

dependence or the lowest level of functioning.

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 a 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) the lowest level of functional performance that 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, in the May 16, 2003 proposed rule we proposed to revise § 412.610(c)(1)(i)(C) to indicate that the IRF-PAI must be completed by the calendar day that follows the admission assessment reference day.

Comment: A commenter expressed agreement with the proposed change.

Response: We are adopting the proposed change as final without modification.

E. 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 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 fiscal intermediary 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. 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 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 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 fiscal intermediary.

In most cases, an IRF will submit claims data, including the patient's CMG, to the fiscal intermediary 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 claims data to its fiscal intermediary, but the submission of the claims 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 require an IRF to send claims data to the FI. The purpose of the IRF sending claims 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 fiscal intermediary claims data even if the inpatient's non-Medicare primary payer paid for all of the IRF services that the IRF furnished to the Medicare Part A fee-for-service inpatient. Another instance when the IRF must still send the FI claims data is when an inpatient's non-Medicare primary payer does not pay for any of the services, and these services 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, in the May 16, 2003 proposed rule, we proposed to revise § 412.614 to specify that paragraph (a) is a general rule.

We also proposed to further revise § 412.614 by adding a new § 412.614(a)(3) to specify that the IRF is not required to, but may, 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.

Comment: We received one public comment supporting the proposed change.

Response: We are adopting the proposed change as final without modification.

F. Revision of the Definition of Discharge

Existing § 412.602 specifies that 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 intention 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.

Various determinations of when a discharge has occurred can lead to inconsistencies in determining the discharge date. In these situations, IRFs furnishing the same services for the same period of time may be paid differently, because the discharge date determines a patient's length-of-stay. The patient's length-of-stay is one of the factors that determines the amount of the CMG payment. For example, under § 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 an 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 an SNF setting. In that situation, according to section 1861(v)(1)(G)(i) of the Act and