



**Center for Clinical Standards and Quality/Survey & Certification Group**

**Ref: S&C: 13-04-IRF**

**DATE:** November 30, 2012

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Collection of Information from Inpatient Rehabilitation Facilities (IRFs)

**Memorandum Summary**

- **Certification Form Processing:** The Centers for Medicare & Medicaid Services (CMS) is revising the process for the Regional Offices (RO) and State Agency (SA) review of the Forms CMS 437A and 437B (Rehabilitation Criteria Worksheets for Rehabilitation Hospitals or Rehabilitation Units in acute care hospitals and the Certification/Attestation Statement State Operations Manual (SOM) Exhibit 127).
- **Revised Time Frame:** Effective November 1, 2012, the IRFs will be reviewed once every three years (consistent with the interval for other hospital surveys).
- **Work Load Implications:** A decrease in SA and RO workload is expected. Implementation will be phased in so that on the effective date, SAs will review the documentation for the excluded status for one third of the IRFs in their State each year.

**Background:**

Inpatient rehabilitation facilities (either hospitals or units) that meet certain requirements are excluded from the Inpatient Hospital Prospective Payment System (IPPS). These excluded facilities are paid by Medicare at a significantly higher rate than the IPPS. To qualify for this higher rate, CMS has a process to verify that the IRFs meet these requirements through a review by the CMS RO, SA, and Medicare Administrative Contractor/Fiscal Intermediary (MAC/FI). The current process is described in more detail below.

A prospective IRF must submit the appropriate Form CMS 437A or 437B. In addition they must submit a signed Attestation Statement that they will meet the applicable requirements for exclusion from IPPS.

Every year, the State Survey Agency collects Form CMS 437A (Rehabilitation Unit) or Form CMS 437B (Rehabilitation Hospital) and an Attestation Statement from all IRFs. On the

Attestation Statement, the hospital Administrator or Chief Executive Officer (CEO) must attest through a signed statement, under penalty of fine or imprisonment, that the hospital meets, and has been meeting the requirements of 42CFR§412 during the current cost report period. The IRFs are also required to include documentation that they have a Director of Rehabilitation.

As part of the Attestation/Certification process, the IRF is required to submit the appropriate Form CMS 437A or CMS 437B, the revised Attestation Statement (attached), and documentation supporting either the Director of Rehabilitation's full time status (for inpatient rehabilitation hospitals) or his/her provision of services in the hospital or Critical Access Hospital (CAH's) rehabilitation unit at least 20 hours per week.

In addition, CMS is strengthening the Attestation process in regard to the Director of Rehabilitation in the IRFs. Specifically, the Attestation Form will now include:

- Additional information from the Director of Rehabilitation including name and license number and full or part-time status at the IRF hospital or unit;
- *Co-signature of the Attestation by the Director of Rehabilitation*; previously only the hospital Administrator or CEO was required to sign the Attestation Statement.

If the Attestation Statement is not complete, it is to be returned to the facility with instructions to complete all sections. Both signatures (refer to Exhibit 127) must be included on the statement for it to be considered complete. The RO is to be notified and the appropriate action taken if the IRF cannot prove it has a Director of Rehabilitation. The IRF must have a Director of Rehabilitation in order to maintain its IPPS excluded status.

The MAC/FI verifies whether IRFs are meeting the 60 percent rule. (The 60 percent rule means that 60 percent of the IRF's patient population received intensive rehabilitation services for one of 13 medical conditions during the IRF's previous cost report year). If an IRF is out of compliance with that requirement, the MAC/FI reports the information to the CMS RO for termination from the IPPS-excluded status. The RO sends a termination letter to the facility; SA and MAC/FI of the termination of the IPPS excluded status. *CMS does not expect the MAC/FI process to change.*

Regardless of whether the IRF's IPPS exclusion status continues to be approved or denied, the RO sends a letter advising the facility of whether or not it continues to hold the excluded status prior to the beginning of the facility's next cost report period.

It is important to remind the facilities of the date the statement is to be returned to the SA (in time to allow the SAs to review the information and to send forward the SA recommendation for approval or denial of the excluded status). The facilities cannot maintain their IPPS exclusion status without submitting all appropriate and complete paperwork prior to the start of their next cost report period.

If you have any questions concerning this memo, please contact Georgia Johnson at 410-786-6859 or e-mail [Georgia.Johnson@cms.hhs.gov](mailto:Georgia.Johnson@cms.hhs.gov).

