

FIM data) such as surgical procedures performed during the preceding acute care stay, the principal diagnosis of the acute care stay, and all the diagnoses for the rehabilitation stay, the length of stay, and the type of facility the beneficiary may be transferred to after the rehabilitation stay. Using these facility and case characteristics, we estimated the CMI. We then combined these CMI estimates with the CMIs derived from those cases for which we had matching bill and FIM data and we calculated the budget neutral conversion factor using the methodology described in the proposed rule and in this final rule.

By using these estimated CMIs, the data used to construct the budget neutral conversion factor better represents IRFS. The overall effect of using more data in the construction of the budget neutral conversion factor is an increase of 1.0 percent. The majority of this increase occurs because IRFs are less likely to report FIM data for very short stay cases.

In summary, in this final rule, we specify under § 412.624(a)(1) the data sources used to construct the budget neutral conversion factor (the basis for the prospective payment). For this final rule, the latest available data include the cost report data from FYs 1996, 1997, and 1998 and calendar year 1998 and 1999 Medicare claims with corresponding FIM data. We used data from 1,024 facilities to calculate the budget neutral conversion factor.

The steps below describe the methodology we used to calculate the budget neutral conversion factor for the payment rates set forth in this final rule.

Step 1—Update the latest operating and capital cost report data to the midpoint of fiscal year 2002.

Section 1886(j)(3)(A)(i) of the Act and § 412.624(b) of these final regulations specify that the per-payment-unit amount is to be updated to the midpoint of the fiscal year 2001, using the weighted average of the applicable percentage increases provided under section 1886(b)(3)(B)(ii) of the Act. The statute allows us more discretion in determining an appropriate methodology to update from the years 2000 to 2001. For this final rule, under § 412.624(c)(2), we update from the midpoint of the year 2001 to the midpoint of the year 2002 using the same methodology provided under section 1886(b)(3)(B)(ii) of the Act. For this final rule, as in the proposed rule, we determine the appropriate update factor for each facility by using one of the following four methodologies:

- For facilities with costs that equal or exceed their target amounts by 10

percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase.

- For facilities that exceed their target by less than 10 percent, the update factor is equal to the market basket minus .25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0).

- For facilities that are at or below their target but exceed two-thirds of the target amount, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0).

- For facilities that do not exceed two-thirds of their target amount, the update factor is 0 percent.

Step 2—Estimate total payments under the current payment system.

Operating payments are calculated using the following methodology:

Step 2a—We determine the facility-specific target amount, subject to the applicable cap on the target amounts for rehabilitation facilities. There are two national caps for rehabilitation facilities. We used the cap amounts for excluded rehabilitation hospitals and units published in the August 1, 2000 **Federal Register** (65 FR 47096). For facilities certified before October 1, 1997, the applicable cap for FY 2001 is \$15,164 for the labor-related share, adjusted by the appropriate geographic wage index and added to \$6,029 for the nonlabor-related share. For facilities certified on or after October 1, 1997, the cap applicable for FY 2001 is \$13,002 for the labor-related share, adjusted by the appropriate geographic wage index and added to \$5,169 for the nonlabor-related share (65 FR 47098). We then inflate these amounts to the midpoint of the year 2002 by applying the excluded hospital operating market basket.

Step 2b—We calculate the lower of the results of Step 2a.

- The facility-specific target amount (including application of the cap) times the Medicare discharges (the ceiling); or

- The facility average operating cost per case times Medicare discharges. We determine payment for operating costs by using one of the following methods:

(1) For facilities whose operating costs are lower than or equal to the ceiling, payment is the lower of either the operating costs plus 15 percent of the difference between the operating costs and the ceiling, or the operating costs plus 2 percent of the ceiling.

(2) For facilities whose operating costs are more than 110 percent of the ceiling, payment is the lower of either the ceiling multiplied by 1.10 or half of the difference between 110 percent of the ceiling and the operating costs.

(3) For facilities whose operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment is the ceiling.

Step 2c—After operating payments are computed, we determine capital payments. As we previously stated in step 1, capital cost report data are updated to the midpoint of FY 2002. Section 4412 of the BBA amended section 1886(g) of the Act by reducing capital payments that would otherwise be made for rehabilitation facilities. Payments for capital-related costs are made on a reasonable cost basis. The BBA mandated the reduction of capital payments by 15 percent. Therefore, we reduce capital payments for IRFs multiplying the costs by .85.

Step 2d—The next step in determining total payments under the current payment system is to add operating and capital payments. Section 1886(j)(1)(A) of the Act specifies that the IRF prospective payment system will include both operating and capital-related costs. Once we determine appropriate payments for operating costs (including bonus and penalty payments as appropriate), and after making reductions for capital payments, we add the operating costs and the reduced capital-related costs together.

Step 2e—The BIPA provides for the Secretary to adjust the rates so that the amount of total payments to IRFs are projected to equal payments that would have been paid in the absence of this new payment methodology. Payments made for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 are based on both the facility-specific payment and the Federal prospective payment that we implement with this final rule.

Therefore, in accordance with § 412.624(d)(2) in this final rule, we adjust the Federal prospective payment rates for FY 2002 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to IRFs had the IRF prospective payment system not been implemented. However, under the amendments made by section 305(b) of BIPA, in calculating the budget neutrality adjustment, we do not take into account payment adjustments resulting from elections by hospitals under section 1886(j)(1)(F) of the Act (as added by section 305(b)(1)(C) of BIPA) to not be paid under the transition period methodology described in section VI.H. of this final rule. In addition, we adjust total estimated payments to reflect the estimated proportion of additional outlier payments under § 412.624(d)(1), and for coding and classification

changes under § 412.624(d)(3). These payments are the numerator of the equation used to calculate the budget neutral adjustment.

Step 3—Calculate the average weighted payment per discharge amount under the excluded hospital payment system.

Once we calculate total payments under the excluded hospital payment system, we can then calculate an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system. We do this by first determining the average payment per discharge amount under the excluded hospital payment system for each facility. We use cost report data to calculate each facility's average payment per discharge by dividing the number of discharges into the total payments. The next step is to determine the weighted average per discharge payment amount. To calculate this amount, we multiply the number of discharges from the Medicare bills by each facility's average payment per discharge amount. We then sum the amounts for all facilities and divide by the total number of discharges from the Medicare bills to derive an average payment per discharge amount that is weighted by the number of Medicare discharges.

Step 4—Estimate payments under the IRF prospective payment system without a budget neutral adjustment.

We then simulate payments under the IRF prospective payment system without a budget neutral adjustment. To do this, we multiply the following: each facility's CMI, the number of discharges from the Medicare bills, the appropriate wage index, the rural adjustment (if applicable), an appropriate LIP adjustment, and the weighted average per discharge payment amount computed in Step 3. We then add together the total payments for each facility. This total is the denominator in the calculation of the budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor.

The denominator of the budget neutral adjustment equation is the total estimated payments for the prospective payment system without a budget neutral adjustment (the total amount calculated in Step 4). We calculate the budget neutral adjustment by dividing total reduced payments under the excluded hospital payment system (the total amount calculated in Step 2) by estimated payments for the prospective payment system implemented with this final rule. We then multiply the resulting budget neutral adjustment by the average weighted per discharge

payment amount under the excluded hospital payment system to derive the budget neutral conversion factor.

Comment: A few commenters suggested that the proposed budget neutral conversion factor was too low.

Response: As explained in the proposed rule, the conversion factor is the payment amount adjusted for budget neutrality and standardized to account for a number of facility-level and case-level adjustments. Because the adjustments in this final rule reflect modifications from the proposed rule (specifically the LIP adjustment), the budget neutral conversion factor is higher compared to the proposed budget neutral conversion factor. We further adjust the budget neutral conversion factor to include a behavioral offset in order to calculate the final budget neutral conversion factor.

As previously stated, to calculate the budget neutral conversion factor, we had to estimate what would have been paid under the excluded hospital payment system. However, due to the incentives for premature discharge inherent in the new IRF prospective payment system, we expect that differences in the utilization of these services might result. In the case of the IRF prospective payment system implemented with this final rule, discharges to other settings of care may take place earlier than under the excluded hospital payment system due to payments based on average costs. This would result in lower payments under that payment system for this care, which must be taken into account when computing budget neutral payment rates. Accounting for this effect through an adjustment is commonly known as a behavioral offset.

For this final rule, the budget neutral conversion factor with a behavioral offset is \$11,838.00. This represents a 1.16 percent reduction in the calculation of the budget neutral conversion factor otherwise calculated under the methodology described in this section VI.E. of this final rule. In determining this adjustment, we actuarially assumed that the IRFs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with CMG or home health care at any point. We applied this actuarial assumption, which was based on consideration of our historical experience with new payment systems, to the estimated "losses" and "gains" among the IRFs.

Comment: Some commenters were concerned about the inclusion of the reduction to the budget neutral conversion factor (the behavioral offset)

and suggested that the reduction be removed in the final calculation of the IRF prospective payments. For example, the commenters advanced various reasons for eliminating the offset, including the perception that the reduction penalizes efficient providers and the concern that the offset further reduces facility revenues to offset the costs of implementing the MDS-PAC.

Response: We apply the behavioral offset as a reduction to the budget neutral conversion factor before applying all case-level and facility-level adjustments to determine a final payment amount. For this final rule, the behavioral offset is very low, at 1.16 percent and represents an integral part of the budget neutrality system. The justification for including an offset relates to the inherent incentives of a discharged-based prospective payment system. Because the prospective payment system bases payment rates on average costs for clinically similar cases, it will be more profitable for facilities to discharge patients earlier than under the excluded hospital cost-based payment system. We have identified the length of stay of a case as an important variable in predicting the costs of the case. Reductions in length of stay will reduce costs for the facilities while Medicare, in the absence of a behavioral offset, would continue to pay based on lengths of stay and rehabilitation services provided prior to the IRF prospective payment system. Our application of this adjustment is consistent with Section 1886(j)(3)(B) of the Act. This provision requires the Secretary, in establishing budget neutral rates, to consider the effects of the new payment system on utilization and other factors reflected in the composition of Medicare payments. Although one of the primary purposes of a prospective payment system is to provide incentives to be efficient, historic reductions in length of stay after a prospective payment system is implemented indicate the need to reduce the budget neutral conversion factor further. The purpose of the budget neutrality provision is to pay the same amount under the prospective payment system as would have been paid under the excluded hospital cost-based payment system for a given set of services, but not to pay that same amount for fewer services furnished as a result of the inherent incentives of the new prospective payment system. Thus, our methodology must account for the change in practice patterns due to new incentives in order to maintain a budget neutral payment system.

Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while

still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral offset. Thus, the purpose of the offset is not just to account for the behavior of inefficient providers but also to account for the behavior of other providers who, due to the new incentives, provide more efficient care. Since providing more efficient care would have lowered reimbursement under the old payment system, the offset does not just account for inefficient behavior, but also accounts for what the costs will be under the new payment system as compared to the old one. For these reasons, we believe that such a minimal behavioral offset will not adversely affect efficient providers.

Prior to BIPA, section 1886(j)(3)(B) of the Act specified that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and 1886(j)(6) of the Act, must be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital-related costs of rehabilitation facilities had section 1886(j) of the Act not been enacted. Section 305(a) of BIPA amended section 1886(j)(3)(B) of the Act to delete the 2-percent reduction of the budget neutrality provision for FY 2002. This statutory change results in higher payment rates for IRFs; these additional monies can be used by IRFs to better assist them with the costs associated

with completing patient assessment instruments.

As we previously discussed, we believe including a behavioral offset is appropriate to ensure a budget neutral payment system for the IRF prospective payment system. We derived the low behavioral offset of the IRF prospective payment system through careful consideration of many factors, including the estimated impacts among the facilities and the analysis of the incentives inherent in the new payment system, as well as the recognition that, as more prospective payment systems evolve, there is a reduction in the extent to which providers can modify their behavior to influence payment.

In summary, in this final rule, we are maintaining the methodology used to calculate the behavioral offset as specified in the proposed rule.

F. Development of the Federal Prospective Payment

Once we calculate the relative weights for each CMG and the budget neutral conversion factor, we can determine the Federal prospective payments. In accordance with § 412.624(c)(4) of these final regulations, we calculate these CMG payments by multiplying the budget neutral conversion factor by each of the CMG relative weights. The equation is as follows:

$$\text{Federal Prospective Payment} = \text{CMG Relative Weight} \times \text{Budget Neutral Conversion Factor}$$

Table 2 in the Addendum to this final rule displays the CMGs, the comorbidity

tiers, and the corresponding Federal prospective payments.

G. Examples of Computing the Adjusted Facility Prospective Payments

We will adjust the Federal prospective payments, described above, to account for geographic wage variation, low-income patients and, if applicable, facilities located in rural areas.

To illustrate the methodology that we will use for adjusting the Federal prospective payments, we provide the following example. One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A's DSH is 5 percent, with a LIP adjustment of 1.0239 and a wage index of 0.987, and the facility is located in a rural area. Rehabilitation facility B's DSH is 15 percent, with a LIP adjustment of 1.0700 and a wage index of 1.234, and the facility is located in an urban area. Both Medicare beneficiaries are classified to CMG 0111 (without comorbidities). This CMG represents a stroke with motor scores in the 27 to 33 range and the patient is between 82 and 88 years old. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment and the rural adjustment (if applicable). The following table illustrates the components of the adjusted payment calculation.

EXAMPLES OF COMPUTING A FACILITY'S FEDERAL PROSPECTIVE PAYMENT

	Facility A	Facility B
Federal Prospective Payment	\$20,033.81	\$20,033.81
Labor Share	× .72395	× .72395
Labor Portion of Federal Payment	= \$14,503.48	= \$14,503.48
Wage Index	× 0.987	× 1.234
Wage Adjusted Amount	= \$14,314.93	\$17,897.29
Non-Labor Amount	+ \$5,530.33	+ \$5,530.33
Wage Adjusted Federal Payment	\$19,845.26	\$23,427.62
Rural Adjustment	× 1.1914	× 1.000.0
Subtotal	23,643.65	= \$23,427.62
DSH Adjustment	× 1.0239	× 1.070
Total Adjusted Federal Prospective Payment	\$24,208.73	\$25,067.56

Thus, the adjusted payment for facility A will be \$24,208.73 and the adjusted payment for facility B will be \$25,067.56.

H. Computing Total Payments Under the IRF Prospective Payment System

Under the BBA, section 1886(j)(1) of the Act describes how to compute a facility's payment during a transition period. Under the transition period, the prospective payment amount consists of

a portion of the amount the facility would have been paid if the prospective payment system had not been implemented (facility-specific payment) and a portion of the adjusted facility Federal prospective payment. The transition period specifically covers cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003. During the first transition period, for cost reporting periods beginning on or after October 1, 2000 and before

October 1, 2001 (FY 2001), payment would consist of 66⅔ percent of the amount of the facility-specific payment and 33⅓ percent of the IRF adjusted facility Federal prospective payment. During the second transition period, for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002 (FY 2002), payment would consist of 33⅓ percent of the amount of the facility-specific payment and 66⅔ percent of the IRF adjusted facility

Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), payment would be 100 percent of the adjusted facility Federal prospective payment.

Section 305(b)(1)(C) of the BIPA added section 1886(j)(1)(F) to the Act, which allows an IRF to elect to be paid 100 percent of the adjusted facility Federal prospective payment for each cost reporting period to which the blended payment methodology would otherwise apply. This provision of the BIPA is effective as though it were included in the enactment of the BBA.

1. Payments Based on the Transition Period for Cost Reporting Periods Beginning During FY 2002

In the proposed rule, we described how the application of the transition period percentages would be affected by the delay in implementation of the IRF prospective payment system. Specifically, as proposed, a facility with a cost reporting period beginning on or after October 1, 2000 and before April 1, 2001 (the planned implementation date as stated in the proposed rule) would not be paid under the IRF prospective payment system for that cost reporting period. For a facility with a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the prospective payment during that period would be comprised of the blended rate for FY 2001 as specified by the statute (66 $\frac{2}{3}$ percent of the facility specific payment and 33 $\frac{1}{3}$ percent of the adjusted facility Federal prospective payment). For a facility with a cost reporting period beginning on or after October 1, 2001 and before October 1, 2002 (FY 2002), the prospective payment during that period would be comprised of the blended rate for FY 2002 as specified by the statute (33 $\frac{1}{3}$ percent of the facility specific payment and 66 $\frac{2}{3}$ percent of the adjusted facility Federal prospective payment). For cost reporting periods beginning on or after October 1, 2002, the prospective payment would be 100 percent of the adjusted facility Federal prospective payment.

Comment: Many commenters suggested that it would be unfair for the transition period to apply to two cost reporting periods for some facilities while other facilities have the transition period apply to only one cost reporting period. In addition, some commenters believed that the law intended for all facilities to be afforded a 2-year transition period.

Response: We recognize that the statute contemplated a 2-year transition period, but the statute (at section 1886(j)(1)(B) of the Act) also provides

that the IRF prospective payment system must be fully implemented for cost reporting periods beginning on or after October 1, 2002. In other words, the statute provides that, for cost reporting periods beginning on or after October 1, 2002, payment will no longer be based on a blend of the Federal prospective payment and the facility-specific payment. As stated earlier, the earliest feasible date for implementation of the IRF prospective payment system is for cost reporting periods beginning on or after January 1, 2002, and we are adhering to the statutory payment formula applicable beginning January 1, 2002.

We recognize that the delayed implementation of the IRF prospective payment system means that hospitals will be paid under the blend methodology for a period of less than 2 years (under section 1886(d)(1)(F) of the Act, as added by section 305 of Public Law 106-554, hospitals may elect to not be paid under the blend methodology at all). But we believe that a shortened transition period caused by a delay in implementation of the IRF prospective payment system is not inequitable. One purpose of the transition period is to give hospitals time to adjust before a prospective payment system is fully implemented. Hospitals have been on notice since the enactment of Public Law 105-33 that the IRF prospective payment system would be fully implemented for cost reporting period beginning on or after October 1, 2002. We did not shorten the timetable for full implementation of the prospective payment system payment rates, and hospitals have had ample time to prepare. Also, we note that, presumably, hospitals that would be "disadvantaged" by a shortened transition period (hospitals whose facility-specific rate is higher than the Federal prospective payment rate) have been "advantaged" by the delay in implementation.

Accordingly, we are adhering to the statutory payment formula applicable for cost reporting periods beginning on January 1, 2002. In § 412.626(a)(1)(i) of this final rule, we are specifying that payment to an IRF for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 consists of 33 $\frac{1}{3}$ percent of the facility-specific payment and 66 $\frac{2}{3}$ percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payment will be based entirely on the Federal prospective payment.

2. Payments Based on the Election To Apply the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2002

Under § 412.626(b) of the final regulations, we are specifying that a provider may elect not to be paid under the transition period described in section VI.H.I. above. Payment to IRFs making this election will be based on 100 percent of the adjusted Federal prospective payment in effect for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

An IRF must request this election no later than 30 days before the start of its first cost reporting period for which payment is based on the IRF prospective payment system. The IRF must make its request in writing to its Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the start of the cost reporting period, regardless of any postmarks or anticipated delivery dates. Requests received (whether mailed or delivered by other means) later than the 30th day before the cost reporting period will not be approved. If the 30th day before the start of the cost reporting period falls on a day on which the postal service or other delivery sources are not open for business, the IRF is responsible to ensure that enough time is allowed for the delivery of the request before the deadline. If an IRF's request is not received timely or is otherwise not approved, payment will be based on the transition period methodology.

3. Payments Based on the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2003 and After

Under § 412.626(a)(1)(ii) of the final regulations, we are specifying that payment made to IRFs with cost reporting periods beginning on or after October 1, 2002 (FY 2003 and after) will consist of 100 percent of the adjusted Federal prospective payment. We described the basis of payments made for fiscal years after FY 2002 in § 412.624 of the final regulations.

