

www.cms.hhs.gov/providers/irfpps/default.asp).

When a 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. (Claims submitted to Medicare must comply with the electronic claim requirements found at <http://www.cms.hhs.gov/providers/edi/default.asp>. All submitted claims must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) program claim memoranda issued by us and also published at that website, 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 Part 3 section 3604 of the Medicare Intermediary Manual.) The Medicare fiscal intermediary 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. The PRICER software also applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments.

D. Issuance of Proposed Rule on the FY 2004 Updates

On May 16, 2003, we issued in the **Federal Register** (68 FR 26788) a proposed rule in which we proposed to update the Federal prospective payments rates under the IRF PPS and to make revisions and clarifying changes to the policies governing the implementation of the IRF PPS. A summary of our proposal follows:

We proposed to use FY 1999 acute care hospital wage data to compute the IRF wage indices for FY 2004. (For FY 2003, we used FY 1997 acute care hospital wage data to compute the IRF wage indices.) 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, we proposed to apply the methodology to update the wage indices for FY 2004, using 1999 acute care hospital data in a budget neutral manner.

We also proposed 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. We proposed to use 1997 cost report data, which are the most recent data available to form the basis of the FY 2004 IRF market basket index.

We further proposed 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 entitled seeking classification as an IRF. Currently, to be paid under the IRF PPS, a hospital or unit of a hospital must first be deemed excluded from the diagnosis-related group (DRG)-based acute care hospital PPS (IPPS) 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 proposed to modify or clarify existing provisions of the IRF PPS relating to the patient assessment process and the transmission of patient data to CMS. However, we note that we did not propose any refinements or changes 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.

We received more than 6,900 timely items of correspondence containing multiple comments on the May 16, 2003 proposed rule. Major issues addressed by commenters included the following: enforcement of the 75 percent rule (as discussed below); definition of a discharge; waiver of the penalty for late transmission of the IRF-PAI; and changes to the outlier policies. Summaries of the public comments received and our responses to those comments are set forth below under the appropriate subject headings.

Many commenters did not agree with our stated intention to enforce the existing regulations at § 412.23(b) whereby at least 75 percent of an IRF's patient population must receive intensive rehabilitation services for treatment of one or more of ten conditions specified in regulations for the facility to be classified as an IRF (also known as the 75 percent rule). In addition, on May 19, 2003, we hosted an IRF Town Hall meeting in Baltimore, MD where patients, providers, and other interested parties presented their views on the May 16, 2003 proposed rule. We

received numerous suggestions concerning changes to the 75 percent rule. Based on the level of public interest generated by this issue, we have decided to revisit our policies concerning the 75 percent rule. In the very near future, we will be issuing a proposed rule in the **Federal Register** that will contain a full discussion of our proposed changes to the existing 75 percent rule.

II. Requirements and Conditions for Payment Under the IRF PPS

A. Background

Existing regulations at § 412.604 describe 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 the section 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 IPPS 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 who 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.

B. Provisions of the May 16, 2003 Proposed Rule

In the May 16, 2003 proposed rule, we described several proposed changes to the conditions or underlying requirements of § 412.604. Below we discuss the proposed change to the general conditions and requirements. The specific changes relating to classification criteria are addressed under section II.C. of this preamble.

As stated earlier, under § 412.604(a), we specify the general conditions for payment to be made under the IRF PPS and the effects on Medicare payment if the conditions are not met. We proposed to make a change in paragraph (a)(2) relating to the entity that takes the action if the IRF fails to comply with the conditions of the section; that is to withhold (in full or in part) or reduce Medicare payment to the IRF until the facility provides adequate assurances of compliance, or to classify the IRF as an inpatient hospital that is subject to the conditions of 42 CFR part 412, subpart