**Effective Date:** January 1, 2013. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

Thomas E. Hamilton

Attachments

SOM Exhibit 127—Certification/Attestation Statement for Exclusion from IPPS  
Forms CMS 437A and CMS-437B

**SOM Exhibit 127**

Attestation Statement for Exclusion from the IPPS  
Covering the Period from \_\_\_\_\_(Month/Year) to the Present  
(Based on the Dates Contained in the Letter from the State Agency)

Name of State Agency Director  
Name of State Agency  
Address  
City, State, Zip  
Date

Dear (State Agency Director):

This Attestation Statement has been completed and signed by *both* our hospital Administrator *or* Chief Executive Officer (including hospitals with excluded units) and the Director of Rehabilitation (physician).

Based upon our personal knowledge and belief, *we* attest that the responses on the attached Rehabilitation Criteria work sheet (Form CMS 437A or CMS 437B) are true and correct, and that (name of IPPS-Excluded Hospital or Unit) has met, meets and will continue to meet all the applicable requirements for exclusion from the IPPS for the period beginning (first day of hospital's fiscal year or cost reporting period), as set out in Subpart B of 42 CFR Part 412. We understand that the Centers for Medicare and Medicaid Services (CMS) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached work sheet are accurate.

We agree that if our inpatient rehabilitation facility (IRF) fails to meet any of these requirements *in the next three cost report years*, we will notify our Regional Office and Medicare Administrative Contractor/ Fiscal Intermediary (MAC/FI) of the change immediately in order to permit a valid determination of the IPPS excluded status prior to the beginning of the *next cost reporting period*.

(Include the next sentence for units only): The unit is located in (enter building name, room numbers and address), and consists of \_\_\_\_\_square feet. The beds remain separate and are not co-mingled with other hospital service beds.

STATEMENTS OR ENTRIES GENERALLY: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both. (18 U.S.C., Sec.1001)

***Signatures:***

Signature \_\_\_\_\_  
(Administrator *or* Chief Executive Officer of the hospital)

Title \_\_\_\_\_

Date \_\_\_\_\_

*Signature* \_\_\_\_\_  
(*Director of Rehabilitation*)

*Director of Rehabilitation's License number* \_\_\_\_\_

*Today's date* \_\_\_\_\_

*Start date of employment* \_\_\_\_\_

*Documentation attached of full time or part-time status.*

## REHABILITATION UNIT CRITERIA WORK SHEET

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS (City, State, Zip Code)
NUMBER OF BEDS IN THE UNIT	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD		VERIFIED BY
_____ / _____ to _____ / _____ MM DD YYYY      MM DD YYYY		

**ALL CRITERIA UNDER SUBPART B OF PART 412 OF THE REGULATIONS MUST BE MET FOR EXCLUSION FROM MEDICARE'S ACUTE CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM OR FROM THE PAYMENT SYSTEM USED TO PAY CRITICAL ACCESS HOSPITALS.**

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
		<ul style="list-style-type: none"> <li>Verification of hospital attestations may be done by CMS surveyors or MACs as applicable.</li> </ul>	The hospital representative is expected to answer all questions accurately.  The representative should verify the answers with the director of rehabilitation, physician, medical records office, or any applicable department to ensure correct responses to this form.  A "yes" response means the hospital is in compliance with the applicable regulation.			
	§412.25 Excluded hospital units: Common requirements.					
	(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a rehabilitation unit must meet the following requirements in addition to the all criteria under Subpart B of Part 412 of the regulations:		In the case of § 412.25 and § 412.29, as related to IRF units, the term hospital includes Critical Access Hospitals.			

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
A3500	(1) Be part of an institution that has in effect an agreement under Part 489 to participate as a hospital, and is not excluded in its entirety from the prospective payment systems, and has enough beds that are not excluded to permit the provision of adequate cost.	<ul style="list-style-type: none"> <li>• The surveyor will verify, through the regional office (RO), that the hospital has an agreement to participate in the Medicare program, and the hospital is not already excluded in its entirety from IPPS, such as a rehabilitation hospital. In other words, the unit seeking exclusions cannot comprise the entire hospital</li> <li>• The hospital must be sufficiently staffed, maintained and IPPS beds utilized that are not part of the rehabilitation unit.</li> <li>• Verification of this information may be done by CMS surveyors or MACs.</li> </ul>	Representative to ensure the hospital has a Medicare provider agreement.			
A3501	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	<ul style="list-style-type: none"> <li>• Verify that the hospital has preadmission criteria for the rehabilitation unit.</li> <li>• Conduct an open and closed record review to determine whether the approved preadmission criteria is applied equally to all patients.</li> </ul>	Representative to verify the rehab unit has preadmission criteria.			
A3502	(3) Have admission & discharge records that are separately identified from those of the hospital in which it is located and are readily available.	<ul style="list-style-type: none"> <li>• Verify that rehabilitation unit medical records are separate and not commingled with other hospital records and are readily available for review.</li> </ul>	Representative to verify that the rehab unit houses only the records of the rehab patients.			
A3503	(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.	<ul style="list-style-type: none"> <li>• Verify that the hospital has a policy detailing the prompt transfer of information, and that it is being followed.</li> <li>• Review rehabilitation unit clinical records to ensure that the clinical information that should be transferred with the record is actually in the medical record.</li> </ul>	Representative to verify the hospital has a policy regarding the transfer of information, and the hospital adheres to the policy.			

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A3504	(5) Meet applicable State licensure laws.	<ul style="list-style-type: none"> <li>• Verify and document that all applicable State licensure laws are met.</li> <li>• Document all unmet State licensure requirements.</li> <li>• Verify the hospital has current licenses for its professional staff.</li> <li>• Are the licenses issued by the State in which the rehabilitation unit is located?</li> <li>• Does the unit meet special licensing requirements issued by the State?</li> </ul>	Representative to verify that all applicable State laws are being met and that all applicable licenses are current.			
A3505	(6) Have utilization review standards applicable for the type of care offered in the unit.	<ul style="list-style-type: none"> <li>• Verify that the hospital has a utilization review plan that includes the review of rehab services (No utilization review (UR) standards are required if the QIO is conducting review activities.)</li> <li>• Verify that the hospital has written UR standards that are applied to the care offered in the unit.</li> </ul>	Representative to verify that the hospital has a UR plan and that the UR standards are being applied to the care offered in the rehab unit.			
A3506	(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds. <b>NOTE:</b> §412.25(a) (8)-(12) are verified by the FI.	<ul style="list-style-type: none"> <li>• Is the space containing the rehab beds physically separate from the beds in other units of the hospital?</li> <li>• There cannot be any beds that are located within the physical confines of the excluded rehab unit that are not excluded beds.</li> <li>• The IRF unit cannot use its beds for medical /surgical patients or any other type of patient. Those beds are solely for the use of IRF patients.</li> <li>• If the unit doesn't have enough patients to fill those beds, the beds must be left empty or the unit can decrease the number of beds in the unit after the hospital has notified CMS of its intent.</li> </ul>	Representative will verify that the beds on the rehab unit do not belong to medical/surgical patients but are dedicated to rehab patients only.			



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A3507	(13) As part of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.	<ul style="list-style-type: none"> <li>• Prior to scheduling the survey, verify with the FI that the unit is operational: fully staffed and equipped.</li> <li>• It is not required that the unit has inpatients on the day of the survey, but must demonstrate capability of caring for patients.</li> </ul>				
A3508	(b) Changes in the size of excluded units. Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.	<ul style="list-style-type: none"> <li>• Verify that the request the IRF is making to add beds is the first and only request during the cost report year.</li> <li>• A decrease in the number of beds or square footage may occur at any time during the cost report period. In both cases, the change must remain in affect for the remainder of the cost report period</li> <li>• No changes can be made without notifying both CMS RO and the FI/MAC at least 30 days prior to the change.</li> </ul>	Representative to verify that if changes were made to the unit, both CMS and the MAC/FI were notified prior to any change.			
	<p><b>§ 412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment systems.</b> To be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.(1)(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:</p>					
A3509	(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.	<ul style="list-style-type: none"> <li>• The SA will check these provisions with the RO prior to the survey.</li> </ul>	Representative to ensure the hospital has a Medicare provider agreement.			

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A3510	(b) Except in the case of a “new” IRF or “new” IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the criteria outlined in § 412.29 (b)(2).	<ul style="list-style-type: none"> <li>• The MAC/FI reviews the inpatient population of the IRF. If the hospital has not demonstrated that it served the appropriate inpatient population as defined in § 412.29 (b)(2), the MAC notifies the RO.</li> </ul>				
A3511	(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (e)(2) of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF’s first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.	<ul style="list-style-type: none"> <li>• In the case of a new IRF unit, the surveyor will verify that the hospital has not previously sought exclusion.</li> <li>• The surveyor will verify that the hospital received approval for the unit under the appropriate State licensure laws.</li> <li>• The IRF must submit an attestation statement in addition to the Form CMS 437A (rehabilitation unit worksheet) to the SA as part of their initial application packet.</li> <li>• Until the SA receives both the attestation statement and the Form CMS 437A, the new unit cannot be recommended for approval.</li> </ul>	The representative completes this form (Form CMS 437A) as well as a signed attestation statement attesting that the rehab unit’s patients it intends to serve meets the requirements outlined in § 412.29(b)(2).			
A3512	(1) <b>New IRFs.</b> An IRF hospital or IRF unit is considered new if it has not been paid under the new IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.	<ul style="list-style-type: none"> <li>• If an IRF unit has been closed for 5 years (more than 60 calendar months), it can open its doors as a new unit.</li> <li>• Verify either through the SA or RO that the IRF unit has been closed for the 5 years before approving the IRF unit as new.</li> </ul>	The representative ensures the IRF unit has not been paid under the IRFPPS for at least 5 calendar years.			

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A3513	<p>(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds declinced or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.</p>	<ul style="list-style-type: none"> <li>• If the hospital added beds to its IRF unit, the surveyor or CMS will verify that the hospital had approval (certificate of need or State license ) before adding beds, if such approval is required.</li> <li>• The surveyor must verify that the hospital received written CMS RO approval before adding any new beds to its IRF unit.</li> <li>• The surveyor will verify that the hospital's IRF unit didn't have more than one increase in beds during a single cost reporting period.</li> <li>• Surveyors must verify that if the hospital's IRF unit decreased beds, it didn't thereafter add beds unless a full 12 month cost reporting period had elapsed.</li> </ul>	<ul style="list-style-type: none"> <li>• The representative verifies that the hospital received State approval (certification of need or State licensure) , if prior approval is required by the State, prior to any IRF unit bed increase.</li> <li>• The representative verifies that the hospital received written approval from the CMS RO before any new beds were added to the IRF unit.</li> <li>• The representative will verify that if the hospital's IRF unit decreased beds, it didn't thereafter add beds unless a full 12 month cost reporting period had elapsed.</li> <li>• The representative will verify that the hospital's IRF unit didn't have more than one increase in beds during a single cost reporting period.</li> </ul>			
A3514	<p><b>(3) Change of ownership or leasing.</b> An IRF hospital or IRF unit that undergoes a change of ownership, or leasing as defined in § 489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment systems specified in § 412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may reapply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements under the new IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in § 412.1(a)(1).</p>	<ul style="list-style-type: none"> <li>• IRF status is lost if a hospital is acquired and the new owners reject assignment of the previous owner's Medicare provider assignment.</li> <li>• Only entire hospitals may be sold or leased.</li> <li>• IRF units may not be sold or leased separately from the hospital of which it is a part.</li> </ul>	<p>The representative of the IRF unit, that has undergone a change of ownership, must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded unit.</p>			

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A3515	<p><b>(4) Mergers.</b> If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF (or the hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.</p>	<ul style="list-style-type: none"> <li>• As with the change of ownership, the owner of the merged hospital must accept assignment of the hospital's (with the IRF unit) provider agreement to ensure uninterrupted reimbursement.</li> <li>• If the owner of the hospital to be merged doesn't accept assignment of the previous owner(s) Medicare provider agreement, the new owner(s) will not be eligible for reimbursement until the new owner(s) reapplies to the Medicare program to operate a new hospital and have additionally been granted IRF status.</li> <li>• IRF status is lost if a hospital is acquired and the new owner(s) reject assignment of the previous owner's Medicare provider agreement. This also applies to an acquisition that is followed by a merger.</li> </ul>	<p>The representative of the IRF unit that has undergone a merger must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded unit.</p>			
A3516	<p>(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.</p>	<ul style="list-style-type: none"> <li>• Review the hospital's procedures, or other alternative documents or records, to verify the hospital's rehabilitation unit has a preadmission screening procedure in place.</li> <li>• A review of the clinical records should indicate whether the IRF has such a screening procedure and whether it is using the screening procedure.</li> <li>• The purpose of the preadmission screen is to reduce the rate of hospital readmission by ensuring that the patients that are accepted to the IRF will benefit from intensive rehabilitation services.</li> </ul>	<p>The representative will ensure the hospital's rehabilitation unit is using the preadmission screening procedure on all patients admitted to the rehab unit.</p>			

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A3517	(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to access the patient both medically and functionally, as well as to modify the courses of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.	<ul style="list-style-type: none"> <li>Review the hospital's procedures or other alternative documents or records to verify the hospital has a procedure detailing close medical supervision for patients, including at least 3 face-to-face visits per week.</li> <li>As part of the clinical record review, look for documentation supporting the physician visits.</li> </ul>	The representative will ensure the rehab unit has a procedure or other alternative documents or records verifying the hospital has a procedure detailing close medical supervision that includes the rehabilitation physician making at least 3 face-to-face visits per week.			
A3518	(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus as needed, speech-language pathology, social services, psychological services (including neuropsychological service) and orthotic and prosthetic services.	<ul style="list-style-type: none"> <li>Review the licenses of all qualified personnel that are required by the State to be licensed, to verify the licenses are up-to-date.</li> <li>Qualified personnel would include either personnel that are licensed in the State in which the services are provided or those personnel that are recognized under reciprocity by the State in which the services are provided.</li> <li>Determine if the hospital has and follows a procedure to evaluate and document that personnel are qualified and that those personnel maintain their qualifications.</li> </ul>	The representative verifies that all qualified personnel, that are required by the State to be licensed, have licenses that are up-to-date.			
A3519	(g) Have a director of rehabilitation who —	<ul style="list-style-type: none"> <li>Verify the rehab unit has a director of rehabilitation by reviewing personnel logs or rosters and organization charts.</li> </ul>	The representative will verify that the rehab unit has a physician Director of Rehabilitation.			
A3520	(1) Provides services to the rehabilitation unit and to unit's inpatients for at least 20 hours per week;	<ul style="list-style-type: none"> <li>The 20 hours may be any combination of patient services and administration. Hours cannot be substituted by a Physician Assistant or by any other qualified professional. Verify the 20 hours through review of personnel time cards/logs, etc.</li> </ul>	The representative will verify that the physician is spending 20 hours per week providing a combination of patient services and administration the rehab unit.			
A3521	(2) Is a doctor of medicine or osteopathy;	<ul style="list-style-type: none"> <li>Review the physician's license to verify the physician is an MD or DO.</li> </ul>	The representative will review the physician's license to ensure the physician is an MD or DO.			
A3522	(3) Is licensed under State law to practice medicine or surgery; and	<ul style="list-style-type: none"> <li>Ensure license is current and issued by the State.</li> </ul>	The representative will review the physician's license is current.			

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A3523	(4) Has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.	<ul style="list-style-type: none"> <li>Review personnel and/or credentialing files to verify the physician's training and experience complies with the regulation.</li> </ul>	The representative reviews the director of rehabilitation's level of training and experience.			
A3524	(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	<ul style="list-style-type: none"> <li>Conduct a clinical record review to verify that each IRF patient has a plan of treatment and that the plans are updated whenever there is a change in the patient's condition.</li> <li>The plan of treatment should include the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay.</li> <li>The anticipated interventions detailed in the overall plan of care should include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.</li> </ul>	The representative verifies that the rehab unit has patient plans of treatment.			
A3525	(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans and that team conferences are held at least once per week to determine the appropriateness of treatment.	<ul style="list-style-type: none"> <li>Review clinical records to determine whether the interdisciplinary team is meeting once a week to review patient progress toward goal attainment and discharge planning.</li> <li>Determine if the documentation complies with the regulatory requirements.</li> </ul>	The representative will determine whether interdisciplinary teams are meeting once weekly to review patient progress and that documentation is in the medical records.			

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0986. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

## COMMENTS

## REHABILITATION HOSPITAL CRITERIA WORK SHEET

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE HOSPITAL	FACILITY NAME AND ADDRESS (City, State, Zip Code)
NUMBER OF BEDS IN THE HOSPITAL	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD		VERIFIED BY
_____ / / to / / MM DD YYYY MM DD YYYY		

**ALL CRITERIA UNDER SUBPART B OF PART 412 OF THE REGULATIONS MUST BE MET FOR EXCLUSION FROM MEDICARE'S ACUTE CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM**

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
		Verification of hospital attestations may be done by CMS surveyors or MACs as applicable.	The hospital representative is expected to answer all questions truthfully. The representative should verify the answers with the Director of Rehabilitation physician, medical records office, or any applicable department to ensure correct responses to this form, A "yes" response means the hospital is in compliance with the applicable regulation.			
	§412.23 Excluded hospital units: Classifications.					
	(b) Rehabilitation hospitals. A rehabilitation hospital must meet the requirements specified in §412.29 of this subpart to be excluded from the prospective payment systems specified in §412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in §412.1(a)(3) of this subpart and in subpart P of this part.					
	§412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system. To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:					

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A3600	(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.	The surveyor will verify, through the regional office (RO), that the hospital has an agreement to participate in the Medicare program.	Representative to ensure the hospital has a Medicare provider agreement.			
A3601	(b) Except in the case of a "new" IRF or "new" IRF beds, as defined in paragraph (c) of this section, an IRF must show that during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b) (2) of this section.	The MAC/FI reviews the inpatient population of the IRF. If the hospital has not demonstrated that it served the appropriate inpatient population as defined in § 412.29 (b)(2), the MAC notifies the RO.				
A3602	<ul style="list-style-type: none"> <li>• (c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2) of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section.</li> <li>• This written certification will apply until the end of the IRF's first full 12-month cost report period or in the case of new IRF beds, until the end of the cost report period during which the new beds are added to the IRF.</li> </ul>	<ul style="list-style-type: none"> <li>• The IRF must submit a written attestation statement as well as Form CMS 437B (rehabilitation hospital worksheet) to the SA as part of their initial application packet or as determined by CMS to maintain their IPPS excluded status.</li> <li>• Until the SA receives both the attestation statement and the Form CMS 437B the new rehabilitation hospital cannot be recommended for approval.</li> </ul>	The representative completes this form (Form CMS 437B) as well as a signed attestation statement attesting that the rehab hospital patients it intends to serve meets the requirements outlined in §412.29(b)(2) and submits the documentation to the State Agency.			
A3603	(1) New IRFs. An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost report period.	<ul style="list-style-type: none"> <li>• If an IRF hospital has been closed for 5 years (more than 60 calendar months), it can open its doors as a new rehabilitation hospital.</li> <li>• Verify either through the SA or RO that the IRF hospital has been closed for the 5 years before approving the IRF hospital as new.</li> </ul>	The representative ensures the IRF hospital has not been paid under the IRFPPS for at least 5 calendar years.			



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A3604	<p>(1) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost report period. A full 12-month cost report period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified, New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.</p>	<ul style="list-style-type: none"> <li>• If the rehabilitation hospital added beds, the surveyor or CMS will verify that the hospital had approval (certificate of need or State license ) before adding beds, if such approval is required.</li> <li>• The surveyor must verify that the hospital received written CMS RO approval before adding any new beds.</li> <li>• The surveyor will verify that the hospital didn't have more than one increase in beds during a single cost reporting period.</li> <li>• Surveyors must verify that if the rehabilitation hospital decreased beds, it didn't thereafter add beds unless a full 12 month cost reporting period had elapsed.</li> </ul>	<p>The representative completes this form (Form CMS 437B) as well as a signed attestation statement attesting that the rehab patients it intends to serve meets the requirements outlined in § 412.29(b)(2).</p>			
A3605	<p>(3) Change of ownership or leasing. An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in § 489, 18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in § 412,1(a)(3) before and after the change of ownership or leasing, if the new owner(s) of the IRF accept assignment of the previous owner's Medicare provider agreement, and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owner's Medicare provider agreement, the IRF is considered to be voluntarily terminated, and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412,(a)(1),</p>	<ul style="list-style-type: none"> <li>• IRF status is lost if a hospital is acquired and the new owners reject assignment of the previous owner's Medicare provider assignment</li> <li>• Only entire hospitals may be sold or leased, IRF units may not be sold or leased,</li> </ul>	<p>The representative of the IRF hospital that has undergone a change of ownership, must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded rehab hospital.</p>			

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A3606	<p>(4) Mergers. If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.</p>	<ul style="list-style-type: none"> <li>• As with the change of ownership, the owner of the merged hospital must accept assignment of the hospital with the existing provider agreement to ensure uninterrupted reimbursement.</li> <li>• If the owner of the hospital to be merged doesn't accept assignment of the previous owner's Medicare provider agreement, the new owner(s) would not be eligible for reimbursement until the new owner(s) reapplied to the Medicare program to operate a new hospital and have additionally been granted IRF status,</li> <li>• IRF status is lost if a hospital is acquired and the new owner(s) reject assignment of the previous owner's Medicare provider agreement. This also applies to an acquisition that is followed by a merger.</li> </ul>	<p>The representative of the IRF hospital that has undergone a merger, must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded rehabilitation hospital.</p>			
A3607	<p>(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF,</p>	<ul style="list-style-type: none"> <li>• Review the hospital's procedures, or other alternative documents or records, to verify the hospital has a preadmission screening procedure in place.</li> <li>• A review of the clinical records should indicate whether the IRF is using the screening procedure.</li> </ul>	<p>The representative will ensure the hospital is using the preadmission screening procedure on all patients admitted to the rehab hospital.</p>			
A3608	<p>(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.</p>	<ul style="list-style-type: none"> <li>• As part of the clinical record review, look for documentation supporting the physician visits.</li> <li>• Review the hospital's procedures or other alternative documents or records to verify the hospital has a procedure detailing close medical supervision for patients.</li> </ul>	<p>The representative will ensure the rehabilitation hospital has a procedure or other alternative documents or records verifying the hospital has a procedure detailing close medical supervision that includes the rehabilitation physician making at least 3 face-to-face visits per week.</p>			

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A3609	(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy; plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.	<ul style="list-style-type: none"> <li>Review the licenses of all qualified personnel, that are required by the State to be licensed, to verify the licenses are up-to-date.</li> <li>Qualified personnel would include either personnel that are licensed in the State in which the services are provided or those personnel that are recognized under reciprocity by the State in which the services are provided.</li> <li>Determine if the hospital has and follows a procedure to evaluate and document that personnel are qualified and that those personnel maintain their qualifications.</li> </ul>	The representative verifies that all qualified personnel, that are required by the State to be licensed, have licenses that are up-to-date.			
A3610	(g) Have a director of rehabilitation who-	Verifies the rehab hospital has a director of rehabilitation by reviewing by reviewing personnel logs or rosters and organization charts.	The representative will verify that the rehab hospital has a physician Director of Rehabilitation.			
A3611	(1) Provides services to the IRF hospital and its inpatients on a full-time basis.	<ul style="list-style-type: none"> <li>The hospital will define the term "full-time" as it applies to all of its employees,</li> <li>The full time hours may be any combination of patient services and administration.</li> <li>A director of rehabilitation hours cannot be substituted by a Physician Assistant,</li> <li>Verify the full time hours through review of personnel time cards/logs, etc."</li> </ul>	The representative will verify that the physician is full time providing a combination of patient services and administration.			
A3612	(2) Is a doctor of medicine or osteopathy;	Review the physician's license to verify the physician is an MD or DO.	The representative will review the physician's license to ensure the physician is a MD or DO.			
A3613	(3) Is licensed under State law to practice medicine or surgery;	Surveyor will verify the physician has a current license issued by the State, as appropriate.	The representative verifies the physician's license is current.			
A3614	(4) Has had, after completing a 1-year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.	Review personnel and/or credentialing files to verify the physician's training and experience complies with the regulation.	The representative reviews the director of rehabilitation's level of training and experience.			

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A3615	(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	<ul style="list-style-type: none"> <li>• Conduct a clinical record review to verify that each IRF patient has a plan of treatment and that the plans are updated whenever there is a change in the patient's condition.</li> <li>• The plan of treatment should include the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay.</li> <li>• The anticipated interventions detailed in the overall plan of care should include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.</li> </ul>	The representative verifies that the rehabilitation hospital has patient plans of treatment.			
A3616	(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans; and that team conferences are held at least once per week to determine the appropriateness of treatment.	<ul style="list-style-type: none"> <li>• Review clinical records to determine whether the interdisciplinary team is meeting once a week to review patient progress toward goal attainment and discharge planning.</li> <li>• Determine if the documentation complies with the regulatory requirement.</li> </ul>	The representative will determine whether interdisciplinary teams are meeting once weekly to review patient progress and that documentation is in the medical records.			
A3617	UI Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in § 412.1(a)(1) and paid under the prospective payment system specified in § 412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in § 412.130.	If the new IRF's inpatient population doesn't meet the 60% rule, the IRF will lose its IPPS exclusionary status. The RO will send notification to the facility prior to the beginning of the next cost report period that the facility has lost its IPPS excluded status and will revert to acute care hospital status.				

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0986. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

## COMMENTS