service inpatient—

We are proposing to amend § 412.614 by adding a new § 412.614(a)(3), which would relieve the IRF 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 claims 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, 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.

We are proposing a new § 412.614(e) to read as follows: "Exemption to being assessed a penalty for transmitting the IRF-PAI data late. CMS may waive the penalty 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)(2) of this section. An extraordinary situation may be, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation 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."

*Proposed Update of Area Wage Data*

In § 412.624(e), "Calculation of the adjusted Federal prospective payment," in paragraph (1), "Adjustment for area wage levels," we are proposing that adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. We are also proposing to determine a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

*Proposed Adjustment for High-Cost Outliers Under the IRF Prospective Payment System (§ 412.624)*

As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under proposed § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report, whichever is later, to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. (Because of the small number of IRFs compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed under the IPPS, would not be statistically valid. Thus, we are proposing to use national average cost-to-charge ratios in place of statewide averages.) As is the case with

the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change.

As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an "overpayment." We also may adjust outlier payments for the time value of money for cases that "underpaid" to the IRF. In these cases, the adjustment will result in additional payments to the IRF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

**VIII. Collection of Information Requirements**

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

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are therefore soliciting public comment on each of these issues for the proposed information collection requirements discussed below.

*Section 412.608 Patients' rights regarding the collection of patient assessment data.*

Under this section, before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient the form entitled