I. Method of Payment

We will base a beneficiary's classification into a CMG on data obtained during the initial patient assessment. The CMG will determine the Federal prospective payment that the IRF receives for the Medicare-covered Part-A services furnished during the Medicare beneficiary's episode of care. However, under § 412.632(a) of these final regulations, the payment arises from the submission

of a discharge bill. This will allow us to pay for comorbidities diagnosed during the stay, classify cases appropriately to one of the five special CMGs (for cases in which the patient expires or has a very short length of stay), adjust the payment to reflect an early transfer, and determine if the case qualifies for an outlier payment. Accordingly, the IRF will record the CMG and other information on the beneficiary's discharge bill, and will submit the bill to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under § 412.622(b) of these final regulations, for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors provided to patients with hemophilia, or other costs not paid for under the IRF prospective payment system.

Under the existing payment system, (1) an IRF may be paid using the periodic interim payment (PIP) method described in § 413.64(h) of the existing regulations; (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under existing § 412.116(b); (3) IRFs may be eligible to receive accelerated payments as described in existing § 413.64(g); or (4) rehabilitation units are eligible for accelerated payments under existing § 412.116(f). The statute does not preclude the continuation of PIP. We presently see no reason to discontinue our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, although we may choose to evaluate its continuing need in the future. Therefore, we will permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at paragraphs (b) and (e) of § 412.632 of the final regulations.

For those services paid under the PIP method, the amount reflects the estimated prospective payments for the year rather than estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in § 412.632 and receives approval by its intermediary. Similarly, if an intermediary determines that an IRF that received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in § 412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to

whether making payment under the PIP method would not entail undue risk of resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the existing regulations at § 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method, it may qualify to receive an accelerated payment. Under § 412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF, or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. The IRF must make a request for an accelerated payment, which is subject to approval by the intermediary and by us. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment occurs as bills are processed or through direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under § 412.624(c)(3)(ii) of the final regulations, future updates, for FY 2003 and subsequent fiscal years, to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which the IRF prospective payment system makes payment. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. We include in Appendix D of this final rule a description of the IRF market basket that we used in developing an increase factor under section 1886(j)(3)(C) of the Act.

K. Publication of the Federal Prospective Payment Rates

In accordance with section 1886(j)(5) of the Act, we will publish in the **Federal Register**, on or before August 1 prior to the beginning of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective

payment rates for that fiscal year (§ 412.628 of these final regulations).

L. Limitation on Administrative or Judicial Review

In accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are specifying under § 412.630 of these final regulations that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

VII. Provisions of the Final Regulations

After careful consideration of the public comments received on the November 3, 2000 proposed rule, we are adopting as final, with the modifications discussed throughout this preamble and summarized below, the proposed regulations set forth in 42 CFR Part 412, Subpart P, to implement the prospective payment system for IRFs, and the proposed technical and conforming changes to §§ 412.1, 412.20, 412.22, 412.23, 412.25, 412.29, 412.116, 412.130, 413.1, 413.40, and 413.64. The table of contents for Subpart P is as follows:

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

Sec.	
412.600	Basis and scope of subpart.
412.602	Definitions.
412.604	Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.
412.606	Patient assessment.
412.608	Patients' rights regarding the collection of patient assessment data.
412.610	Assessment schedule.
412.612	Coordination of the collection of patient assessment data.
412.614	Transmission of patient assessment data.
412.616	Release of information collected using the patient assessment instrument.
412.618	Assessment process for interrupted stays.
412.620	Patient classification system.
412.622	Basis of payment.
412.624	Methodology for calculating the Federal prospective payment rates.
412.626	Transition period.
412.628	Publication of the Federal prospective payment rates.
412.630	Limitation on review.
412.632	Method of payment under the inpatient rehabilitation facility prospective payment system.

- Throughout Subpart P and in §§ 412.1, 412.20, 412.116, 412.130,

413.1, and 413.40, we are changing the date and any related references for implementation of the IRF prospective payment system from "April 1, 2001" to "January 1, 2002". Effective for cost reporting periods beginning on or after January 1, 2002, IRFs must meet the conditions specified in the Subpart P for payment of all covered inpatient hospital services furnished to beneficiaries under the IRF prospective payment system.

- Throughout Subpart P, we are changing all references to the MDS-PAC to either the CMS inpatient rehabilitation facility patient assessment instrument or deleting reference to the MDS-PAC, as appropriate, including deletion of the definition in § 412.602. We are adding a new definition of "patient assessment instrument" to conform to the replacement of the MDS-PAC.

- Use of Authorized Clinician in Patient Assessments (§§ 412.602—Definitions; 412.606—Patient assessment; 412.608—Patients' rights regarding the collection of patient assessment data; and 412.612—Coordination of the collection of patient assessment data). As explained in section IV.A.3. of this final rule, we are deleting the definition of "authorized clinician" in proposed § 412.602. In addition, we are revising proposed §§ 412.606(c) and 412.612 to specify that any IRF clinician may perform the patient assessment and any clinician who is employed or contracted by the IRF and who is trained on how to conduct a patient assessment using our inpatient rehabilitation facility patient assessment instrument may complete items on the assessment instrument. We are deleting the provisions under proposed §§ 412.606(c)(4) and 412.612(b) and (c) that an authorized clinician must sign the patient assessment instrument attesting to its completion and accuracy. We are revising proposed § 412.606(c)(3) to clarify one of the other sources, in addition to direct patient observation, from which patient data may be obtained for the assessment process when appropriate and to the extent feasible. We are deleting the "friends" source and adding instead "someone personally knowledgeable about the patient's clinical condition or capabilities".

We are revising proposed § 412.612(d) (§ 412.612(b) in this final rule) to specify that a person who knowingly and willfully completes or causes another person to complete a false patient assessment is subject to a civil money penalty. We are making conforming changes to proposed § 412.608 to

indicate that an IRF clinician must inform inpatients of their patient rights relating to the collection of patient assessment data.

- Patient Assessment Schedule and Data Transmission (§§ 412.602—Definitions; 412.610—Assessment schedule; 412.614—Transmission of patient assessment data; and 412.624—Methodology for calculating the Federal prospective payment rates). We are revising proposed §§ 412.610(c) to specify that the patient assessment instrument is to be completed only twice, at the time of the patient's admission and at discharge. We are revising the definition of "discharge" in § 412.602 to add a provision that a Medicare patient in an IRF is also considered discharged when the patient stops receiving Medicare-covered Part A inpatient rehabilitation services.

In addition, we are specifying the time period the admission assessment must cover; the assessment reference date for the admission and discharge assessments; and the dates by which the admission and discharge assessments must be completed. As conforming changes, we are revising the definition of "assessment reference date" in proposed § 412.602; we are deleting the contents of proposed § 412.610(d), which described the late assessment reference dates and related penalties for late completion of the patient assessment, which are no longer applicable; and we are deleting from proposed § 412.610(e) the provisions on assessment completion dates, which are now specified in § 412.610(c).

We are revising proposed § 412.610(e) (paragraph (d) in this final rule) to specify that admission and discharge assessments must be encoded by the 7th calendar day from the applicable assessment completion dates. (As conforming changes, proposed §§ 412.610(f) and (g) are now §§ 412.610(e) and (f), respectively.)

We are revising proposed § 412.614(c) to specify data transmission dates to us that are adjusted to reflect changes in the completion dates for admission and discharge assessments and for encoding data under §§ 412.610(c) and (d).

We are revising proposed § 412.614(d)(2) to specify the date by which transmission of the assessment data is considered late (late transmission means more than 10 days after the 7th calendar day in the period beginning with the last permitted patient assessment encoding date) and to modify the penalties associated with late transmission of the patient assessment data. We also are revising proposed § 412.624(e)(5) to specify the adjustment to the prospective payment

to the IRF for late transmission of patient assessment data to reflect the provisions in § 412.614(d)(2).

These changes from the proposed rule are discussed in detail in sections IV.B. and IV.D. of this preamble.

- Interrupted Stays (§§ 412.602—Definitions; 412.618—Assessment process for interrupted stays; and 412.624—Methodology for calculating the prospective payment rates). We are revising the proposed definition of "interrupted stay" in proposed § 412.602 to clarify that an interruption in a stay in an IRF is 3 consecutive calendar days that begins with the day of discharge and ends at midnight of the third day.

We are revising proposed §§ 412.618(a)(1) and (a)(3) (paragraphs (a)(1) and (a)(2) in this final rule) to specify that the initial case-mix classification from the admission assessment remains in effect during the interrupted stay(s); and to specify that a discharge assessment must be completed when the patient stay (that includes one or more interrupted stays) is completed. We are deleting proposed § 412.618(a)(2), which referenced the proposed multiple patient assessments that we are not adopting in this final rule; and deleting proposed § 412.618(c), which discussed the transmission of data from the interrupted stay tracking form.

In addition, we are revising proposed § 412.618(d)(1) through (d)(4) (paragraphs (c)(1) and (c)(2) in this final rule) to specify the adjustment to dates to be used if an interrupted stay occurs before the patient admission assessment is completed or after the admission assessment is completed but before the discharge assessment is completed.

We are adding new § 412.624(g) to codify in this regulation text the policy on the adjustment to the IRF prospective payment for interrupted stays.

These changes from the proposed rule are discussed in detail in sections IV.D. and VI.C.3. of this preamble.

- Patient Classification (§ 412.620—Patient classification system). We are revising proposed § 412.620(a)(3) to specify that we will use the data from the admission assessment to classify the patient into the appropriate case-mix group as opposed to proposed data from the Day 4 assessment (the assessment schedule has been revised to specify only two assessments as discussed earlier).

We are adding a definition of "comorbidity" in § 412.602 and adding new paragraphs (a)(4) and (b)(4) under § 412.620 to specify that we will determine a weighting factor(s) to account for the presence of a

comorbidity that is relevant to resource use in the classification system in determining payment rates under the IRF prospective payment system, and that we will use data from the discharge assessment to determine this weighting factor. These changes are discussed in detail in section VI.A. of the preamble in relation to our use in this final rule of a 3-tiered approach to determining adjustments in payment rates for CMGs based on differences in costs among relevant comorbidities.

- **Payment Rates (§ 412.624—Methodology for calculating the prospective payment rates).** We are revising the budget neutrality provision of proposed § 412.624(d)(2) to reflect the deletion of the 2-percent reduction as specified in section 305(a) of BIPA.

We are revising proposed § 412.624(e) to specify that the prospective payment rate for each IRF discharge will be based on whether the IRF's cost reporting period begins on or after January 1, 2002 and before October 1, 2002 or begins after October 1, 2002.

We are revising proposed §§ 412.624(f)(2)(ii) and (f)(2)(iii) (paragraph (f)(2)(v) in this final rule) and adding new §§ 412.624(f)(2)(iii) and (f)(2)(iv) to specify the adjustment to the prospective payment to the IRF for patients who are transferred to another site of care.

These changes from the proposed rule are discussed in detail in sections VI.B., VI.D., and VI.E. of this preamble.

- **Transition Period (§§ 412.622—Basis of payment and 412.626—Transition period).** We are revising proposed §§ 412.622(a)(2) and 412.626(a)(1) and adding new § 412.626(b) to reflect the provisions under section 305(b) of BIPA that provide that, during the transition period, facilities may elect to be paid the full prospective payment rather than the payment determined under the transition period methodology.

These changes from the proposed rule are discussed in detail in section VI.H. of this preamble.

Technical Changes

- **Noncovered Items and Services (§ 412.604—Conditions for payment under the prospective payment system for inpatient rehabilitation facilities).** We are revising proposed § 412.604(d) to specify that in addition to the applicable deductible and coinsurance amounts, a facility may charge Medicare beneficiaries and other individuals on their behalf only for items and services as provided under existing regulations at § 489.20(a).

We are revising proposed § 412.604(e)(1) to conform it to the

provisions of existing § 412.50 which lists the types of services that are not included as inpatient hospital services.

We also are adding to § 412.604(e)(1) a citation to the provisions of § 412.622(b) to clarify that payments for certain services are not included in the full prospective payment to IRFs for inpatient rehabilitation services (that is, payment for approved educational activities, bad debts, and blood clotting factors).

These changes from the proposed rule are discussed in detail in section II.B. of this preamble.

VIII. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandate Reform Act of 1995 (Public Law 104-4), the Regulatory Flexibility Act (RFA) (Public Law 96-354), and Executive Order 13132 (Federalism).

1. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more annually).

We estimate that the impact of this final rule that implements section 1886(j) of the Act will result in a total cost to the Medicare program. Section 305(a) of BIPA eliminated the 2-percent reduction to the budget neutral adjustment. Under the amendments made by section 305(a) of BIPA, then, we set payment amounts under the prospective payment system for FY 2002 so that payments under the IRF prospective payment system for FY 2002 are projected to equal “100 percent * * * of the amount of payments that would have been made under this title * * * for operating and capital costs of rehabilitation facilities had this subsection not been enacted,” but under the amendments made by section 305(b) of BIPA, in calculating the budget neutrality adjustment, we do not take into account payment adjustments resulting from elections by hospitals under section 1886(j)(1)(F) of the Act (as added by section 305(b)(1)(C) of BIPA) to not be paid under the transition period methodology described in section VI.H. of this final rule. Because

elections under section 1886(j)(1)(F) of the Act are not taken into account in calculating the budget adjustment requirement, the implementation of the prospective payment system results in a cost.

Payment to facilities that elect not to be paid under the transition period methodology will be based on 100 percent of the adjusted facility Federal prospective payment in effect for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002. Providers that will be paid more under the IRF prospective payment system than they would have been paid had the system not been in effect will likely elect to be paid based on 100 percent of the Federal prospective payment rate. We estimate that, of the 1024 IRFs used to simulate the impacts among the various classes of IRFs, approximately 48 percent or 496 of these IRFs will elect not to be paid under the transition period methodology. For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, we estimate that the IRF prospective payment system will cost \$60 million, and for FY 2003, the costs will be \$10 million. Because cost reporting periods can begin in one fiscal year and end in the next fiscal year, the FY 2002 estimated costs of \$60 million are associated with the portion of IRF cost reporting periods between January 1, 2002 and September 30, 2002. The FY 2003 estimated costs of \$10 million are associated with the portion of IRF cost reporting periods between October 1, 2002, and September 30, 2003.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze the economic impact of our regulations on small entities. If we determine that the regulation will impose a significant burden on a substantial number of small entities, we must examine options for reducing the burden. For purposes of the RFA, businesses include small businesses, nonprofit organizations, and governmental agencies. Most hospitals are considered small entities, either by nonprofit status or by having receipt of less than \$25 million per year. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary rehabilitation hospitals. Therefore, the analysis that follows is based on all rehabilitation facilities doing business with Medicare. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

3. Unfunded Mandate

Section 202 of the Unfunded Mandate Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least \$110 million. This final rule will not have an effect on the governments mentioned nor will it affect private sector costs.

4. Executive Order 13132

We examined this final rule in accordance with Executive Order 13132 and determined that it will not have any negative impact on the rights, roles, or responsibilities of State, local, or tribal governments.

5. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that will have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

6. Overall Impact

For the reasons stated above, we have prepared an analysis under the RFA and section 1102(b) of the Act because we have determined that this final rule will have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small a rural hospitals. As discussed earlier in this preamble, we are adjusting payments for IRFs located in rural areas. Therefore, the impacts shown below reflect the adjustments that are designed to minimize or eliminate the negative impact that the IRF prospective payment system would otherwise have on rural facilities.

This final rule sets forth the factors used to determine prospective payments under the Medicare program for IRFs. While section 1886(j) of the Act specifies the basic methodology of constructing a case-mix adjusted prospective payment system, the statute does allow us some discretion in designing the key elements of the system, and we did consider alternatives for patient classification methodology based on functional-related groups, and adjustments to the prospective payments. We have included a detailed discussion of these elements and the alternatives that we

considered in sections IV., V., and VI., respectively, of the preamble of this final rule.

B. Anticipated Effects of the Final Rule

We discuss below the impacts of this final rule on the budget and on IRFs.

1. Budgetary Impact

Section 1886(j)(3)(B) of the Act, as amended by section 305(a) of BIPA, requires us to set the payment rates contained in this final rule at levels such that total payments under the IRF prospective payment system are projected to equal the amount that would have been paid for operating and capital-related costs of rehabilitation facilities if this prospective payment system had not been implemented, but under the amendments made by section 305(b) of BIPA, in calculating budget neutrality, we do not take into account elections by facilities to receive the full Federal prospective payment rather than the payment determined under the transition period methodology. We project that implementing the IRF prospective payment system (as amended by section 305(b) of BIPA) for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 will cost the Medicare program \$70 million over 2 years, as follows:
\$60 million for FY 2002
\$10 million for FY 2003

2. Impact on Providers

In order to understand the impact of the new IRF prospective payment system on different categories of facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the prospective payment system as set forth in this final rule (new prospective payments). To estimate the impact among the various classes of IRFs, it is imperative that the estimates of current payments and new prospective payments contain similar inputs. More specifically, we simulate new prospective payments only for those IRFs for which we are able to calculate current payment, and vice versa.

As previously stated in section VI.D. of this preamble, we have both case-mix and cost data for 714 rehabilitation facilities. We used data from these facilities to analyze the appropriateness of various adjustments to the Federal unadjusted payment rates. However, for the impact analyses shown in the following tables, we simulate payments for 1024 facilities. As we previously stated in section VI. of this final rule, we estimate the case-mix index for those IRFs and cases for which we do not

have FIM data to match corresponding Medicare bills. Therefore, in this final rule, we are able to include more facilities in the impact analysis among the various classes of IRFs. Table I below reflect the estimated "losses/gains" among the various classifications of IRFs for cost reporting periods that begin on or after January 1, 2002 and before October 1, 2002. Table II below reflects the estimated "losses/gains" among the various classifications of IRFs for cost reporting periods that begin on or after October 1, 2002 and before October 1, 2003.

3. Calculation of Current Payments

To calculate current payments, we trend cost report data forward from the midpoint of the cost reporting period to the midpoint of FY 2002, using the methodology set forth in section VI.E.2. of this preamble. To estimate current payments, we calculate operating payments for each rehabilitation facility in accordance with section 1886(b) of the Act. Further, we compute capital payments by reducing reasonable costs by 15 percent, consistent with section 1886(g)(4) of the Act, as added by section 4412 of the BBA. To determine each facility's average per discharge payment amount under the current payment system, we add operating and capital-related payments together, and then divide the total payment by the number of Medicare discharges from the cost reports. We compute total payments for each facility by multiplying the number of discharges from the Medicare bills by the average per discharge payment amount.

4. Calculation of New Prospective Payments

To estimate payments under the IRF prospective payment system as set forth in this final rule, we multiply each facility's case-mix index by the facility's number of Medicare discharges, the budget neutral conversion factor, the applicable wage index, a low income patient adjustment, and a rural adjustment (if applicable). We include a detailed description of the following specific adjustments in section VI.D. of the preamble of this final rule.

- The wage adjustment, calculated as follows: $(.27605(.72395 \times \text{Wage Index}))$.
- The disproportionate share adjustment, calculated as follows: $(1 + \text{Disproportionate Share Percentage})$ raised to the power of .4838.
- The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

After calculating the new Federal rate payments for each facility, we blend

together the appropriate percentages of the current payments and the new Federal rate payments to determine the appropriate amount for the first year of implementation of the IRF prospective payment system. Specifically, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 we combine 33 $\frac{1}{3}$ percent of the current payment amount with 66 $\frac{2}{3}$ percent of the new Federal rate payment amount as shown in Table I below. However, for those providers that will receive higher payments under the IRF prospective payment system than they would have if the system had not been

in effect, we simulate their payments in Table I as though they chose not to be paid under the transition payment methodology. (We estimate that 48 percent of the IRFs will elect not to be paid under the transition payment methodology.) For cost reporting periods beginning in FY 2003, we show the impact of the fully phased-in IRF prospective payment amount. All payment simulations reflect data trended to the midpoint of FY 2002. These data were not trended out to the midpoint of FY 2003.

