

§ 412.20 Hospital services subject to the prospective payment systems.

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(b) * * *

(2) CMS will not pay for services under Subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an inpatient rehabilitation facility for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

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3. In § 412.22, the following changes are made:

A. Revise paragraph (h)(2)

introductory text.

B. Add and reserve paragraph (h)(6).

C. Add paragraph (h)(7).

The revisions and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) * * *

(2) Except as provided in paragraphs (h)(3) and (h)(7) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(6) [Reserved]

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

4. In § 412.25, the following changes are made:

A. Revise paragraph (e)(2) introductory text.

B. Add paragraph (e)(5).

The revision and addition read as follows:

§ 412.25 Excluded hospital units: Common requirements.

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(e) * * *

(2) Except as provided in paragraphs (e)(3) and (e)(5) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

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(5) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

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5. In § 412.29, revise paragraph (a)(2) to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

(a) * * *

(2) Converted units under § 412.30(c).

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6. In § 412.30, the following changes are made:

A. Revise paragraph (b)(3).

B. Revise paragraph (d)(2)(i).

§ 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

(b) * * *

(3) The written certification described in paragraph (b)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care.

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(d) * * *

(2) *Conversion of existing bed capacity.* (i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (d)(1) of this section.

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Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

7. In § 412.602, republish the introductory text and revise the definition of “Discharge” to read as follows:

§ 412.602 Definitions.

As used in this subpart—

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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.

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8. In § 412.604, revise paragraph (a)(2) introductory text to read as follows:

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) * * *

(2) 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—

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9. Section 412.608 is revised to read as follows:

§ 412.608 Patients' rights regarding the collection of patient assessment data

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient each of these forms—

(1) The form entitled “Privacy Act Statement—Health Care Records;” and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled “Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.”

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) The Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities is the simplified plain language description of the Privacy Act Statement—Health Care Records.

(d) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(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.

10. In § 412.610, revise paragraph (c)(1)(i)(C) to read as follows: