

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) *Weighting factors*—(1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire.* We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities.* We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors.* We may periodically adjust the case-mix groups and weighting factors to reflect changes in—

- (1) Treatment patterns;
- (2) Technology;
- (3) Number of discharges; and
- (4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, inpatient

rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.75 and 413.85 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

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§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 of this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included

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in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates—(1) General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects,

as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard payment conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(5) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under § 412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(4) *Payment adjustment for Federal fiscal year 2006 and applicable Federal fiscal*

years. CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (e)(3), (e)(4) and (e)(7), of this section, and to any revision specified in §412.620(c) by a factor as specified by the Secretary.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in §412.602. 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. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

(2) *Adjustments for low-income patients.* We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) *Adjustments for rural areas.* We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in §412.602.

(4) *Adjustments for teaching hospitals.* For discharges on or after October 1, 2005, CMS adjusts the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions. This adjustment is made on a claim basis as an in-

terim payment and the final payment in full for the claim is made during the final settlement of the cost report.

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at §412.84(i), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio and national averages that will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at §412.84(m), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio.

(6) *Adjustments related to the patient assessment instrument.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made, as specified under §412.614(d), if the transmission of data from a patient assessment instrument is late.

(7) Adjustments for certain facilities geographically redesignated in FY 2006. (i) *General.* For a facility defined as an urban facility under §412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under §412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY 2006 and it no longer qualified for the rural adjustment under §412.624(e)(3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before

September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) *Exception.* For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e)(7)(i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under § 412.624(e)(3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e)(7)(i)(A) and (e)(7)(i)(B) of this section as determined by us.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in § 412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustments described in paragraphs (e)(1), (e)(2), (e)(3), (e)(4), and (e)(7) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount.

(g) *Special payment provision for interrupted stays.* When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in § 412.602 and as indicated on the patient assessment instrument in accordance with § 412.618(b), we will make payments in the following manner:

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under § 412.602, will be—

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in § 412.1(a)(1) made to the acute care hospital.

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