Tables I and II below illustrate the aggregate impact of the new payment

system among various classifications of facilities. The first column, Facility Classifications, identifies the type of facility. The second column identifies the number of cases. The third column lists the number of facilities of each classification type, and the fourth column is the ratio of new prospective payments to current payments. The impact reflects the adjustments that we are making, including the specific geographic wage adjustment, the adjustment for rural facilities (if applicable), and a low-income patient adjustment for all facilities.

TABLE I.—PROJECTED IMPACT REFLECTING 2/3 OF NEW PROSPECTIVE PAYMENTS PLUS 1/3 OF CURRENT PAYMENTS AND OPTION TO DECLINE THE BLENDED PAYMENT METHOD

Facility Classifications	Number of cases	Number of facilities	New payment to current payment ratio
All facilities	347,809	1,024	1.03
Geographic location			
Large Urban	163,970	489	1.04
Other Urban	152,647	392	1.01
Rural	31,192	143	1.03
Region			
New England	15,868	36	1.00
Middle Atlantic	66,466	143	1.05
South Atlantic	59,172	132	1.06
East North Central	60,223	200	1.02
East South Central	27,024	51	1.05
West North Central	21,907	92	1.03
West South Central	59,663	186	0.97
Mountain	15,697	65	1.04
Pacific	21,789	119	1.04
Urban by Region			
Urban-New England	15,039	32	1.01
Urban-Middle Atlantic	64,042	133	1.04
Urban-South Atlantic	52,980	112	1.06
Urban-East North Central	55,071	171	1.02
Urban-East South Central	23,434	41	1.07
Urban-West North Central	18,087	70	1.03
Urban-West South Central	52,346	154	0.96
Urban-Mountain	14,655	56	1.04
Urban-Pacific	20,963	112	1.04
Rural by Region			
Rural-New England	829	4	0.95
Rural-Middle Atlantic	2,424	10	1.16
Rural-South Atlantic	6,192	20	1.09
Rural-East North Central	5,152	29	1.01
Rural-East South Central	3,590	10	0.98
Rural-West North Central	3,820	22	1.04
Rural-West South Central	7,317	32	1.01
Rural-Mountain	1,042	9	1.05
Rural-Pacific	826	7	1.00
Type and Size of Facility			
Unit of acute hospital	233,433	856	1.04
Average Daily Census<10	39,123	289	1.00
Average Daily Census 10–25	122,904	436	1.05
Average Daily Census>25	71,406	131	1.06
Freestanding hospital	114,376	168	0.99
Average Daily Census<25	8,437	36	0.92
Average Daily Census 25–50	41,626	71	0.98
Average Daily Census>50	64,313	61	1.01
Disproportionate Share			
Disproportionate Share<10%	121,046	329	1.05
Disproportionate Share 10%–19%	101,405	261	1.02
Disproportionate Share 20%–29%	24,216	70	1.01
Disproportionate Share>= 30%	14,851	72	1.05
Disproportionate Share Missing	86,291	292	1.01

TABLE I.—PROJECTED IMPACT REFLECTING 2/3 OF NEW PROSPECTIVE PAYMENTS PLUS 1/3 OF CURRENT PAYMENTS AND OPTION TO DECLINE THE BLENDED PAYMENT METHOD—Continued

Facility Classifications	Number of cases	Number of facilities	New payment to current payment ratio
Teaching Status			
Non-Teaching	285,112	872	1.03
Resident to Average Daily Census < 10%	41,944	86	1.02
Resident to Average Daily Census 10%–19%	15,741	38	1.00
Resident to Average Daily Census >19%	5,012	28	1.02
Alaska/Hawaii	991	4	0.99

TABLE II.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS

Facilities classifications	Number of cases	Number of facility	New payment to current payment ratio
All facilities	347,809	1,024	1.00
Geographic Location			
Large Urban	163,970	489	1.01
Other Urban	152,647	392	0.99
Rural	31,192	143	1.00
Region			
New England	15,868	36	0.98
Middle Atlantic	66,466	143	1.02
South Atlantic	59,172	132	1.04
East North Central	60,223	200	0.99
East South Central	27,024	51	1.03
West North Central	21,907	92	1.01
West South Central	59,663	186	0.93
Mountain	15,697	65	1.01
Pacific	21,789	119	1.02
Urban by Region			
Urban-New England	15,039	32	0.99
Urban-Middle Atlantic	64,042	133	1.02
Urban-South Atlantic	52,980	112	1.03
Urban-East North Central	55,071	171	0.99
Urban-East South Central	23,434	41	1.05
Urban-West North Central	18,087	70	1.01
Urban-West South Central	52,346	154	0.92
Urban-Mountain	14,655	56	1.01
Urban-Pacific	20,963	112	1.02
Rural by Region			
Rural-New England	829	4	0.91
Rural-Middle Atlantic	2,424	10	1.14
Rural-South Atlantic	6,192	20	1.07
Rural-East North Central	5,152	29	0.98
Rural-East South Central	3,590	10	0.94
Rural-West North Central	3,820	22	1.02
Rural-West South Central	7,317	32	0.97
Rural-Mountain	1,042	9	1.04
Rural-Pacific	826	7	0.97
Type and Size of Facility			
Unit of acute hospital	233,433	856	1.02
Average Daily Census <10	39,123	289	0.96
Average Daily Census 10–25	122,904	436	1.03
Average Daily Census >25	71,406	131	1.04
Freestanding hospital	114,376	168	0.96
Average Daily Census < 25	8,437	36	0.86
Average Daily Census 25–50	41,626	71	0.95
Average Daily Census >50	64,313	61	0.99
Disproportionate Share			
Disproportionate Share <10%	121,046	329	1.02
Disproportionate Share 10%-19%	101,405	261	0.99
Disproportionate Share 20%-29%	24,216	70	0.98
Disproportionate Share >= 30%	14,851	72	1.03
Disproportionate Share Missing	86,291	292	0.98
Teaching Status			
Non-Teaching	285,112	872	1.00
Resident to Average Daily Census < 10%	41,944	86	1.00
Resident to Average Daily Census 10%-19%	15,741	38	0.97

TABLE II.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS—Continued

Facilities classifications	Number of cases	Number of facility	New payment to current payment ratio
Resident to Average Daily Census >19%	5,012	28	0.98
Alaska/Hawaii	991	4	0.97

5. Costs Associated With the Patient Assessment Instrument

In this final rule, it is specified that an IRF must assess its Medicare Part A fee-for-service patients using the CMS IRF patient assessment instrument. Costs associated with the collection of the patient assessment data using the CMS IRF patient assessment instrument, and the associated reporting of data, are related to both personnel and equipment. These two classes of costs include the costs associated with using the CMS IRF patient assessment instrument to assess patients (data collection costs), the IRF's costs to start the patient assessment process using our patient assessment instrument, and the IRF's ongoing costs after the patient assessment process has been initiated. We note that many of the components of the costs associated with initiation of the patient assessment process specified in this final rule and the IRF's ongoing costs are the same.

a. Patient Assessment Instrument Data Collection Costs

As stated in section IV. of this preamble, in this final rule we are using a modified version of the UDSmr patient assessment instrument that is frequently referred to as the FIM, as the CMS IRF patient assessment instrument. We are permitting any clinician who is employed or contracted by the IRF, and is trained on how to complete a patient assessment using our patient assessment instrument, to complete the data items on our patient assessment instrument (§ 412.606(c)).

For this final rule, we calculated the cost to collect the patient assessment data using the CMS IRF patient assessment instrument by using the wage data and assumptions below. Although we are only specifying wage data for nine different types of clinicians, this should not be interpreted as meaning that these nine types are the only types of clinicians permitted to complete our patient assessment instrument.

Note: The 2000–2001 version of the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, is still our most current source of salary data available.

- The hourly wage data for the nine specific types of clinicians, according to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, are as follows (presented in ascending order):

(1) The median earnings of social work assistants, which is included in the human service workers and assistants category, in 1998 were \$21,360. That is equivalent to a median hourly wage of \$10.27. (\$21,360/52 weeks = \$410.77/week. \$410.77/40 hours = \$10.27).

(2) The median earnings of licensed practical nurses (licensed vocational nurses) in 1998 were \$26,940. That is equivalent to a median hourly wage of \$12.95. (\$26,940/52 weeks = \$518.07/week. \$518.07/40 hours = \$12.95).

(3) The median earnings of recreational therapists in 1998 were \$27,760. That is equivalent to a median hourly wage of \$13.35. (\$27,760/52 weeks = \$533.84/week. \$533.84/40 hours = \$13.35).

(4) The median earnings of social workers in 1998 were \$30,590. That is equivalent to a median hourly wage of \$14.71. (\$30,590/52 weeks = \$588.27/week. \$588.27/40 hours = \$14.7067).

(5) The median earnings of dietitians and nutritionists in 1998 were \$35,020. That is equivalent to a median hourly wage of \$16.84. (\$35,020/52 weeks = \$673.46/week. \$673.46/40 hours = \$16.8365).

(6) The median earnings of registered nurses in 1998 were \$40,690. That is equivalent to a median hourly wage of \$19.56. (\$40,690/52 weeks = \$782.50/week. \$782.50/40 hours = \$19.5625).

(7) The median earnings of speech-language pathologists and audiologists in 1998 were \$43,080. That is equivalent to a median hourly wage of \$20.71. (\$43,080/52 weeks = \$828.46/week. \$828.46/40 hours = \$20.7115).

(8) The median earnings of occupational therapists in 1998 were \$48,230. That is equivalent to a median hourly wage of \$23.19. (\$48,230/52 weeks = \$927.50/week. \$927.50/40 hours = \$23.1875).

(9) The median earnings of physical therapists in 1998 were \$56,600. That is equivalent to a median hourly wage of \$27.21. (\$56,600/52 weeks = \$1088.46/week. \$1088.46/40 hours = \$27.2115).

- IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 85 minutes to complete an admission intake assessment.

- IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 48 minutes to complete an update assessment.

- Our data indicate that in 1999 there were 390,048 IRF admissions and 1,165 IRFs, an average of 334.8 admissions per IRF. (For the calculations in the tables that follow, 334.8 admissions was rounded to 335 admissions.)

We stated in the proposed rule that data from a non-HCFA associated source indicated that it could take a maximum of 45 minutes to complete an admission assessment using the FIM. However, according to information obtained from UDSmr, it takes an estimated combined time of 25 minutes to collect both the admission and discharge patient assessment data using the UDSmr patient assessment instrument. We believe that the UDSmr estimated combined time of 25 minutes to collect both the admission and discharge data is the more accurate span of time estimate to use. Although in 2000 both the other non-HCFA source and UDSmr performed surveys to obtain instrument completion data, there is more precise data from the UDSmr survey results. Specifically, for the surveys that both performed: (1) The other non-HCFA associated source did not state its sample size or the numerical size of the universe from which the sample was obtained, while UDSmr had a sample size of 303 facilities out of a universe of 600 to 700 IRFs; (2) the other non-HCFA associated source only gave ranges of the span of times it took experienced or inexperienced personnel to complete the UDSmr instrument, while UDSmr provided the mean and median spans of times it took experienced and inexperienced personnel to complete the UDSmr instrument. In addition, we believe that UDSmr, instead of the other non-HCFA source, is more knowledgeable of the span of time it takes to complete its own instrument. We estimate that it will take a combined time of 45 minutes to collect both the

admission and discharge patient assessment data using our patient assessment instrument.

We believe that IRFs that currently use the UDSmr patient assessment instrument to collect admission and discharge data, which we believe is 85 percent of the 1,165 IRFs (990 IRFs), are completing the entire UDSmr patient assessment instrument when collecting the admission and discharge data. Therefore, for IRFs currently using the UDSmr patient assessment instrument, we believe that the estimated additional time to collect both the admission and

discharge patient assessment data using our patient assessment instrument

For IRFs that are not currently using the UDSmr patient assessment instrument, or a similar instrument, which we believe is 15 percent of the 1,165 IRFs (175 IRFs), we estimate an additional assessment time burden of 45 minutes.

The 1998 median hourly wages from the U.S. Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000-2001 Edition*, specified above have been updated, using our Occupational Compensation Index from

the excluded hospital market basket. The update factor is 1.159. Using the updated 1998 median hourly wages, we show in Table III below the range of the costs of the estimated additional patient assessment time burden by clinician discipline. In addition, we show in Table III the range of the costs of the minimum and maximum additional time burden by clinician discipline using the 1999 data of 390,048 IRF admissions and 1,165 IRFs (an average of approximately 335 admissions per IRF).

TABLE III.—RANGE OF THE INCREMENTAL COSTS, TO COLLECT BOTH THE A RGE PATIENT ASSESSMENT DATA USING THE CMS IRF PATIENT ASSESSMENT INSTRUMENT

(Column 1) Updated hourly wages for each clinician discipline	(Column 2) Range of incremental time of 20 minutes—incremental cost per clinician discipline column 1 times 0.333333	(Column 3) Range of incremental cost per clinical discipline per IRF—column 2 times 335 admissions	(Column 4) Range of incremental time of 45 minutes—incremental cost per clinical discipline column 1 times 0.75	(Column 5) Range of incremental cost per clinical discipline per IRF column 4 times 335 admissions
\$11.90	\$3.97	\$1,328.83	\$8.93	\$2,989.88
15.01	5.00	1,676.11	11.26	3,771.26
15.47	5.16	1,727.48	11.60	3,886.84
17.05	5.68	1,903.91	12.79	4,283.81
19.52	6.51	2,179.73	14.64	4,904.40
22.67	7.56	2,531.48	17.00	5,695.84
24.00	8.00	2,680.00	18.00	6,030.00
26.88	8.96	3,001.60	20.16	6,753.60
31.54	10.51	3,521.96	23.66	7,924.43

Table IV below compares the average estimated time to complete the inpatient rehabilitation facility patient assessment instrument as specified in this final rule to the average estimated time to complete the MDS-PAC in the proposed rule, assuming that the expanded list of clinicians could complete the proposed

MDS-PAC. We are only comparing the costs to perform the combined admission and discharge assessment using the CMS IRF patient assessment instrument in this final rule to the cost to perform the admission MDS-PAC assessment because the best time span data we have is how long it takes to do

the admission MDS-PAC assessment. The admission MDS-PAC assessment took 85 minutes to perform, that is, to collect the data, (85 minutes divided by 60 minutes is 1.412 (rounded)). Table IV is based on the assumption that all 1,165 IRFs would collect the assessment data.

TABLE IV.—COMPARISON OF THE COSTS OF PERFORMING THE PATIENT ASSESSMENT USING THE CMS IRF PATIENT ASSESSMENT INSTRUMENT TO COSTS USING THE PROPOSED MDS-PAC

(Column 1) Updated Hourly Wages for each clinical discipline	Costs to perform the combined admission and discharge assessments using the CMS IFR patient assessment instrument			Costs to perform only the admission assessment using the MDS-PAC		
	(Column 2) Range of incremental time of 45 minutes—incremental cost per clinician discipline column 1 times 0.75 Hour)	(Column 3) Range of incremental cost per clinical discipline per IRF—column 2 times 335 admissions	(Column 4) National costs—(column 3 times 1,165 IRFs)	(Column 5) Range of maximum incremental time of 85 minutes per clinical discipline (column 1 times 1.412)	(Column 6) Range of maximum incremental cost per clinical discipline per IRF (column 5 times 335 admissions)	(Column 7) National costs (column 6 Times 1,165 IRFs)
\$11.90	8.93	\$2,990	\$3,483,204	\$16.80	\$5,629	\$6,557,713
\$15.01	11.26	3,771	4,393,521	21.19	7,100	8,271,535
\$15.47	11.60	3,887	4,528,166	21.84	7,318	8,525,027
\$17.05	12.79	4,284	4,990,642	24.07	8,065	9,395,715
\$19.52	14.64	4,904	5,713,626	27.56	9,233	10,756,853

TABLE IV.—COMPARISON OF THE COSTS OF PERFORMING THE PATIENT ASSESSMENT USING THE CMS IRF PATIENT ASSESSMENT INSTRUMENT TO COSTS USING THE PROPOSED MDS—PAC—Continued

(Column 1) Updated Hourly Wages for each clinical discipline	Costs to perform the combined admission and discharge assessments using the CMS IFR patient assessment instrument			Costs to perform only the admission assessment using the MDS—PAC		
	(Column 2) Range of incremental time of 45 minutes—incremental cost per clinician discipline column 1 times 0.75 Hour)	(Column 3) Range of incremental cost per clinical discipline per IRF—column 2 times 335 admissions	(Column 4) National costs—(column 3 times 1,165 IRFs)	(Column 5) Range of maximum incremental time of 85 minutes per clinical discipline (column 1 times 1.412)	(Column 6) Range of maximum incremental cost per clinical discipline per IRF (column 5 times 335 admissions)	(Column 7) National costs (column 6 Times 1,165 IRFs)
\$22.67	17.00	5,696	6,635,651	32.01	10,723	12,492,718
\$24.00	18.00	6,030	7,024,950	33.89	11,352	13,225,639
\$26.88	20.16	6,754	7,867,944	37.95	12,715	14,812,716
\$31.54	23.66	7,924	9,231,955	44.53	14,919	17,380,694

b. Start-Up Costs

The costs that an IRF will incur to start the patient assessment process using our assessment instrument consist of material costs and personnel costs. Our data indicate that in 1999 there were 1,165 IRFs.

(1) Start-Up Hardware Costs

We believe that all IRFs have the hardware computer capability (that is, hard drive, printer, RAM memory, modem) and the related software (that is, Internet Browser software) to be able to handle the computerization, data transmission, and GROUPER software requirements associated with our patient assessment instrument. Our belief is based on indications that (a) approximately 99 percent of all hospital inpatient claims currently are submitted electronically; (b) approximately 100 percent of IRFs submit their cost reports electronically; and (c) approximately 85 percent of IRFs that use the FIM subscribe to the full UDSmr FIM system and submit their data to UDSmr electronically.

Because we will supply to the IRFs free of charge the software that performs the electronic functions associated with our patient assessment instrument, the IRFs will incur no software costs to purchase that software. Although we will supply the software version of our patient assessment instrument, which includes the GROUPER software and the data transmission software, IRFs may incur costs, which we are not able to estimate, associated with making changes to their information management systems to incorporate our patient assessment process software.

IRFs have the option of purchasing data collection software that can be used to support other clinical or operational

needs (for example, care planning, quality assurance, or billing), or other regulatory requirements for reporting patient information. However, the software associated with our patient assessment instrument will be available to IRFs at no charge through our IRF prospective payment system website. That website is: www.hcfa.gov/medicare/irfpps.htm. Our patient assessment instrument software will allow users to computerize their assessment data and transmit the data in a standard format specified by us to the CMS patient data system. Therefore, IRFs that plan to use our patient assessment instrument software will need Internet access and a dial-up Internet Service Provider account in order to be able to download and install our software into their computer system. We believe that all IRFs currently have the capability to access the Internet.

(2) Start-Up Training Costs

IRF staff will require training in performing assessments with the CMS IRF patient assessment instrument, encoding assessment data, preparing the assessment data for electronic submission, and actually transmitting the data. We believe that the initial training of IRF clinical and data entry personnel will require about 129.5 hours of staff time.

We expect that the IRF will send one discipline-specific lead clinician to a training session of 16 hours sponsored by us, and then have that individual train the other IRF clinicians. We estimate that, on average, nine nonlead clinicians per IRF will require 12 hours of training. These nonlead clinicians will be trained at their respective IRF. As stated in section IV. of this preamble, in this final rule we are permitting any

clinician who is employed or contracted by the IRF and who is trained on how to perform a patient assessment using the CMS IRF patient assessment instrument to complete the data items on the CMS IRF patient assessment instrument.

We also estimate that one data entry staff person will require approximately 5.5 hours of training. The estimated hourly wage cost of the data entry staff person from the proposed rule is \$12.50. Using the update factor for hourly wages of the 1.159 cited earlier, we estimate that the updated hourly wage for the data entry staff person is \$14.49 (rounded). Using this updated hourly wage rate, we estimate that the 5.5 hours of training will cost approximately \$79.70 (5.5 hours × \$14.49) per IRF, for an estimated cost of \$92,844 nationally (\$79.70 × 1,165 IRFs).

(3) Start-Up Data Entry and Data Transmission Costs

We do not know the time span it takes to enter the UDSmr data into the UDSmr patient assessment software, or the time span it takes to perform a data entry audit on those data. Our patient assessment data will be collected for the admission and discharge assessments. The estimated wage cost of the data entry staff person is \$14.49 per hour. We estimate 6 minutes for data entry and data review per assessment, for approximately 335 assessments per IRF, which equals 2,010 minutes (34 hours) per IRF per year. We estimate the associated data entry cost per IRF per year to be \$493 (34 hours × \$14.49), and the national costs to be \$573,949 (\$493 × 1,165 IRFs).

We estimate that an IRF will perform a 15-minute monthly data entry audit for quality assurance purposes, equaling

3 hours per IRF per year (15 minutes per month × 12 months). We estimate the cost per IRF per year to be \$43 (3 hours × \$14.49), and the national costs to be \$50,643 (\$43 × 1,165 IRFs).

We believe that the combination of checking all the data prior to transmission of the data, and actual transmission of the data, will take an IRF 1 hour per month. Although we believe that approximately 85 percent of the IRFs already transmit data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we are estimating for all 1,165 IRFs the same additional burden of 1 hour per month for the combination of checking all the data prior to transmission of the data and the actual transmission of the data. We estimate the cost per IRF per year to be \$174 (rounded) (12 months × \$14.49/hour), and the national costs to be \$202,570 (\$174 × 1,165 IRFs).

IRFs will have flexibility in choosing the data entry software used to computerize the patient assessment data, but the software must, at a minimum, perform the same functions as our patient assessment software. In addition, when IRFs are performing data entry functions themselves, or contracting for the performance of these functions, the IRFs must ensure that the performance of data entry complies with our requirement for safeguarding the confidentiality of clinical records.

IRFs must collect and transmit the patient assessment data to the CMS patient data system in accordance with the assessment schedule and transmission requirements specified in section IV. of this final rule. The data

may be entered into the computerized version of the CMS IRF patient assessment instrument by an IRF staff member, using a paper version that has been completed by a clinical staff member who has been trained to perform a patient assessment using our patient assessment instrument according to this final rule, or by a data entry operator under contract to the IRF to key in data. The patient assessment data will be transmitted to the CMS patient data system. This system is similar to the systems that HHAs use to report OASIS data and that SNFs use to report MDS 2.0 data. IRFs will transmit the patient assessment data using the toll-free MDCN line.

(4) Start-Up Systems Maintenance and Supplies Costs

There are costs associated with normal maintenance related to computer equipment. Typically, this maintenance is provided through warranty agreements with the original equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than \$100 per year per IRF. Although we believe that approximately 85 percent of the IRFs already have systems maintenance costs associated with transmitting data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we estimate for all 1,165 IRFs the same additional systems maintenance costs of \$100 per IRF per year, for an estimated \$116,500 national yearly cost (\$100 × 1,165 IRFs).

Supplies necessary for collection and transmission of data, including forms,

diskettes, computer paper, and toner, will vary according to the size of the IRF, the number of patients served, and the number of assessments conducted. Although we believe that approximately 85 percent of the IRFs already have supplies costs associated with transmitting data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we estimate for all 1,165 IRFs the same additional supplies costs of \$200 per IRF per year, for an estimated national yearly cost of \$233,000 (\$200 × 1,165 IRFs).

Tables V–A, V–B, V–C, and V–D below illustrate our estimates of the different categories of start-up costs that we have discussed above. In addition, in the proposed rule we proposed to only allow four types of clinicians to collect patient assessment data. Table V illustrates the effect of allowing more types of clinicians to collect patient assessment data on IRF start-up costs. Also, instead of averaging the hourly wages of the nonlead clinicians, as we did in the proposed rule, in order to better specify costs in Table Va–A, we are illustrating a range of the nonlead clinicians’ hourly wages and, thus, presenting a range of the training start-up costs for these nonlead clinicians. Due to the changes in illustrating and estimating the start-up costs, particularly the range of costs for training the nonlead clinicians, we estimate the total start-up costs to be approximately \$2,988,580 to \$5,825,775, which equal approximately \$2,565 to \$5,001 per IRF.

TABLE V–A.—IRF START-UP COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: TRAINING COSTS PER IRF¹

(Column 1) Type of cost	(Column 2) Hours per IRF	(Column 3) Hourly Wages per staff member	(Column 4) Number of staff	(Column 5) Range of the costs per IRF (column 2 times column 3 times column 4)	(Column 6) Range of national costs
Training on data collection for lead clinicians for the admission and discharge assessments.	16	\$11.90	1	\$190	Column 5 Low and High Times 1,165 \$221,816 to \$587,906
	16	15.01	1	240	
	16	15.47	1	248	
	16	17.05	1	273	
	16	19.52	1	312	
	16	22.67	1	363	
	16	24.00	1	384	
	16	26.88	1	430	
Training on data collection for other IRF clinicians for the admission and discharge assessments.	12	11.90	9	1,285	Column 5 Low and High Times 1,165 \$1,497,258 to \$3,968,363
	12	15.01	9	1,621	
	12	15.47	9	1,671	
	12	17.05	9	1,841	

TABLE V-A.—IRF START-UP COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: TRAINING COSTS PER IRF¹—Continued

(Column 1) Type of cost	(Column 2) Hours per IRF	(Column 3) Hourly Wages per staff member	(Column 4) Number of staff	(Column 5) Range of the costs per IRF (column 2 times column 3 times column 4)	(Column 6) Range of national costs
Data Entry (encoding and Transmission) training	12	19.52	9	2,108	Column 5 Times 1,165 \$92,844
	12	22.67	9	2,448	
	12	24.00	9	2,592	
	12	26.88	9	2,903	
	12	31.54	9	3,406	
	5.5	14.49	1	79.70	
Total	\$1,811,919 to \$4,649,113

¹ Excludes the incremental clinician labor costs associated with collecting the patient assessment data.

TABLE V-B.—IRF START-UP COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: DATA ENTRY AND DATA TRANSMISSION COSTS PER IRF

(Column 1) Type of Cost	(Column 2) Hours per IRF per year	(Column 3) Hourly wage	(Column 4) Cost per IRF (column 2 times column 3)	(Column 5) Number of IRFs	(Column 6) National costs (column 4 times Column 5)
Data Entry	34	\$14.49	\$493	1,165	\$573,949
Data Entry Audits	3	14.49	43	1,165	50,643
Data Transmissions	12	14.49	174	1,165	202,570
Total .....	.....	.....	.....	.....	827,162

TABLE V-C.—IRF START-UP COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: SYSTEM MAINTENANCE AND SUPPLIES COSTS

(Column 1) Type of Cost	(Column 2) Cost per IRF per year	(Column 3) Number of IRFs	(Column 4) National costs (column 2 times column 3)
Systems Maintenance	\$100	1,165	\$116,500
Supplies	200	1,165	233,000
Total .....	.....	.....	349,500

TABLE V-D.—IRF START-UP COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: TOTAL RANGE OF START-UP COSTS

Range of Start-up Training-Low to High (From Table V-A)	\$1,811,919 \$4,649,113
Start-up Data Entry and Data Transmission Costs (From Table V-B)	\$827,162
Start-up Systems Maintenance and Supplies Costs (From Table V-C)	\$349,500
Grand Total Range of Start-up Costs Per IRF	\$2,988,580 to \$5,825,775
Low Start-Up Cost per IRF (\$2,988,580 Divided by 1,165 IRFs)	\$2,565.31
High Start-Up Cost per IRF (\$5,825,775 Divided by 1,165 IRFs)	\$5,000.67
High Start-Up Costs Per Admission (\$4,971.69 Divided by 335 Admissions)	\$14.93

c. Ongoing Costs

We want to differentiate between the one-time start-up costs the IRF will

incur and costs we believe the IRFs will incur on a regular, yearly basis. Therefore, using the same cost concepts

discussed above for the startup costs, we illustrate in Tables VI-A, VI-B, VI-C, and VI-D below the different categories of costs an IRF will incur on an ongoing basis.

TABLE VI-A.—IRF ONGOING COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: ONGOING TRAINING COSTS PER IRF ¹

(Column 1) Type of cost	(Column 2) Hours per IRF	(Column 3) Hourly wages	(Column 4) Number of staff	(Column 5) Range of costs per IRF column 2 times column 3 times column 4)	(Column 6) Range of national costs
Clinician training on data collection for lead clinician.	12	\$11.90	1	\$143	Column 5 Low and High Times 1,165. \$166,362 to \$440,929.
	12	15.01	1	180	
	12	15.47	1	186	
	12	17.05	1	205	
	12	19.52	1	234	
	12	22.67	1	272	
	12	24.00	1	288	
	12	26.88	1	323	
Clinician training on data collection for non-lead clinicians.	2	11.90	9	214	\$249,543 to \$661,394.
	2	15.01	9	270	
	2	15.47	9	278	
	2	17.05	9	307	
	2	19.52	9	351	
	2	22.67	9	408	
	2	24.00	9	432	
	2	26.88	9	484	
Data entry (encoding and transmission) training.	5	14.49	1	72.45	Column 5 times 1,165. \$84,404.
Total					\$500,309 to \$1,186,727.

¹ Excludes the incremental clinician labor costs associated with collecting the patient assessment data.

TABLE VI-B.—IRF ONGOING COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: DATA ENTRY AND DATA TRANSMISSION COSTS PER IRF

(Column 1) Type of cost	(Column 2) Hours per IRF per year	(Column 3) Hourly wage	(Column 4) Cost per IRF (column 2 times column 3)	(Column 5) Number of IRFs	(Column 6) National costs (column 4 times column 5)
Data entry	34	\$14.49	\$493	1,165	\$573,949
Data entry audits	3	14.49	43	1,165	50,643
Data transmissions	12	14.49	174	1,165	202,570
Total					827,162

TABLE VI-C.—IRF ONGOING COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: SYSTEM MAINTENANCE AND SUPPLIES COSTS

(Column 1) Type of cost	(Column 2) Cost per IRF per year	(Column 3) Number of IRFs	(Column 4) National costs (column 2 times column 3)
Systems maintenance	\$100	1,165	\$116,500
Supplies	200	1,165	233,000
Total			349,500

TABLE VI-D.—IRF ONGOING COSTS ASSOCIATED WITH THE CMS IRF PATIENT ASSESSMENT INSTRUMENT: TOTAL RANGE OF ONGOING COSTS

Range of ongoing training—low to high (from Table VI-A)	\$500,309 to \$1,186,727.
Ongoing data entry and data transmission costs (from Table VI-B)	\$827,162.
Ongoing systems maintenance and supplies cost (from Table VI-C)	\$349,500.
Grand total range of ongoing costs per IRF	\$1,676,971 to \$2,363,389.

d. Clinical Labor Data Collection Costs

As stated more fully in section VIII.B.5.a. of this final rule, we estimate that it will take a combined time of 45 minutes to collect both the admission and discharge patient assessment data

using our patient assessment instrument. In addition, we stated more fully that it currently takes 25 minutes for 85 percent of 1,165 IRFs (990 IRFs) to complete the admission and discharge UDSmr patient assessment instrument, and that we believe that 15

percent of the IRFs (175 IRFs) are not currently using the UDSmr patient assessment instrument or a similar instrument.

Table VII below illustrates the costs of the data collection burden for all IRFs.

TABLE VII.—CLINICIAN INCREMENTAL LABOR DATA COLLECTION COSTS FOR ALL IRFS

(Column 1) Incremental data collection time	(Column 2) Hours per IRF per year (column 1 times 335; admissions divided by 60 minutes)	(Column 3) Hourly wages per clinician (from Table III)	(Column 4) Range of the costs per IRF (column 2 times column 3)	(Column 5) Number of IRFs	(Column 6) Range of national costs (column 4 times column 5)
20	111.67	\$11.90 15.01 15.47 17.05 19.52 22.67 24.00 26.88 31.54	\$1,328.83 1,676.12 1,727.48 1,903.92 2,179.73 2,531.48 2,680.00 3,001.60 3,521.97	990.25	\$1,315,877 to \$3,487,627.
45	251.25	11.90 15.01 15.47 17.05 19.52 22.67 24.00 26.88 31.54	2,989.88 7,924.43	174.75	\$522,481 to \$1,384,793.
Total for All IRFs .....	.....	.....	.....	.....	\$1,838,358 to \$3,487,656.

e. Conclusion

As discussed above, IRFs will incur costs associated with the patient assessment process. In section IV. of this preamble, we specified each item of the CMS IRF patient assessment instrument that must be collected on either the admission or discharge assessment. In order to complete our analysis, we summarize in Table VIII below, by category of data, the data items of the CMS IRF patient assessment instrument.

Table VIII illustrates the possible maximum number of items collected on the admission and discharge assessment. The term “possible maximum” means that an item may allow for recording up to 10 separate pieces of information. For example, the item that collects data on a patient’s comorbid conditions allows the clinician to record up to 10 separate comorbid conditions. However, due to the patient’s clinical status, the patient

may only have 5 comorbid conditions, so only 5 comorbid conditions will be recorded. The combined total of all possible maximum admission and discharge items is 83 + 72, which equals 155. Therefore, as is illustrated in Table VIII, 53.5 percent (83 divided by 155) of the items may be collected during the admission assessment, and 46.5 percent (72 divided by 155) of the items may be collected during the discharge assessment.

TABLE VIII.—NUMBER OF ADMISSION AND DISCHARGE ITEMS BY ITEM CATEGORY

Item category	Admission items	Discharge items
Identification Information	17	0
Admission Information	8	0
Payer Information	2	0
Medical Information	13	11
Medical Needs	4	2
Function Modifiers	10	10
FIM Instrument	18	18
Discharge Information	0	19
Quality Indicators	11	12
Total	83	72

Table IX below reflects an analysis of the per case costs for the approximately 85 percent of IRFs that we believe currently use the UDSmr patient assessment instrument to collect admission and discharge data. In Table IX, the time to complete each patient assessment instrument item is weighted equally at 1.000, which means that each data item

takes the same span of time to collect. The percentages in Table IX, column 2, are based on the data in Table VIII above. The maximum costs shown in Table IX will decrease after the first year of implementation because the greatest costs are in the first year.

TABLE IX.—MAXIMUM PATIENT ASSESSMENT COSTS PER CASE FOR 85 PERCENT OF THE IRFS

(Column 1) Assessment type	(Column 2) Percent of patient assessment instrument items completed (see Table VIII)	(Column 3) Maximum incremental clinician (physical therapist) cost per IRF (from Table III)	(Column 4) Total incremental maximum cost per IRF (column 2 times column 3)	(Column 5) Average maximum incremental cost per case (column 4 divided by 335 average admissions per IRF)
Admission	0.535	\$3,521.96	\$1,884.25	\$5.62
Discharge	0.465	3,521.96	1,637.71	4.89
Total Average Maximum Costs Per Case				\$10.51

The estimated maximum start-up cost per IRF is approximately \$5,001. We estimate a start-up cost per case of \$14.93 (\$5,001 by 335 average admissions per IRF). Therefore, when we add the \$10.51 average maximum incremental cost per case from column 5 of Table IX above to the \$14.93 start-up costs per case, we arrive at an estimated total average maximum first year cost per case of \$25.44 for 85 percent of the IRFs.

Table X below reflects an analysis of the per case costs for the approximately 15 percent of IRFs that we believe do not currently use the UDSmr patient assessment instrument or a similar patient assessment instrument to collect admission and discharge data.

TABLE X.—MAXIMUM PATIENT ASSESSMENT COSTS PER CASE FOR 15 PERCENT OF THE IRFS

(Column 1) Assessment type	(Column 2) Percent of patient assessment instrument items completed (see Table VIII)	(Column 3) Maximum incremental clinician (physical therapist) cost per IRF (from Table III)	(Column 4) Total incremental maximum cost per IRF (column 2 times column 3)	(Column 5) Average maximum incremental cost per case (column 4 divided by 335 average admissions per IRF)
Admission	0.535	\$7,924.43	\$4,239.57	\$12.66
Discharge	0.465	7,924.43	3,684.86	11.00
Total Average Maximum Cost Per Case				23.66

As stated above, we estimate the maximum start-up cost per IRF is approximately \$5,001. We estimate a start-up cost per case of \$14.93 (\$5,001 divided by 335 average admissions per IRF). Therefore, when we add the \$23.66 average maximum incremental cost per case from column 5 of Table X above to the \$14.93 start-up costs per case, we arrive at a total average maximum first year cost per case of \$38.59 for 15 percent of the IRFs.

Table XI below illustrates the maximum national incremental start-up costs when 85 percent of IRFs have an average maximum cost of \$25.44 per case, and 15 percent of IRFs have an average maximum cost of \$38.59 per case.

TABLE XI.—TOTAL MAXIMUM PATIENT ASSESSMENT START-UP COSTS FOR ALL IRFS

(Column 1) Cost per case per IRF	(Column 2) Average admissions per IRF	(Column 3) Number of IRFs	(Column 4) Average maximum national costs (column 1 times column 2 times column 3)
\$25.44 (for 85 Percent of IRFs)	335	990.25	\$8,437,176
\$38.59 (for 15 Percent of IRFs)	335	174.75	2,262,339
Total Maximum Start-up Costs			10,699,515

We believe that the estimated costs of administering our patient assessment instrument are justified when considered within the context of the statutory requirement and the methodology needed to implement the IRF prospective payment system, the probability that our patient assessment process will lead to increased quality of

care for IRF patients, as well as the potential uses of the automated data by the IRFs themselves, States, fiscal intermediaries, and us. Our cost estimates may actually overstate anticipated costs, because they do not take into account cost savings that IRFs may achieve by improving their management information systems, as

well as potential improvements in the quality of patients' clinical care resulting from improved care planning under the patient assessment process.

C. Alternatives Considered

In the proposed rule, we proposed to use the MDS-PAC as the patient assessment instrument. However, as

more fully explained in section IV. of this preamble, we have decided to use a modified version of the UDSmr patient assessment instrument as the CMS IRF patient assessment instrument. We agree with the vast majority of the commenters who stated that a patient assessment instrument and patient assessment schedule patterned after the UDSmr patient assessment instrument and assessment schedule will achieve our goals of paying IRFs appropriately and monitoring the quality of the care the IRFs furnish. Our payment system was in part determined by using both UDSmr and COS patient admission and discharge assessment data. Therefore, we believe that using a modified version of the UDSmr patient assessment instrument that retains the basic UDSmr items used by RAND in its data analysis to determine the CMGs and payment rates (our payment system) is appropriate. (Note: COS has ceased its IRF patient assessment data business operations, so we are patterning our assessment system after the UDSmr system.)

D. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the November 3, 2000 proposed rule, we solicited public comment for 60 days on each of these issues for the sections that contain information collection requirements.

Section 412.23 Excluded hospitals: Classifications

- Section 412.23(b)(2) requires that, except in the case of a newly participating hospital seeking classification as a rehabilitation hospital for its first 12-month cost reporting period, the entity show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more specified conditions.

- Section 412.23(b)(8) requires that a hospital seeking classification as a rehabilitation hospital for the first 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of § 412.23(b)(2), instead of showing that it has treated this population during its most recent 12-month cost reporting period.

The information collection requirements of these two paragraphs of this section are currently approved under OMB approval number 0938-0358 (Psychiatric Unit Criteria Work Sheet, Rehabilitation Hospital Criteria Work Sheet, Rehabilitation Unit Criteria Work Sheet) through November 30, 2003. Any changes to these two paragraphs and the work sheets will be submitted to OMB for approval.

Sections 412.116(a)(3) Method of Payment and 412.632(b) Method of Payment Under Inpatient Rehabilitation Facility Prospective Payment System: Periodic Interim Payments

Under § 412.116(a)(3), for cost reporting periods beginning on or after January 1, 2002, payment to a rehabilitation hospital or rehabilitation unit for inpatient hospital services under the prospective payment system will be made as described in § 412.632. Section 412.632(b) provides that a rehabilitation hospital or unit under the prospective payment system may receive periodic interim payments for Part A services subject to the provisions of § 413.64(h). Section 413.64(h)(3) specifies that the request for periodic interim payments must be made to the fiscal intermediary.

The burden associated with this provision is the time it takes a hospital to prepare and submit its request for periodic interim payments. We estimate that 34 IRFs will request periodic interim payments under the prospective payment system and that it will take each 1 hour to prepare and make the request.

Sections 412.604(c) Completion of Patient Assessment Instrument, 412.606(a) Patient Assessment, 412.606(c) Comprehensive Assessments, and 412.610(c) Assessment Schedule

- Section 412.604(c) requires an IRF to complete the CMS IRF patient assessment instrument for each Medicare fee-for-service patient who is admitted to or discharged (or who stopped receiving Medicare Part A inpatient rehabilitation services) from the IRF on or after January 1, 2002. Section 412.606(c) requires that an IRF clinician perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare fee-for-service patient using the CMS IRF patient assessment instrument as part of his or her assessment. The assessment must include direct patient observation and communication with the patient, and, when appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources. Section 412.610(c) provides for an assessment upon admission, an assessment upon discharge, and, if the patient is not discharged but stops receiving Medicare Part A covered inpatient rehabilitation services, an assessment at the time he or she stops receiving these services.

For the proposed rule, we used 1997 data that showed that there were approximately 359,000 admissions to 1,123 IRFs, averaging 320 admissions annually. For the final rule, we are using more recent 1999 data that showed that there were approximately 390,000 admissions to 1,165 IRFs, averaging 335 admissions annually. We estimate that it will take 45 minutes to complete both the admission and discharge assessments. The costs associated with the IRF patient assessment instrument are discussed in detail in section VIII.B.5. of this preamble. The IRF patient assessment instrument has been submitted to OMB for approval and was published in the **Federal Register** on July 13, 2001 (66 FR 36795), in which the information collection is referred to as "Request to Use Inpatient Rehabilitation Assessment Instrument and Data Set for PPS for Inpatient Rehabilitation Facilities."

We are furnishing an estimate that assumes that no facility is currently completing all items of the FIM instrument. With that in mind, we estimate a national burden of 292,500 hours (390,000 admissions x 45 minutes/60 minutes).

We also are including training in our burden estimates: 16 hours to train the lead clinician and 12 hours to train the other clinicians (an average of 9 hours). This totals 144,460 hours nationally for a one-time burden. In addition, we estimate an ongoing burden for training of 14 hours per IRF per year (16,310 hours nationally).

- Section 412.606(a) requires that, at the time each Medicare patient is admitted, the facility must have physician orders for the patient's care during the time the patient is hospitalized.

This requirement is subject to the PRA. However, we believe that the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with the requirement are incurred by persons in the normal course of their activities.

Section 412.608 Patients' Rights Regarding the Collection of Patient Assessment Data

Under § 412.608(a), before performing an assessment of a Medicare inpatient using the IRF patient assessment instrument, an IRF clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the collection of the patient assessment data;

(2) The right to have the patient assessment information collected kept confidential and secure;

(3) 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;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on his or her patient assessment.

Under § 412.608(b), the IRF must ensure that a clinician documents in the patient's clinical record that the patient was informed of these patient rights. The patient rights in § 412.608(a) are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

The burden of disclosure to IRF patients and documenting that disclosure is in addition to the burden in § 482.13 on hospitals furnishing a patient rights statement. The hospitals will easily be able to give both statements to patients upon admission, along with other required notifications. The burden for the general patient rights statement has not yet been approved but is under development. We estimate that

it takes each hospital 5 minutes to disclose the general hospital statement to each patient on admission. The disclosure of the IRF patient rights statement will increase that time by an estimated 2 minutes. Since this disclosure will occur for each admission and there are, on average, an estimated 335 admissions annually per IRF, we are estimating that this disclosure will occur, on average, 335 times annually per IRF.

Section 412.610(f) Patient Assessment Instrument Record Retention

Section 412.610(f) requires an IRF to maintain all patient assessment data sets completed within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the IRF can easily obtain.

We estimate that, for IRFs that choose to file a paper copy, it will take the IRF 5 minutes to print out, or copy, each assessment and file it in the patient's record. On average, we estimate that each IRF will need to obtain a copy of and file 670 assessments per year, for a burden of 56 hours. We cannot estimate how many facilities will choose to file paper copies. However, we are assuming that most facilities will choose to retain the assessments in an electronic format, which would not add to the paperwork burden.

Section 412.614 Transmission of Patient Assessment

Section 412.614(a) requires each IRF to encode and transmit data using the computer program(s) available from us; or using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment data set, and meets our other specifications. Section 412.614(b) requires each IRF to electronically transmit complete, accurate, and encoded data to our patient data system using electronic communications software that provides a direct telephone connection from the IRF to our system.

The patient assessment data may be entered into the computerized system by an IRF staff member from a paper document completed by an IRF clinician or by a data entry operator under contract to the IRF to key in data. Also, IRFs will have to allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the inpatient rehabilitation facility patient assessment system.

We estimate that an average IRF with 335 admissions per year will require 3

minutes for data review and entry per assessment for up-front review and another 3 minutes for data entry review, for a total of 6 minutes. The burden of entering and reviewing the data is contained in that 6 minutes. We estimate the yearly burden will be 34 hours per facility.

In addition, we estimate that an IRF will perform a 15-minute monthly data entry audit for quality assurance purposes. We estimate the yearly burden will be 3 hours per facility.

Other Data Transmission Functions

We estimate that it will take about one additional hour of staff time to perform data transmission-related tasks each month. With 1,165 facilities, we estimate the national burden will be 13,980 hours.

We estimate that it will require a one-time burden of 5.5 hours per hospital to train the personnel to be able to complete data transmission tasks. With 1,165 facilities, we estimate the national burden will be 6,408 hours.

Section 412.616 Release of Information Collected Using the Patient Assessment Instrument

Under § 412.616(b), an IRF may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and to the extent the facility itself is permitted to do so.

The burden associated with this information collection requirement is the time required to include the necessary information in the contract. While this requirement is subject to the PRA, we believe the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement will be incurred by persons in the normal course of their activities.

Section 412.618(b) Assessment Process for Interrupted Stay: Recording and Encoding the Data

Section 412.618(b) requires that if a patient has an interrupted stay, the IRF must record the interrupted stay data on the patient assessment instrument.

We currently have no data on the incidence of interrupted stays. We estimate, however, that it will take no more than 5 minutes to record the interrupted stay data.

Section 412.626(b) Transition Period: Election Not To Be Paid Under the Transition Period Methodology

Under § 412.626(b), an IRF may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002 without regard to the transition period percentages. Section 412.626(b)(2) specifies that the request to make the election must be made in writing to the Medicare fiscal intermediary for the facility.

We estimate that 580 IRFs will make a request under this section and that it will take each IRF 1 hour to complete the request.

Public Comments Received and Departmental Responses

Comment: Many commenters stated that the length and complexity of the MDS-PAC patient assessment instrument in the proposed rule create an unreasonable burden for performing patient assessments and result in excessive IRF patient assessment costs.

Response: As indicated in section IV of this final rule, we are changing the patient assessment instrument from the MDS-PAC to the CMS IRF patient assessment instrument that is similar to the UDSmr patient assessment instrument, FIM. Because the patient assessment instrument we are adopting in this final rule is based upon the FIM, we have estimated the burden hours based upon the actual estimate contained in the special study completed by RAND. In the study entitled "Assessment Instruments for PPS," two tests of administration times were performed (that is, institutional teams and calibration teams). The institutional and calibration teams were not familiar with the MDS-PAC and, therefore, they were trained to complete it. The institutional teams were familiar with the FIM and had previously completed the instrument. The calibration teams were not familiar with the FIM instrument and, therefore, they were trained to complete it. The study found that the average time to complete the admission FIM (the instrument we will be using for the purposes of payment) was 25 minutes for the institutional team. For the calibration team, the FIM burden was 148 minutes for a small number of cases. The estimated burden hours for the MDS-PAC were 145 minutes for the institutional team and 221 minutes for the calibration team.

We have expanded the UDSmr patient assessment instrument to include a minimal number of questions related to

quality of care. For the purposes of estimating the burden, we are maintaining the burden estimates for the assessment stated in the proposed rule. In that proposed rule, we estimated that there was a range of 30 to 45 minutes to complete the UDSmr patient assessment instrument. For the purpose of the estimate in this final rule, we are using the maximum number of 45 minutes to calculate the burden required to complete the admission and discharge assessments associated with our IRF patient assessment instrument. In addition, because the majority of IRFs currently use the UDSmr patient assessment instrument, we have used the experience from the institutional teams in our time burden estimates.

The burden estimate for this final rule represents a considerable reduction in the burden that we had estimated using the MDS-PAC in the proposed rule.

Submission to OMB

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§ 412.23, 412.116, 412.604 through 412.610, 412.614 through 412.618, and 412.626. These requirements are not effective until they have been approved by OMB. As stated earlier, the information collection requirements under § 412.23 are already approved by OMB through November 30, 2003 (OMB approval number 0938-0358).

X. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and it incorporates a statement of the finding and its reasons in the rule issued.

On November 3, 2000, we published a proposed rule addressing proposed policies for establishment of the Medicare prospective payment system for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (65 FR 66304). On December 21, 2000, Public Law 106-554 was enacted. Section 305 of Public Law 106-554 amends section 1886(j) of the Act, and this final rule incorporates the amendments made by section 305 of Public Law 106-554. We

find good cause to waive notice and comment procedures with respect to the provisions of this final rule implementing the amendments made to section 305 of Public Law 106-554 because the amendments do not require an exercise of discretion and therefore publishing a notice of proposed rulemaking with respect to the amendments is unnecessary.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. Section § 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct

costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with § 413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of § 412.604.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after January 1, 2002.

Subpart B—Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

- A. Revising paragraph (a).
- B. Redesignating paragraph (b) as paragraph (c).
- C. Adding a new paragraph (b).
- D. Revising the introductory text of the redesignated paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2002,

covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

* * * * *

- 4. Section 412.22 is amended by:
 - A. Revising paragraphs (a) and (b).
 - B. Revising the introductory text of paragraph (e).
 - C. Revising introductory text of paragraph (h)(2).

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and § 412.20(b), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraph (h)(3) 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 prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

- 5. Section 412.23 is amended by:
 - A. Revising the introductory text of the section.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2) and in Subpart P of this part:

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in § 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in

accordance with the provisions in § 412.130.

* * * * *

6. In § 412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§ 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 psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) *Satellite facilities.* * * * (2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

7. In § 412.29, the introductory text is revised to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

In order 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)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

8. In § 412.116, paragraph (a) is revised to read as follows:

§ 412.116 Method of payment.

(a) *General rule.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§ 413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the

conditions of § 412.604 are made as described in § 412.632.

* * * * *

9. In § 412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* * * *

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

* * * * *

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002,

the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

Subparts N and O—[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§ 412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632, is added to read as follows:

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

Sec.

- 412.600 Basis and scope of subpart.
- 412.602 Definitions.
- 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.
- 412.606 Patient assessments.
- 412.608 Patients' rights regarding the collection of patient assessment data.
- 412.610 Assessment schedule.
- 412.612 Coordination of the collection of patient assessment data.
- 412.614 Transmission of patient assessment data.
- 412.616 Release of information collected using the patient assessment instrument.
- 412.618 Assessment process for interrupted stays.
- 412.620 Patient classification system.
- 412.622 Basis of payment.
- 412.624 Methodology for calculating the Federal prospective payment rates.
- 412.626 Transition period.
- 412.628 Publication of the Federal prospective payment rates.
- 412.630 Limitation on review.
- 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

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

§ 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart—
Assessment reference date means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

CMS stands for the Centers for Medicare & Medicaid Services.

Comorbidity means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Discharge. A Medicare patient in a inpatient rehabilitation facility is considered discharged when—

- (1) The patient is formally released;
- (2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services; or
- (3) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized patient assessment software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient

rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Patient assessment instrument refers to a document that contains clinical, demographic, and other information on a patient.

Rural area means an area as defined in § 412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in § 412.62(f)(1)(ii).

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

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(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, we may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the

inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606.

(d) *Limitation on charges to beneficiaries—(1) Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under § 489.20(a) of this chapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.*

(1) Subject to the provisions of § 412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this subchapter. Inpatient hospital services do not include the following:

(i) Physicians' services that meet the requirements of § 415.102(a) of this subchapter for payment on a fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in § 410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare

beneficiary either directly or under arrangements (as defined in § 409.3 of this subchapter).

(f) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

§ 412.606 Patient assessments.

(a) *Admission orders.* At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service inpatients who—

(1) Are admitted on or after January 1, 2002; or

(2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(c) *Comprehensive assessments.* (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

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

(a) Before performing an assessment using the patient assessment

instrument, a clinician of the IRF must inform the Medicare Part A fee-for-service inpatient of the following patient rights:

(1) The right to be informed of the purpose of the collection of the patient assessment data;

(2) The right to have the patient assessment information collected be kept confidential and secure;

(3) 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;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on his or her patient assessment.

(b) The inpatient rehabilitation facility must ensure that a clinician documents in the Medicare Part A fee-for-service inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13 of this chapter.

§ 412.610 Assessment schedule.

(a) *General.* For each Medicare Part A fee-for-service inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in § 412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the Medicare Part A fee-for-service inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) *Assessment schedules and reference dates.* The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-service patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) *Admission assessment.*

(i) *General rule.* The admission assessment—

(A) Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization;

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in

paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed on the calendar day that follows the admission assessment reference day.

(ii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) *Discharge assessment.*

(i) *General rule.* The discharge assessment—

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) *Discharge assessment reference date.* The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the IRF; or

(B) The patient stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services.

(iii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) *Encoding dates.* The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) *Accuracy of the patient assessment data.* The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) *Patient assessment instrument record retention.* An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic

computer file format that the inpatient rehabilitation facility can easily obtain.

§ 412.612 Coordination of the collection of patient assessment data.

(a) *Responsibilities of the clinician.* A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under § 412.610(c).

(b) *Penalty for falsification.*

(1) Under Medicare, an individual who knowingly and willfully—

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§ 412.614 Transmission of patient assessment data.

(a) *Data format.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient—

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) *Transmission dates.* The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data

system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in § 412.610(d).

(d) *Late transmission penalty.* (1) We assess a penalty when an inpatient rehabilitation facility does not transmit the required data from the patient assessment instrument to the our patient data system in accordance with the transmission timeframe in paragraph (c) of this section.

(2) If the actual patient assessment data transmission date is later than 10 calendar days from the transmission date specified in paragraph (c) of this section, the patient assessment data is considered late and the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

§ 412.616 Release of information collected using the patient assessment instrument.

(a) *General.* An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ 412.618 Assessment process for interrupted stays.

For purposes of the patient assessment process, if a Medicare Part A fee-for-service patient has an interrupted stay, as defined under § 412.602, the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) *Recording and encoding of data.* The clinician must record the interruption of the stay on the patient assessment instrument.

(c) *Revised assessment schedule.* (1) If the interruption in the stay occurs before the admission assessment, the assessment reference date, completion dates, encoding dates, and data transmission dates for the admission

and discharge assessments are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

(2) If the interruption in the stay occurs after the admission assessment and before the discharge assessment, the completion date, encoding date, and data transmission date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

§ 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 §§ 413.85 and 413.86 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.

§ 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 under 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 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 budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* We apply 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, we estimate 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 budget neutral conversion factor.* The budget neutral 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, we compute a budget neutral conversion factor for fiscal year 2002, as specified by us, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The budget neutral 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 budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the budget neutral conversion factor.* The budget neutral

conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* We determine a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* We adjust 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 subchapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* We adjust the budget neutral conversion factor for a given year if we determine that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such 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.

(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.

(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) *Adjustment for high-cost outliers.* We provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by us. 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.

(5) *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.

(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), and (e)(3) 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) *Interruption of one day or less.*

Payment for a patient stay with an interruption of one day or less 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 an interruption of one day or less will only be made to the inpatient rehabilitation facility.

(2) *Interruption of more than one day.*

Payment for a patient stay with an interruption of more than one day but less than 3 consecutive days, as defined in § 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.

§ 412.626 Transition period.

(a) *Duration of transition period and proportion of the blended transition rate.* (1) Except for a facility that makes an election under paragraph (b) of this section, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under § 412.624(e) or § 412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates

the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) *Election not to be paid under the transition period methodology.* An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received or not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

§ 412.628 Publication of the Federal prospective payment rates.

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act,

or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.*

(1) *Criteria for receiving periodic interim payments.*

(i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for

less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.*

Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.*

For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an

accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

- A. Revising paragraph (d)(2)(ii).
- B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§ 413.1 Introduction.

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(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units

(distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

- A. Republishing the introductory text of paragraph (a)(2)(i).
- B. Adding a new paragraph (a)(2)(i)(C).
- C. Revising paragraph (a)(2)(ii).
- D. Adding a new paragraph (a)(2)(iii).

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after January 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§ 412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before January 1, 2002, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

* * * * *

Subpart E—Payments to Providers

4. In § 413.64, paragraph (h)(2)(i) is revised to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement—* * * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: June 11, 2001.

Thomas A. Scully,
Administrator, Centers for Medicare & Medicaid Services.

Dated: July 23, 2001.

Tommy G. Thompson,
Secretary.

Editorial Note: The following Addendum and Appendix A through Appendix D to the preamble will not appear in the Code of Federal Regulations.

Addendum—Tables

This section contains tables referred to throughout the preamble to this final rule. The tables presented below are as follows:

Table 1—Relative Weights for Case-Mix Groups (CMGs)

Table 2—Federal Prospective Payments for Case-Mix Groups

Table 3A—Wage Index for Urban Areas

Table 3B—Wage Index for Rural Areas

TABLE 1.—RELATIVE WEIGHTS FOR CASE-MIX GROUPS (CMGs)

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weights				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke; M=69–84 and C=23–35	0.4778	0.4279	0.4078	0.3859	10	9	6	8
0102	Stroke; M=59–68 and C=23–35	0.6506	0.5827	0.5553	0.5255	11	12	10	10
0103	Stroke; M=59–84 and C=5–22	0.8296	0.7430	0.7080	0.6700	14	12	12	12
0104	Stroke; M=53–58	0.9007	0.8067	0.7687	0.7275	17	13	12	13
0105	Stroke; M=47–52	1.1339	1.0155	0.9677	0.9158	16	17	15	15

TABLE 1.—RELATIVE WEIGHTS FOR CASE-MIX GROUPS (CMGs)—Continued

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weights				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0106	Stroke; M=42–46	1.3951	1.2494	1.1905	1.1267	18	18	18	18
0107	Stroke; M=39–41	1.6159	1.4472	1.3790	1.3050	17	20	21	21
0108	Stroke; M=34–38 and A≥83	1.7477	1.5653	1.4915	1.4115	25	27	22	23
0109	Stroke; M=34–38 and A≤82	1.8901	1.6928	1.6130	1.5265	24	24	22	24
0110	Stroke; M=12–33 and A≥89	2.0275	1.8159	1.7303	1.6375	29	25	27	26
0111	Stroke; M=27–33 and A=82–88	2.0889	1.8709	1.7827	1.6871	29	26	24	27
0112	Stroke; M=12–26 and A=82–88	2.4782	2.2195	2.1149	2.0015	40	33	30	31
0113	Stroke; M=27–33 and A=81	2.2375	2.0040	1.9095	1.8071	30	27	27	28
0114	Stroke; M=12–26 and A=81	2.7302	2.4452	2.3300	2.2050	37	34	32	33
0201	Traumatic brain injury; M=52–84 and C=24–35	0.7689	0.7276	0.6724	0.6170	13	14	14	11
0202	Traumatic brain injury; M=40–51 and C=24–35	1.1181	1.0581	0.9778	0.8973	18	16	17	16
0203	Traumatic brain injury; M=40–84 and C=5–23	1.3077	1.2375	1.1436	1.0495	19	20	19	18
0204	Traumatic brain injury; M=30–39	1.6534	1.5646	1.4459	1.3269	24	23	22	22
0205	Traumatic brain injury; M=12–29	2.5100	2.3752	2.1949	2.0143	44	36	35	31
0301	Non-traumatic brain injury; M=51–84	0.9655	0.8239	0.7895	0.7195	14	14	12	13
0302	Non-traumatic brain injury; M=41–50	1.3678	1.1672	1.1184	1.0194	19	17	17	16
0303	Non-traumatic brain injury; M=25–40	1.8752	1.6002	1.5334	1.3976	23	23	22	22
0304	Non-traumatic brain injury; M=12–24	2.7911	2.3817	2.2824	2.0801	44	32	34	31
0401	Traumatic spinal cord injury; M=50–84	0.9282	0.8716	0.8222	0.6908	15	15	16	14
0402	Traumatic spinal cord injury; M=36–49	1.4211	1.3344	1.2588	1.0576	21	18	22	19
0403	Traumatic spinal cord injury; M=19–35	2.3485	2.2052	2.0802	1.7478	32	32	31	30
0404	Traumatic spinal cord injury; M=12–18	3.5227	3.3078	3.1203	2.6216	46	43	62	40
0501	Non-traumatic spinal cord injury; M=51–84 and C=30–35	0.7590	0.6975	0.6230	0.5363	12	13	10	10
0502	Non-traumatic spinal cord injury; M=51–84 and C=5–29	0.9458	0.8691	0.7763	0.6683	15	17	10	12
0503	Non-traumatic spinal cord injury; M=41–50	1.1613	1.0672	0.9533	0.8206	17	17	15	14
0504	Non-traumatic spinal cord injury; M=34–40	1.6759	1.5400	1.3757	1.1842	23	21	21	19
0505	Non-traumatic spinal cord injury; M=12–33	2.5314	2.3261	2.0778	1.7887	31	31	29	28
0601	Neurological; M=56–84	0.8794	0.6750	0.6609	0.5949	14	13	12	12
0602	Neurological; M=47–55	1.1979	0.9195	0.9003	0.8105	15	15	14	15
0603	Neurological; M=36–46	1.5368	1.1796	1.1550	1.0397	21	18	18	18
0604	Neurological; M=12–35	2.0045	1.5386	1.5065	1.3561	31	24	25	23
0701	Fracture of lower extremity; M=52–84	0.7015	0.7006	0.6710	0.5960	13	13	12	11
0702	Fracture of lower extremity; M=46–51	0.9264	0.9251	0.8861	0.7870	15	15	16	14
0703	Fracture of lower extremity; M=42–45	1.0977	1.0962	1.0500	0.9326	18	17	17	16
0704	Fracture of lower extremity; M=38–41	1.2488	1.2471	1.1945	1.0609	14	20	19	18
0705	Fracture of lower extremity; M=12–37	1.4760	1.4740	1.4119	1.2540	20	22	22	21
0801	Replacement of lower extremity joint; M=58–84	0.4909	0.4696	0.4518	0.3890	9	9	8	8
0802	Replacement of lower extremity joint; M=55–57	0.5667	0.5421	0.5216	0.4490	10	10	9	9
0803	Replacement of lower extremity joint; M=47–54	0.6956	0.6654	0.6402	0.5511	9	11	11	10
0804	Replacement of lower extremity joint; M=12–46 and C=32–35	0.9284	0.8881	0.8545	0.7356	15	14	14	12
0805	Replacement of lower extremity joint; M=40–46 and C=5–31	1.0027	0.9593	0.9229	0.7945	16	16	14	14
0806	Replacement of lower extremity joint; M=12–39 and C=5–31	1.3681	1.3088	1.2592	1.0840	21	20	19	18
0901	Other orthopedic; M=54–84	0.6988	0.6390	0.6025	0.5213	12	11	11	11
0902	Other orthopedic; M=47–53	0.9496	0.8684	0.8187	0.7084	15	15	14	13
0903	Other orthopedic; M=38–46	1.1987	1.0961	1.0334	0.8942	18	18	17	16
0904	Other orthopedic; M=12–37	1.6272	1.4880	1.4029	1.2138	23	23	23	21
1001	Amputation, lower extremity; M=61–84	0.7821	0.7821	0.7153	0.6523	13	13	12	13
1002	Amputation, lower extremity; M=52–60	0.9998	0.9998	0.9144	0.8339	15	15	14	15
1003	Amputation, lower extremity; M=46–51	1.2229	1.2229	1.1185	1.0200	18	17	17	18
1004	Amputation, lower extremity; M=39–45	1.4264	1.4264	1.3046	1.1897	20	20	19	19
1005	Amputation, lower extremity; M=12–38	1.7588	1.7588	1.6086	1.4670	21	25	23	23
1101	Amputation, non-lower extremity; M=52–84	1.2621	0.7683	0.7149	0.6631	18	11	13	12
1102	Amputation, non-lower extremity; M=38–51	1.9534	1.1892	1.1064	1.0263	25	18	17	18
1103	Amputation, non-lower extremity; M=12–37	2.6543	1.6159	1.5034	1.3945	33	23	22	25
1201	Osteoarthritis; M=55–84 and C=34–35	0.7219	0.5429	0.5103	0.4596	13	10	11	9
1202	Osteoarthritis; M=55–84 and C=5–33	0.9284	0.6983	0.6563	0.5911	16	11	13	13
1203	Osteoarthritis M=48–54	1.0771	0.8101	0.7614	0.6858	18	15	14	13
1204	Osteoarthritis M=39–47	1.3950	1.0492	0.9861	0.8882	22	19	16	17
1205	Osteoarthritis M=12–38	1.7874	1.3443	1.2634	1.1380	27	21	21	20
1301	Rheumatoid, other arthritis M=54–84	0.7719	0.6522	0.6434	0.5566	13	14	13	11
1302	Rheumatoid, other arthritis M=47–53	0.9882	0.8349	0.8237	0.7126	16	14	14	14
1303	Rheumatoid, other arthritis M=36–46	1.3132	1.1095	1.0945	0.9469	20	18	16	17
1304	Rheumatoid, other arthritis M=12–35	1.8662	1.5768	1.5555	1.3457	25	25	29	22
1401	Cardiac; M=56–84	0.7190	0.6433	0.5722	0.5156	15	12	11	11
1402	Cardiac; M=48–55	0.9902	0.8858	0.7880	0.7101	13	15	13	13
1403	Cardiac; M=38–47	1.2975	1.1608	1.0325	0.9305	21	19	16	16
1404	Cardiac; M=12–37	1.8013	1.6115	1.4335	1.2918	30	24	21	20
1501	Pulmonary; M=61–84	0.8032	0.7633	0.6926	0.6615	15	13	13	13
1502	Pulmonary; M=48–60	1.0268	0.9758	0.8855	0.8457	17	17	14	15
1503	Pulmonary; M=36–47	1.3242	1.2584	1.1419	1.0906	21	20	18	18
1504	Pulmonary; M=12–35	2.0598	1.9575	1.7763	1.6965	30	28	30	26
1601	Pain syndrome; M=45–84	0.8707	0.8327	0.7886	0.6603	15	14	13	13
1602	Pain syndrome; M=12–44	1.3320	1.2739	1.2066	1.0103	21	20	20	18
1701	Major multiple trauma without brain or spinal cord injury; M=46–84	0.9996	0.9022	0.8138	0.7205	16	14	11	13
1702	Major multiple trauma without brain or spinal cord injury; M=33–45	1.4755	1.3317	1.2011	1.0634	21	21	20	18
1703	Major multiple trauma without brain or spinal cord injury; M=12–32	2.1370	1.9288	1.7396	1.5402	33	28	27	24
1801	Major multiple trauma with brain or spinal cord injury; M=45–84 and C=33–35	0.7445	0.7445	0.6862	0.6282	12	12	12	10
1802	Major multiple trauma with brain or spinal cord injury; M=45–84 and C=5–32	1.0674	1.0674	0.9838	0.9007	16	16	16	16

TABLE 1.—RELATIVE WEIGHTS FOR CASE-MIX GROUPS (CMGs)—Continued

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weights				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1803	Major multiple trauma with brain or spinal cord injury; M=26–44	1.6350	1.6350	1.5069	1.3797	22	25	20	22
1804	Major multiple trauma with brain or spinal cord injury; M=12–25	2.9140	2.9140	2.6858	2.4589	41	29	40	40
1901	Guillian Barre; M=47–84	1.1585	1.0002	0.9781	0.8876	15	15	16	15
1902	Guillian Barre; M=31–46	2.1542	1.8598	1.8188	1.6505	27	27	27	24
1903	Guillian Barre; M=12–30	3.1339	2.7056	2.6459	2.4011	41	35	30	40
2001	Miscellaneous; M=54–84	0.8371	0.7195	0.6705	0.6029	12	13	11	12
2002	Miscellaneous; M=45–53	1.1056	0.9502	0.8855	0.7962	15	15	14	14
2003	Miscellaneous; M=33–44	1.4639	1.2581	1.1725	1.0543	20	18	18	18
2004	Miscellaneous; M=12–32 and A≥82	1.7472	1.5017	1.3994	1.2583	30	22	21	22
2005	Miscellaneous; M=12–32 and A≤81	2.0799	1.7876	1.6659	1.4979	33	25	24	24
2101	Burns; M=46–84	1.0357	0.9425	0.8387	0.8387	18	18	15	16
2102	Burns; M=12–45	2.2508	2.0482	1.8226	1.8226	31	26	26	29
5001	Short-stay cases, length of stay is 3 days or fewer				0.1651				3
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.4279				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.2390				23
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.5436				9
5104	Expired, not orthopedic, length of stay is 16 days or more				1.7100				28

TABLE 2.—FEDERAL PROSPECTIVE PAYMENTS FOR CASE-MIX GROUPS (CMGs)

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidities
0101	\$5,656.20	\$5,065.48	\$4,827.54	\$4,568.28
0102	7,701.80	6,898.00	6,573.64	6,220.87
0103	9,820.80	8,795.63	8,381.30	7,931.46
0104	10,662.49	9,549.71	9,099.87	8,612.15
0105	13,423.11	12,021.49	11,455.63	10,841.24
0106	16,515.19	14,790.40	14,093.14	13,337.87
0107	19,129.02	17,131.95	16,324.60	15,448.59
0108	20,689.27	18,530.02	17,656.38	16,709.34
0109	22,375.00	20,039.37	19,094.69	18,070.71
0110	24,001.55	21,496.62	20,483.29	19,384.73
0111	24,728.40	22,147.71	21,103.60	19,971.89
0112	29,336.93	26,274.44	25,036.19	23,693.76
0113	26,487.53	23,723.35	22,604.66	21,392.45
0114	32,320.11	28,946.28	27,582.54	26,102.79
0201	9,102.24	8,613.33	7,959.87	7,304.05
0202	13,236.07	12,525.79	11,575.20	10,622.24
0203	15,480.55	14,649.53	13,537.94	12,423.98
0204	19,572.95	18,521.73	17,116.56	15,707.84
0205	29,713.38	28,117.62	25,983.23	23,845.28
0301	11,429.59	9,753.33	9,346.10	8,517.44
0302	16,192.02	13,817.31	13,239.62	12,067.66
0303	22,198.62	18,943.17	18,152.39	16,544.79
0304	33,041.04	28,194.56	27,019.05	24,624.22
0401	10,988.03	10,318.00	9,733.20	8,177.69
0402	16,822.98	15,796.63	14,901.67	12,519.87
0403	27,801.54	26,105.16	24,625.41	20,690.46
0404	41,701.72	39,157.74	36,938.11	31,034.50
0501	8,985.04	8,257.01	7,375.07	6,348.72
0502	11,196.38	10,288.41	9,189.84	7,911.34
0503	13,747.47	12,633.51	11,285.17	9,714.26
0504	19,839.30	18,230.52	16,285.54	14,018.56
0505	29,966.71	27,536.37	24,597.00	21,174.63
0601	10,410.34	7,990.65	7,823.73	7,042.43
0602	14,180.74	10,885.04	10,657.75	9,594.70
0603	18,192.64	13,964.10	13,672.89	12,307.97
0604	23,729.27	18,213.95	17,833.95	16,053.51
0701	8,304.36	8,293.70	7,943.30	7,055.45
0702	10,966.72	10,951.33	10,489.65	9,316.51
0703	12,994.57	12,976.82	12,429.90	11,040.12
0704	14,783.29	14,763.17	14,140.49	12,558.93
0705	17,472.89	17,449.21	16,714.07	14,844.85
0801	5,811.27	5,559.12	5,348.41	4,604.98
0802	6,708.59	6,417.38	6,174.70	5,315.26
0803	8,234.51	7,877.01	7,578.69	6,523.92
0804	10,990.40	10,513.33	10,115.57	8,708.03
0805	11,869.96	11,356.19	10,925.29	9,405.29
0806	16,195.57	15,493.57	14,906.41	12,832.39
0901	8,272.39	7,564.48	7,132.40	6,171.15

TABLE 2.—FEDERAL PROSPECTIVE PAYMENTS FOR CASE-MIX GROUPS (CMGs)—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidities
0902	11,241.36	10,280.12	9,691.77	8,386.04
0903	14,190.21	12,975.63	12,233.39	10,585.54
0904	19,262.79	17,614.94	16,607.53	14,368.96
1001	9,258.50	9,258.50	8,467.72	7,721.93
1002	11,835.63	11,835.63	10,824.67	9,871.71
1003	14,476.69	14,476.69	13,240.80	12,074.76
1004	16,885.72	16,885.72	15,443.85	14,083.67
1005	20,820.67	20,820.67	19,042.61	17,366.35
1101	14,940.74	9,095.14	8,462.99	7,849.78
1102	23,124.35	14,077.75	13,097.56	12,149.34
1103	31,421.60	19,129.02	17,797.25	16,508.09
1201	8,545.85	6,426.85	6,040.93	5,440.74
1202	10,990.40	8,266.48	7,769.28	6,997.44
1203	12,750.71	9,589.96	9,013.45	8,118.50
1204	16,514.01	12,420.43	11,673.45	10,514.51
1205	21,159.24	15,913.82	14,956.13	13,471.64
1301	9,137.75	7,720.74	7,616.57	6,589.03
1302	11,698.31	9,883.55	9,750.96	8,435.76
1303	15,545.66	13,134.26	12,956.69	11,209.40
1304	22,092.08	18,666.16	18,414.01	15,930.40
1401	8,511.52	7,615.39	6,773.70	6,103.67
1402	11,721.99	10,486.10	9,328.34	8,406.16
1403	15,359.81	13,741.55	12,222.74	11,015.26
1404	21,323.79	19,076.94	16,969.77	15,292.33
1501	9,508.28	9,035.95	8,199.00	7,830.84
1502	12,155.26	11,551.52	10,482.55	10,011.40
1503	15,675.88	14,896.94	13,517.81	12,910.52
1504	24,383.91	23,172.89	21,027.84	20,083.17
1601	10,307.35	9,857.50	9,335.45	7,816.63
1602	15,768.22	15,080.43	14,283.73	11,959.93
1701	11,833.26	10,680.24	9,633.76	8,529.28
1702	17,466.97	15,764.66	14,218.62	12,588.53
1703	25,297.81	22,833.13	20,593.38	18,232.89
1801	8,813.39	8,813.39	8,123.24	7,436.63
1802	12,635.88	12,635.88	11,646.22	10,662.49
1803	19,355.13	19,355.13	17,838.68	16,332.89
1804	34,495.93	34,495.93	31,794.50	29,108.46
1901	13,714.32	11,840.37	11,578.75	10,507.41
1902	25,501.42	22,016.31	21,530.95	19,538.62
1903	37,099.11	32,028.89	31,322.16	28,424.22
2001	9,909.59	8,517.44	7,937.38	7,137.13
2002	13,088.09	11,248.47	10,482.55	9,425.42
2003	17,329.65	14,893.39	13,880.06	12,480.80
2004	20,683.35	17,777.12	16,566.10	14,895.76
2005	24,621.86	21,161.61	19,720.92	17,732.14
2101	12,260.62	11,157.32	9,928.53	9,928.53
2102	26,644.97	24,246.59	21,575.94	21,575.94
5001	.....	.....	.....	1,954.45
5101	.....	.....	.....	5,065.48
5102	.....	.....	.....	14,667.28
5103	.....	.....	.....	6,435.14
5104	.....	.....	.....	20,242.98

TABLE 3A.—WAGE INDEX FOR URBAN AREAS

MSA—Urban area (constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.8240
Taylor, TX	
0060 Aguadilla, PR	0.4391
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9541
Portage, OH	
Summit, OH	
0120 Albany, GA	0.9893

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8480
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
0200 Albuquerque, NM	0.9146
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8121
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9839
Carbon, PA	
Lehigh, PA	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index	MSA—Urban area (constituent counties or county equivalents)	Wage index	MSA—Urban area (constituent counties or county equivalents)	Wage index
Northampton, PA		0720 Baltimore, MD	0.9223	1150 Bremerton, WA	1.0975
0280 Altoona, PA	0.9317	Anne Arundel, MD		Kitsap, WA	
Blair, PA		Baltimore, MD		1240 Brownsville-Harlingen-San Benito, TX	0.8714
0320 Amarillo, TX	0.8673	Baltimore City, MD		Cameron, TX	
Potter, TX		Carroll, MD		1260 Bryan-College Station, TX	0.8237
Randall, TX		Harford, MD		Brazos, TX	
0380 Anchorage, AK	1.2775	Howard, MD		1280 Buffalo-Niagara Falls, NY	0.9455
Anchorage, AK		Queen Annes, MD		Erie, NY	
0440 Ann Arbor, MI	1.1093	0733 Bangor, ME	0.9550	Niagara, NY	
Lenawee, MI		Penobscot, ME		1303 Burlington, VT	1.0840
Livingston, MI		0743 Barnstable-Yarmouth, MA	1.3801	Chittenden, VT	
Washtenaw, MI		Barnstable, MA		Franklin, VT	
0450 Anniston, AL	0.8284	0760 Baton Rouge, LA	0.8796	Grand Isle, VT	
Calhoun, AL		Ascension, LA		1310 Caguas, PR	0.4548
0460 Appleton-Oshkosh-Neenah, WI	0.9052	East Baton Rouge		Caguas, PR	
Calumet, WI		Livingston, LA		Cayey, PR	
Outagamie, WI		West Baton Rouge, LA		Cidra, PR	
Winnebago, WI		0840 Beaumont-Port Arthur, TX	0.8734	Gurabo, PR	
0470 Arecibo, PR	0.4525	Hardin, TX		San Lorenzo, PR	
Arecibo, PR		Jefferson, TX		1320 Canton-Massillon, OH	0.8480
Camuy, PR		Orange, TX		Carroll, OH	
Hatillo, PR		0860 Bellingham, WA	1.1439	Stark, OH	
0480 Asheville, NC	0.9479	Whatcom, WA		1350 Casper, WY	0.8724
Buncombe, NC		0870 Benton Harbor, MI	0.8671	Natrona, WY	
Madison, NC		Berrien, MI		1360 Cedar Rapids, IA	0.8716
0500 Athens, GA	0.9739	0875 Bergen-Passaic, NJ	1.1818	Linn, IA	
Clarke, GA		Bergen, NJ		1400 Champaign-Urbana, IL	0.9189
Madison, GA		Passaic, NJ		Champaign, IL	
Oconee, GA		0880 Billings, MT	0.9604	1440 Charleston-North Charleston, SC	0.9029
0520 Atlanta, GA	1.0097	Yellowstone, MT		Berkeley, SC	
Barrow, GA		0920 Biloxi-Gulfport-Pascagoula, MS	0.8236	Charleston, SC	
Bartow, GA		Hancock, MS		Dorchester, SC	
Carroll, GA		Harrison, MS		1480 Charleston, WV	0.9235
Cherokee, GA		Jackson, MS		Kanawha, WV	
Clayton, GA		0960 Binghamton, NY	0.8600	Putnam, WV	
Cobb, GA		Broome, NY		1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9321
Coweta, GA		Tioga, NY		Cabarrus, NC	
De Kalb, GA		1000 Birmingham, AL	0.8360	Gaston, NC	
Douglas, GA		Blount, AL		Lincoln, NC	
Fayette, GA		Jefferson, AL		Mecklenburg, NC	
Forsyth, GA		St. Clair, AL		Rowan, NC	
Fulton, GA		Shelby, AL		Stanly, NC	
Gwinnett, GA		1010 Bismarck, ND	0.7625	Union, NC	
Henry, GA		Burleigh, ND		York, SC	
Newton, GA		Morton, ND		1540 Charlottesville, VA	1.0581
Paulding, GA		1020 Bloomington, IN	0.8733	Albemarle, VA	
Pickens, GA		Monroe, IN		Charlottesville City, VA	
Rockdale, GA		1040 Bloomington-Normal, IL	0.9095	Fluvanna, VA	
Spalding, GA		McLean, IL		Greene, VA	
Walton, GA		1080 Boise City, ID	0.9006	1560 Chattanooga, TN-GA	0.9790
0560 Atlantic City-Cape May, NJ	1.1167	Ada, ID		Catoosa, GA	
Atlantic City, NJ		Canyon, ID		Dade, GA	
Cape May, NJ		1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1086	Walker, GA	
0580 Auburn-Opelika, AL	0.8079	Bristol, MA		Hamilton, TN	
Lee, AL		Essex, MA		Marion, TN	
0600 Augusta-Aiken, GA-SC	0.9127	Middlesex, MA		1580 Cheyenne, WY	0.8308
Columbia, GA		Norfolk, MA		Laramie, WY	
McDuffie, GA		Plymouth, MA		1600 Chicago, IL	1.1092
Richmond, GA		Suffolk, MA		Cook, IL	
Aiken, SC		Worcester, MA		De Kalb, IL	
Edgefield, SC		Hillsborough, NH		Du Page, IL	
0640 Austin-San Marcos, TX	0.9540	Merrimack, NH		Grundy, IL	
Bastrop, TX		Rockingham, NH		Kane, IL	
Caldwell, TX		Strafford, NH		Kendall, IL	
Hays, TX		1125 Boulder-Longmont, CO	0.9731	Lake, IL	
Travis, TX		Boulder, CO		McHenry, IL	
Williamson, TX		1145 Brazoria, TX	0.8658	Will, IL	
0680 Bakersfield, CA	0.9684	Brazoria, TX			

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
1620 Chico-Paradise, CA	0.9918
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9349
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8173
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9528
Ashtabula, OH	
Geauga, OH	
Cuyahoga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9698
El Paso, CO	
1740 Columbia MO	0.8920
Boone, MO	
1760 Columbia, SC	0.9557
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8531
Russell, AL	
Chattanooga, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9573
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8746
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1326
Benton, OR	
1900 Cumberland, MD-WV	0.8369
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9792
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8589
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8897
Scott, IA	
Henry, IL	
Rock Island, IL	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
2000 Dayton-Springfield, OH	0.9384
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9165
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8534
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8095
Macon, IL	
2080 Denver, CO	1.0120
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9073
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0364
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7943
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0078
Kent, DE	
2200 Dubuque, IA	0.8746
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0032
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0187
Dutchess, NY	
2290 Eau Claire, WI	0.8761
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9332
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9145
Elkhart, IN	
2335 Elmira, NY	0.8546
Chemung, NY	
2340 Enid, OK	0.8610
Garfield, OK	
2360 Erie, PA	0.8892
Erie, PA	
2400 Eugene-Springfield, OR	1.0960
Lane, OR	
2440 Evansville-Henderson, IN-KY	0.8137
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN ...	0.8750
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8655
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.7910

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0681
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1153
Genesee, MI	
2650 Florence, AL	0.7616
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8737
Florence, SC	
2670 Fort Collins-Loveland, CO ..	1.0620
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0118
Broward, FL	
2700 Fort Myers-Cape Coral, FL ..	0.9247
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9538
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8052
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9607
Okaloosa, FL	
2760 Fort Wayne, IN	0.8647
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Fort Worth-Arlington, TX	0.9392
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0057
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8423
Etowah, AL	
2900 Gainesville, FL	0.9741
Alachua, FL	
2920 Galveston-Texas City, TX ...	0.9796
Galveston, TX	
2960 Gary, IN	0.9451
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8361
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8423
Wayne, NC	
2985 Grand Forks, ND-MN	0.8774
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.8947
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0070
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
3040 Great Falls, MT	0.9065
Cascade, MT	
3060 Greeley, CO	0.9664
Weld, CO	
3080 Green Bay, WI	0.9207
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9068
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9402
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.8894
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9409
Washington, MD	
3200 Hamilton-Middletown, OH ...	0.9061
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9338
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1236
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7490
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9008
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1865
Honolulu, HI	
3350 Houma, LA	0.8100
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9663
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9876
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8932

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9747
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9537
Johnson, IA	
3520 Jackson, MI	0.9134
Jackson, MI	
3560 Jackson, MS	0.8749
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8796
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.9186
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.7777
Onslow, NC	
3610 Jamestown, NY	0.7818
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9587
Rock, WI	
3640 Jersey City, NJ	1.1440
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8272
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8767
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7831
Craighead, AR	
3710 Joplin, MO	0.8148
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI ...	1.0440
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9902
Kankakee, IL	
3760 Kansas City, KS-MO	0.9458
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9611
Kenosha, WI	
3810 Killeen-Temple, TX	1.0164
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8221
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9518
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9197
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8390
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.8834
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7399
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	
Polk, FL	
4000 Lancaster, PA	0.9247
Lancaster, PA	
4040 Lansing-East Lansing, MI ...	0.9880
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8168
Webb, TX	
4100 Las Cruces, NM	0.8639
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.0796
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8190
Douglas, KS	
4200 Lawton, OK	0.8996
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9003
Androscoggin, ME	
4280 Lexington, KY	0.8774
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9320
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9619
Lancaster, NE	
4400 Little Rock-North Little, AR	
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
4420 Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8922
4480 Los Angeles-Long Beach, CA Los Angeles, CA	1.1984
4520 Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9261
4600 Lubbock, TX Lubbock, TX	0.8848
4640 Lynchburg, VA Amherst, VA Bedford City, VA Bedford, VA Campbell, VA Lynchburg City, VA	0.8851
4680 Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.8848
4720 Madison, WI Dane, WI	1.0316
4800 Mansfield, OH Crawford, OH Richland, OH	0.8690
4840 Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4577
4880 McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8566
4890 Medford-Ashland, OR Jackson, OR	1.0344
4900 Melbourne-Titusville-Palm Bay, FL Brevard, FL	0.9688
4920 Memphis, TN-AR-MS Crittenden, AR De Soto, MS Fayette, TN Shelby, TN Tipton, TN	0.8688
4940 Merced, CA Merced, CA	0.9559
5000 Miami, FL Dade, FL	1.0110
5015 Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.0987
5080 Milwaukee-Waukesha, WI .. Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	0.9664

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
5120 Minneapolis-St. Paul, MN-WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Sherburne, MN Washington, MN Wright, MN Pierce, WI St. Croix, WI	1.0971
5140 Missoula, MT Missoula, MT	0.9274
5160 Mobile, AL Baldwin, AL Mobile, AL	0.8006
5170 Modesto, CA Stanislaus, CA	1.0401
5190 Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.1293
5200 Monroe, LA Ouachita, LA	0.8316
5240 Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.7642
5280 Muncie, IN Delaware, IN	1.0683
5330 Myrtle Beach, SC Horry, SC	0.8440
5345 Naples, FL Collier, FL	0.9661
5360 Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN	0.9327
5380 Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.3784
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2192
5523 New London-Norwich, CT ... New London, CT	1.2061
5560 New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9235
5600 New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY	1.4483

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Queens, NY Richmond, NY Rockland, NY Westchester, NY	
5640 Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1828
5660 Newburgh, NY-PA Orange, NY Pike, PA	1.0847
5720 Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA York, VA	0.8374
5775 Oakland, CA Alameda, CA Contra Costa, CA	1.5029
5790 Ocala, FL Marion, FL	0.9243
5800 Odessa-Midland, TX Ector, TX Midland, TX	0.9206
5880 Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8774
5910 Olympia, WA Thurston, WA	1.0689
5920 Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9470
5945 Orange County, CA Orange, CA	1.1453
5960 Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9550
5990 Owensboro, KY Daviess, KY	0.8159
6015 Panama City, FL Bay, FL	0.9010
6020 Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8258
6080 Pensacola, FL Escambia, FL	0.8176

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8494
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0753
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9628
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7771
Jefferson, AR	
6280 Pittsburgh, PA	0.9570
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0130
Berkshire, MA	
6340 Pocatello, ID	0.9076
Bannock, ID	
6360 Ponce, PR	0.4993
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9687
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR- WA	1.0913
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Paw- tucket, RI	1.0771
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0014
Utah, UT	
6560 Pueblo, CO	0.8783
Pueblo, CO	
6580 Punta Gorda, FL	0.9602
Charlotte, FL	
6600 Racine, WI	0.9231
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9583
Chatham, NC	
Durham, NC	
Franklin, NC	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8779
Pennington, SD	
6680 Reading, PA	0.9105
Berks, PA	
6690 Redding, CA	1.1641
Shasta, CA	
6720 Reno, NV	1.0550
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1460
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA ..	0.9618
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1229
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8663
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1334
Olmsted, MN	
6840 Rochester, NY	0.8991
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.8819
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.8849
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1932
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9557
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9994
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9071
Andrews, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8947

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
Sullivan City, MO	
7080 Salem, OR	1.0189
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4518
Monterey, CA	
7160 Salt Lake City-Ogden, UT ...	0.9782
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8083
Tom Green, TX	
7240 San Antonio, TX	0.8540
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1784
San Diego, CA	
7360 San Francisco, CA	1.4250
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.3759
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4651
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo- Atascadero-Paso Robles, CA	1.0673

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0580
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.4040
Santa Cruz, CA	
7490 Santa Fe, NM	1.0538
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2649
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9809
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9601
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8401
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.0985
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.7900
Mercer, PA	
7620 Sheboygan, WI	0.8379
Sheboygan, WI	
7640 Sherman-Denison, TX	0.8694
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8705
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8471
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8790
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9848
St. Joseph, IN	
7840 Spokane, WA	1.0496
Spokane, WA	
7880 Springfield, IL	0.8656
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8484
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0485
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9022
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8548
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0606
San Joaquin, CA	
8140 Sumter, SC	0.8271
Sumter, SC	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
8160 Syracuse, NY	0.9378
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1553
Pierce, WA	
8240 Tallahassee, FL	0.8482
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.8960
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8268
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8341
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9742
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9051
Shawnee, KS	
8480 Trenton, NJ	1.0113
Mercer, NJ	
8520 Tucson, AZ	0.8785
Pima, AZ	
8560 Tulsa, OK	0.8480
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8064
Tuscaloosa, AL	
8640 Tyler, TX	0.9340
Smith, TX	
8680 Utica-Rome, NY	0.8547
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.2849
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1040
Ventura, CA	
8750 Victoria, TX	0.8154
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0501
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9551
Tulare, CA	
8800 Waco, TX	0.8253
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0711
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	

TABLE 3A.—WAGE INDEX FOR URBAN AREAS—Continued

MSA—Urban area (constituent counties or county equivalents)	Wage index
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8404
Black Hawk, IA	
8940 Wausau, WI	0.9418
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9699
Palm Beach, FL	
9000 Wheeling, OH-WV	0.7665
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9502
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7647
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8332
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	
New Castle, DE	1.0826
Cecil, MD	
9200 Wilmington, NC	0.9394
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	0.9876
Yakima, WA	
9270 Yolo, CA	1.0199
Yolo, CA	
9280 York, PA	0.9196
York, PA	
9320 Youngstown-Warren, OH	0.9477
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0706
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9529
Yuma, AZ	

TABLE 3B.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7483

TABLE 3B.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Alaska	1.2380
Arizona	0.8309
Arkansas	0.7444
California	0.9857
Colorado	0.8967
Connecticut	1.1715
Delaware	0.9058
Florida	0.8918
Georgia	0.8326
Guam .....	.....
Hawaii	1.1053
Idaho	0.8650
Illinois	0.8152
Indiana	0.8602
Iowa	0.8000
Kansas	0.7574
Kentucky	0.7921
Louisiana	0.7655
Maine	0.8736
Maryland	0.8651
Massachusetts	1.1205
Michigan	0.8969
Minnesota	0.8864
Mississippi	0.7481
Missouri	0.7693
Montana	0.8679
Nebraska	0.8055
Nevada	0.9228
New Hampshire	0.9741
New Jersey ¹ .....	.....
New Mexico	0.8495

TABLE 3B.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
New York	0.8472
North Carolina	0.8437
North Dakota	0.7676
Ohio	0.8663
Oklahoma	0.7484
Oregon	1.0124
Pennsylvania	0.8535
Puerto Rico	0.4264
Rhode Island ¹ .....	.....
South Carolina	0.8369
South Dakota	0.7550
Tennessee	0.7836
Texas	0.7490
Utah	0.9029
Vermont	0.9266
Virginia	0.8181
Virgin Islands .....	.....
Washington	1.0422
West Virginia	0.8206
Wisconsin	0.8865
Wyoming	0.8805

¹ All counties within the State are classified urban.

Appendix A—Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data

files used to develop the final IRF prospective payment system. A general description of the process to create this data file is contained in section III.B. of this final rule. RAND has performed the following analysis to match FIM data (that is, collectively, patient assessment data from the Uniform Data System for medical rehabilitation (UDSmr) (1996 through 1999); the Caredata Data System (COS) for medical rehabilitation (1996 and 1997); and the HealthSouth Corporation (HS) (1998 and 1999)) and our Medicare data files.

Table A shows that, for 1996 through 1999, the MedPAR files had over 12 million records per year. We are interested in a subset of these records: Cases paid by Medicare as rehabilitation stays that were excluded from the acute care hospital prospective payment system.

TABLE A.—NUMBER OF MEDPAR CASES AND FACILITIES

Calendar year	Number of cases	Number of facilities
1996	12,231,275	6,339
1997	12,263,463	6,257
1998	12,266,445	6,235
1999	12,073,949	6,223

Table B shows total 1996 through 1999 rehabilitation stays by type of provider (freestanding rehabilitation facility versus excluded unit of an acute care hospital). This was the “sampling” frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining “complete” records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would be representative of the 1996 through 1999 rehabilitation stays in the “sampling” frames.

TABLE B.—NUMBER OF REHABILITATION MEDPAR CASES AND FACILITIES

Calendar year	Type	Number of cases	Number of facilities	Total number of cases	Total number of facilities
1996	Excluded Unit	229,193	877	344,126	1,081
	Freestanding	114,933	204		
1997	Excluded Unit	240,491	911	359,032	1,123
	Freestanding	118,541	212		
1998	Excluded Unit	248,015	941	370,352	1,155
	Freestanding	122,337	214		
1999	Excluded Unit	260,745	961	390,048	1,165
	Freestanding	129,303	204		

Note: Freestanding facilities have characters 3–6 of the Medicare provider number in the range 3025–3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a “provider code” of T in their MedPAR records.

Table C shows the number of facilities and the number of FIM records for calendar years 1996 through 1999. Our sources for 1996 and 1997 were UDSmr and COS. For 1998 and 1999, we used UDSmr data and data from Caredata’s principal client, HealthSouth Corporation. (Caredata ceased to exist prior to our getting its 1998 and 1999 data.) Our tables combine data from the different sources to preserve confidentiality.

TABLE C.—NUMBER OF FIM RECORDS AND FACILITIES, BY YEAR

Calendar year	Sources	Number of Records	Number of Facilities *
1996	UDSmr/COS	269,547	692
1997	UDSmr/COS	326,265	759
1998	UDSmr/HS	343,004	751

TABLE C.—NUMBER OF FIM RECORDS AND FACILITIES, BY YEAR—Continued

Calendar year	Sources	Number of Records	Number of Facilities *
1999	UDSmr/HS	381,453	766

* For the discussion that follows, consider facilities as distinct entities within a FIM source. We adjust our counts later for possible overlap and double counting.

Matching MedPAR and FIM Facilities

The first step in the matching process is to link MedPAR facilities to FIM facilities. For each of these combinations, RAND counted the number of exact matches of MedPAR and FIM records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our FIM data sets is slightly more than half of all IRFs.

TABLE D.—NUMBERS OF FIM FACILITIES LINKED TO MEDPAR FACILITIES

Calendar year	Sources	MedPAR unique ^a	MedPAR multiple ^b	MedPAR nonmatch ^c	Total
1996	UDSmr/COS	568	18	106	692
1997	UDSmr/COS	625	33	101	759
1998	UDSmr/HS	730	19	2	751
1999	UDSmr/HS	729	35	2	766

^a FIM IRFs that appear to have a single MedPAR provider.

^b FIM IRFs that appear to have more than one MedPAR provider.

^c FIM IRFs that did not link to our Medicare files. The large drop between 1997 and 1998 is because SNF and long-term care hospital data were excluded from our 1998/1999 request.

The FIM data do not contain the Medicare beneficiary identifier and, therefore, it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

- (1) Identify match variables;
- (2) Recode certain FIM variables to be consistent with MedPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;
- (3) Run a match algorithm to link FIM and MedPAR records; and
- (4) Choose a single MedPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility

identifier pairings was performed. An attempt was made to match all MedPAR records to a FIM record for all facilities.

For MedPAR, in addition to facility identity, six variables were used to link the records: admission date, discharge date, zip code, age at admission, sex, and race. For FIM, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payer was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create/Delete FIM Records

COS and HS coded interrupted stays in a manner similar to Medicare: one record per rehabilitation discharge episode. Therefore, these records did

not require any additional processing. However, UDSmr codes multiple stays via a series of “transfer/return” dates on a single UDSmr record. To facilitate matching UDSmr and MedPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records were then given the same chance of matching MedPAR records as any noninterrupted stay.

For UDSmr, COS, and HS files, there were some duplicate cases that had to be eliminated.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MedPAR.

TABLE E.—NUMBER OF FIM RECORDS AT VARIOUS STAGES OF PROCESSING

Calendar year	Source	Number of records		
		Original	After expansion	After duplicate elimination
1996	UDSmr/COS	269,547	276,554	275,378
1997	UDSmr/COS	326,265	334,794	333,370
1998	UDSmr/HS	343,004	352,602	352,469
1999	UDSmr/HS	381,453	391,820	391,627

Step 3: Match Discharges from MedPAR and FIM Facilities

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect—

any variable can be in error. A scoring function was developed, based on Bayes’ Theorem, which gives the odds of a match based on how consistent

variables tend to be for true matching and nonmatching cases.

The scoring function selects pairs with the greatest likelihood of being correct matches. A cutoff under which

scores below are considered “nonmatches” and scores above are considered “matches” is chosen empirically. We sorted the pairings by score, and examined candidate matches as a function of this score. We wanted a conservative criterion—agreement between two “matched” records not likely to be resulting from chance. We noticed that cases in the 3.2 range and above appeared to be the same: race and sex agreeing, mild disagreement between usually at most one of the other match variables (admission date, discharge date, age, and zip code). We also looked at additional variables not

employed in the matching process. For cases above the 3.2 threshold, a FIM variable tended to indicate that Medicare was the “primary payer,” and the Medicare provider code tended to be “T” in acute care hospitals; both were less likely below 3.2. Thus, we chose 3.2 as our cutoff.

Step 4: Choose a Single MedPAR Case for Multiple FIM Matches

While the matching was unique within a facility/provider pair, some MedPAR providers were paired with different facilities, as shown in Table F. Also, some UDSmr and COS/HS facilities were the same: 6 overlaps in

1996, 7 in 1997, 26 in 1998, and 1 in 1999.

TABLE F.—MEDPAR FACILITIES PAIRED WITH MULTIPLE FACILITIES

Calendar year	Sources	Number of Facilities
1996	UDSmr	5
	COS	5
1997	UDSmr	8
	COS	10
1998	UDSmr	10
	HS	0
1999	UDSmr	18
	HS	0

Each nonunique pairing had the potential of creating multiple matches to a single MedPAR record. We eliminated these matches in two steps. First, working within each UDSmr, COS, and HS file, we eliminated MedPAR duplicate links, keeping the match with the highest score. Then we checked for duplicate links between UDSmr and the corresponding COS/HS files within the same year, again keeping the match with the highest score. Table G provides results for cutoff score 3.2, as discussed in Step 3.

TABLE G.—NUMBER OF LINKED RECORDS AFTER DUPLICATES ELIMINATION

Calendar year	Sources	Number of records		
		Total records	Duplicates eliminated ¹	Overlap eliminated ²
1996	UDSmr/COS	191,173	190,480	188,889
1997	UDSmr/COS	227,696	226,411	222,682
1998	UDSmr/HS	252,662	247,296	246,450
1999	UDSmr/HS	281,230	273,772	273,548

¹ Multiple pairings can link the same MedPAR record to more than one FIM case. This step eliminates those multiple links, keeping the link with the highest match score.

² The same MedPAR provider might show up in both UDSmr and COS, again allowing the same MedPAR record to match more than one FIM case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: FIM and MedPAR, by year. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these FIM facilities for the eligible population in the IRF prospective payment system to be almost 90 percent. This was slightly higher than expected—the Carter, Relles, et al. (1997) match rates were about 86 percent.

TABLE H.—MEDPAR MATCH RATES, PROVIDERS WITH A FULL YEAR OF DATA

Calendar year	Sources	MedPAR cases	Matched cases	Percent matched
1996	UDSmr/COS	162,659	142,410	87.6
1997	UDSmr/COS	212,581	190,069	89.4
1998	UDSmr/HS	234,623	208,769	89.0
1999	UDSmr/HS	263,785	237,568	90.1

Note: Tabulations are for patients eligible for IRF prospective payment system.

The FIM files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Accordingly, restricting our attention to Medicare cases, we obtain the percentages shown in Table I.

TABLE I.—FIM MATCH RATES FOR MEDICARE AS THE PRIMARY PAYER

Calendar year	Sources	FIM cases	Matched cases	Percent matched
1996	UDSmr/COS	188,892	180,783	95.7
1997	UDSmr/COS	223,351	213,053	95.4
1998	UDSmr/HS	246,727	235,261	95.4
1999	UDSmr/HS	273,303	261,969	95.9

Note: FIM cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MedPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in freestanding facilities differed from costs in excluded units of acute care hospitals, we would consider re-

weighting the sample of linked cases to adjust our total cost estimates.

Tables J through N present an analysis of the characteristics of the facilities and cases in the matched sample described in the previous tables. The data in Tables J through N are the latest data available for the purposes of constructing a data file used to develop the IRF prospective payment system in this final rule.

Representativeness of Linked MedPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the FIM file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare

beneficiaries, and the extent to which FIM patients are representative of all Medicare eligible patients under the IRF prospective payment system. This analysis reflects the effects of the partial-year sample available for some FIM facilities as well as the sampling of MedPAR facilities. The MedPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into freestanding rehabilitation facilities (freestanding rehabilitation) and excluded rehabilitation units of acute care hospitals (excluded units). It presents the number of facilities in the linked MedPAR sample, along with the total MedPAR counts of rehabilitation patients at these facilities.

TABLE J.—COMPARISON OF NUMBER OF FIM AND MEDPAR REHABILITATION FACILITIES, BY TYPE

Year	Type of facility	Number of facilities			Number of rehabilitation patients		
		FIM ^a	Total MedPAR ^b	Percent FIM	FIM ^a	Total MedPAR ^b	Percent FIM
1996	Freestanding rehabilitation	130	204	64	86,301	114,933	75
	Excluded unit	435	877	50	130,623	229,193	57
	Total	565	1,081	42	216,924	344,126	63
1997	Freestanding rehabilitation	142	212	67	94,327	118,541	80
	Excluded unit	489	911	54	150,787	240,491	63
	Total	631	1,123	56	245,114	359,032	68
1998	Freestanding rehabilitation	171	214	80	111,503	122,337	91
	Excluded unit	515	941	55	157,483	248,015	63
	Total	686	1,155	59	268,986	370,352	73
1999	Freestanding rehabilitation	170	204	83	120,284	129,303	93
	Excluded unit	554	961	58	171,886	260,745	66
	Total	724	1,165	62	292,170	390,048	75

^aHospitals with at least one linked MedPAR/ FIM rehabilitation record.

^bTotal (matched and unmatched) rehabilitation cases.

As shown in Table J, for 1999, FIM facilities represented 62 percent of the facilities, but served almost 75 percent of all MedPAR IRF cases. Based on data found in the table, in 1999, FIM freestanding facilities had an average of 708 patients, 442 more than other-MedPAR freestanding facilities; and FIM excluded units had an average of 310 patients, 92 more than other-MedPAR excluded units.

Table K shows the distribution of FIM IRFs by size. This shows both that freestanding facilities are larger than excluded units and that FIM IRFs tend to be larger than other MedPAR facilities within type of facility.

TABLE K.—COMPARISON OF SIZES OF FIM AND MEDPAR FACILITIES, BY TYPE OF FACILITY

Number of MedPAR patients	Freestanding		Excluded unit		Freestanding		Excluded unit	
	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR
	1996				1997			
1-100	2	23	30	97	4	24	33	105
101-200	14	9	139	140	14	7	143	126
201-300	14	2	105	102	11	5	123	103
301-400	14	10	59	48	17	9	65	40
401-500	8	8	38	27	12	7	52	29
501-1000	56	16	58	26	59	15	67	18
1001-2000	20	6	6	2	24	3	6	1
2001-3000	1	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	130	74	435	442	142	70	489	422
	1998				1999			
1-100	6	19	50	115	3	13	57	100
101-200	14	9	136	125	10	9	148	115
201-300	11	5	130	82	12	5	130	85
301-400	18	2	78	52	15	1	79	63
401-500	17	2	51	28	20	1	66	26
501-1000	80	3	60	24	76	2	62	17
1001-2000	24	3	10	0	33	3	12	1
2001-3000	0	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	171	43	515	426	170	34	554	407

Table L shows the percentage of cases in FIM facilities in each State.

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR FIM SAMPLE HOSPITALS, BY STATE

State	MedPAR rehabilitation cases				Percent of cases in FIM hospital sample			
	1996	1997	1998	1999	1996	1997	1998	1999
AL	7,839	8,654	8,855	8,667	91	96	79	81
AK	247	302	280	301	55	51	56	55
AR	6,581	6,973	8,349	9,626	43	48	63	65
AZ	3,672	4,084	4,436	5,244	62	57	63	67
CA	15,294	15,559	15,579	16,936	53	51	56	58
CO	4,757	4,263	4,035	3,946	27	65	33	69
CT	2,217	2,290	1,901	1,989	69	88	90	89
DC	1,097	996	1,076	1,167	12	10	8	20
DE	1,399	1,361	1,375	1,628	76	72	70	66
FL	23,021	23,630	24,058	24,741	74	79	91	90
GA	9,615	10,716	10,874	11,062	64	65	66	68
HI	1,087	1,016	831	696	100	100	100	100
IA	1,264	1,404	1,324	1,579	100	100	98	100
ID	1,829	1,807	1,782	1,903	97	98	97	97
IL	14,953	14,894	14,720	16,111	54	62	60	62
IN	8,943	8,884	9,301	9,683	60	60	83	86
KS	3,224	3,333	3,647	4,074	27	24	64	72
KY	5,198	5,201	5,653	6,489	74	79	86	80
LA	9,206	10,061	10,292	11,079	36	50	68	67
MA	8,765	8,631	8,973	9,582	52	67	77	78
MD	867	715	767	782	77	80	80	86
ME	1,255	1,460	1,629	1,873	10	72	79	80
MI	16,523	17,255	18,157	18,797	82	82	80	81
MN	2,048	2,112	2,508	2,594	54	74	49	49
MO	9,788	10,513	10,677	11,009	34	42	58	62
MS	1,968	2,021	2,050	2,442	86	86	85	83
MT	878	766	652	681	100	100	100	100
NC	7,123	8,771	9,588	9,912	89	88	97	98
ND	1,821	1,636	1,627	1,697	86	83	73	71
NE	1,195	1,107	1,143	1,083	92	91	89	88
NH	2,310	2,505	2,435	2,375	57	58	77	75
NJ	11,234	11,083	11,172	11,988	89	96	93	99
NM	1,283	1,277	1,355	1,537	28	35	40	45

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR FIM SAMPLE HOSPITALS, BY STATE—Continued

State	MedPAR rehabilitation cases				Percent of cases in FIM hospital sample			
	1996	1997	1998	1999	1996	1997	1998	1999
NV	2,230	2,303	2,855	3,471	0	0	52	51
NY	21,431	22,875	25,755	26,271	37	51	58	72
OH	11,837	13,888	13,683	13,938	76	73	75	71
OK	6,356	6,949	7,757	8,716	51	59	58	54
OR	1,179	1,184	1,198	1,173	70	61	74	75
PA	36,989	35,700	34,201	35,552	63	69	71	73
RI	2,247	2,307	1,771	1,460	61	66	100	100
SC	4,536	4,878	5,691	6,182	83	86	83	82
SD	2,096	2,101	2,031	2,071	80	81	79	78
TN	10,731	11,917	12,317	12,744	71	71	72	76
TX	33,619	36,616	38,871	40,387	58	62	70	72
UT	858	984	1,044	1,673	43	62	57	65
VA	6,738	7,235	7,544	7,671	73	78	70	73
VT	603	567	582	691	74	73	68	75
WA	3,753	3,608	3,598	3,918	99	99	99	91
WI	6,591	6,690	6,468	6,643	87	93	89	89
WV	3,497	3,574	3,467	3,899	100	99	99	100
WY	334	376	418	315	31	75	23	49
Total	344,126	359,032	370,352	390,048	63	68	73	75

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched FIM sample. Of all the characteristics examined, the FIM sample of discharges appears very similar.

TABLE M.—PATIENT CHARACTERISTICS FOR MEDPAR REHABILITATION INPATIENTS, BY FIM STATUS

Patient characteristic	FIM	Other MedPAR	Total MedPAR	FIM	Other MedPAR	Total MedPAR
	1996			1997		
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0–50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51–60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61–70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71–80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81–90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%
	1998			1999		
Sample Size	232,691	137,661	370,352	257,024	133,024	390,048
Average Age	75.5	75.7	75.6	75.8	76.0	75.9
Age 0–50	2.8%	2.9%	2.8%	2.8%	2.8%	2.8%
Age 51–60	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%
Age 61–70	18.9%	18.4%	18.7%	18.1%	17.8%	18.0%
Age 71–80	43.6%	42.1%	43.0%	42.8%	41.5%	42.3%
Age 81–90	27.8%	28.8%	28.2%	28.9%	29.9%	29.2%
Age 91+	3.6%	4.2%	3.8%	3.9%	4.5%	4.1%
Male	37.9%	37.3%	37.7%	37.6%	37.2%	37.4%
White	86.5%	84.8%	85.9%	86.6%	84.8%	86.0%
Black	10.1%	10.8%	10.4%	9.8%	10.8%	10.2%
In-hospital death	0.3%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked FIM stays with those for other Medicare rehabilitation patients. Average length of stay for FIM cases is the same as for non-FIM patients in 1996 and 1997, but is higher for FIM patients in 1998 and 1999. For cases in freestanding hospitals, FIM stays consume fewer resources in the first half of the data period, but not in the second half. During this time, the FIM database grew from 75 percent to 93 percent of all freestanding cases.

TABLE N.—COMPARISON OF RESOURCE USE FOR MEDICARE REHABILITATION INPATIENTS, BY FIM STATUS

Year	Hospitalization characteristic	All hospitals			Freestanding hospitals		
		FIM	Other MedPAR	Total MedPAR	FIM	Other MedPAR	Total MedPAR
1996	Sample size	171,626	172,500	344,126	65,349	49,584	114,933
	Length of stay (days)	16.2	16.2	16.2	18.0	18.9	18.4
	Daily therapy charges	\$360	\$351	\$355	\$360	\$387	\$371
	Total therapy charges	\$5,960	\$5,829	\$5,894	\$6,652	\$7,605	\$7,063
1997	Total charges	\$18,013	\$18,790	\$18,403	\$19,443	\$21,214	\$20,207
	Sample size	206,032	153,000	359,032	82,393	36,148	118,541
	Length of stay (days)	15.7	15.7	15.7	17.8	19.2	18.2
	Daily therapy charges	\$379	\$368	\$374	\$384	\$406	\$391
1998	Total therapy charges	\$6,064	\$5,924	\$6,004	\$7,002	\$8,064	\$7,325
	Total charges	\$18,348	\$19,287	\$18,748	\$20,202	\$22,541	\$20,915
	Sample size	232,691	137,661	370,352	96,262	26,075	122,337
	Length of stay (days)	15.8	14.6	15.3	18.2	17.1	18.0
1999	Daily therapy charges	\$396	\$383	\$391	\$398	\$414	\$402
	Total therapy charges	\$6,361	\$5,676	\$6,106	\$7,458	\$7,285	\$7,421
	Total charges	\$19,230	\$19,090	\$19,178	\$21,129	\$21,558	\$21,220
	Sample size	257,024	133,024	390,048	108,290	21,013	129,303
1999	Length of stay (days)	15.4	14.0	14.9	17.8	16.1	17.5
	Daily therapy charges	\$425	\$409	\$419	\$428	\$436	\$430
	Total therapy charges	\$6,621	\$5,843	\$6,355	\$7,789	\$7,231	\$7,698
	Total charges	\$20,000	\$19,359	\$19,781	\$21,821	\$21,449	\$21,761

Note: FIM case totals count matched cases; hence, they differ from the total in Table J, which counts matched and unmatched cases.

Appendix B—CMS Inpatient Rehabilitation Facility Patient Assessment Instrument

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT	
Identification Information*	Payer Information*
<p>1. Facility Information A. Facility Name _____ _____ _____ B. Facility Medicare Provider Number _____</p> <p>2. Patient Medicare Number _____</p> <p>3. Patient Medicaid Number _____</p> <p>4. Patient First Name _____</p> <p>5. Patient Last Name _____</p> <p>6. Birth Date _____ MM/DD/YYYY</p> <p>7. Social Security Number _____</p> <p>8. Gender (1 - Male; 2 - Female) _____</p> <p>9. Race/Ethnicity (Check all that apply) American Indian or Alaska Native A. _____ Asian B. _____ Black or African American C. _____ Hispanic or Latino D. _____ Native Hawaiian or Other Pacific Islander E. _____ White F. _____</p> <p>10. Marital Status _____ (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)</p> <p>11. Zip Code of Patient's Pre-Hospital Residence: _____</p>	<p>20. Payment Source A. Primary Source _____ B. Secondary Source _____ (Score using 01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers Compensation; 07 - Crippled Children's Service; 08 - Developmental Disabilities Service; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 - No Fault auto insurance; 51 - Medicare MCO; 52 - Medicaid MCO)</p>
Medical Information*	
<p>12. Admission Date _____ MM/DD/YYYY</p> <p>13. Assessment Reference Date _____ MM/DD/YYYY</p> <p>14. Admission Class _____ (1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation)</p> <p>15. Admit From _____ (01 - Home; 02 - Board & Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence)</p> <p>16. Pre-Hospital Living Setting _____ (Use codes from item 15 above)</p> <p>17. Pre-Hospital Living With _____ (Code only if item 16 is 01 - Home; Score using 1 - Alone; 2 - Family/Relatives; 3 - Friends; 4 - Attendant; 5 - Other)</p> <p>18. Pre-Hospital Vocational Category _____ (1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability)</p> <p>19. Pre-Hospital Vocational Effort _____ (Code only if item 18 is coded 1 - 4; Score using 1 - Full-time; 2 - Part-time; 3 - Adjusted Workload)</p>	<p>21. Impairment Group _____ Admission _____ Discharge _____ Condition requiring admission to rehabilitation.</p> <p>22. Etiologic Diagnosis: _____ (Use ICD-9 codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation)</p> <p>23. Date of Onset of Etiologic Diagnosis _____ (MM/DD/YYYY)</p> <p>24. Comorbid Conditions; Use ICD-9 Codes to enter up to ten medical conditions A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____</p>
Medical Needs	
<p>25. Is patient comatose at admission? _____ 0 - No, 1 - Yes</p> <p>26. Is patient delirious at admission? _____ 0 - No, 1 - Yes</p> <p>27. Swallowing Status: _____ Admission _____ Discharge _____ 3 - <u>Regular Diet</u>: solids and liquids swallowed safely without supervision or modified diet 2 - <u>Modified Diet/Supervision</u>: subject requires modified diet and/or needs supervision for safety 1 - <u>Tube/Parenteral Feeding</u>: tube / parenteral feeding used wholly or partially as a means of sustenance</p> <p>28. Clinical signs of dehydration _____ Admission _____ Discharge _____ (Evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation; Score 0 - No; 1 - Yes)</p>	<p>*The FIM™ data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.</p>

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT																																														
Page 3																																														
Discharge Information*	Quality Indicators																																													
<p>40. Discharge Date _____ (MM/DD/YYYY)</p> <p>41. Patient discharge against medical advice: _____ (0 - No, 1 - Yes)</p> <p>42. Program Interruptions _____ (0 - No; 1 - Yes)</p> <p>43. Program Interruption Dates _____ (Score only if Item 42 is 1 - Yes)</p> <p>A. 1st Transfer Date _____ MM/DD/YYYY</p> <p>B. 1st Return Date _____ MM/DD/YYYY</p> <p>C. 2nd Transfer Date _____ MM/DD/YYYY</p> <p>D. 2nd Return Date _____ MM/DD/YYYY</p> <p>E. 3rd Transfer Date _____ MM/DD/YYYY</p> <p>F. 3rd Return Date _____ MM/DD/YYYY</p> <p>44A. Discharge to Living Setting: _____ 01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute unit of own facility; 07 - Acute unit of another facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence</p> <p>44B. Was patient discharged with Home Health Services? _____ (0 - No; 1 - Yes) (Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)</p> <p>45. Discharge to Living With: _____ (Code only if Item 44A is 01 - Home) Score using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other</p> <p>46. Diagnosis for Transfer or Death: _____ (Score using ICD-9 code)</p> <p>47. Complications during rehabilitation stay (Use ICD-9 codes to specify up to six conditions that began with this rehabilitation stay)</p> <p>A. _____ B. _____</p> <p>C. _____ D. _____</p> <p>E. _____ F. _____</p>	<p>PAIN</p> <p>51. Rate the highest level of pain reported by the patient within the assessment period: Admission: _____ Discharge: _____</p> <p>(Score using the scale below; report whole numbers only)</p> <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td> </td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td> </td> </tr> <tr> <td>No</td><td></td><td></td><td></td><td></td><td>Moderate</td><td></td><td></td><td></td><td></td><td>Worst</td> </tr> <tr> <td>Pain</td><td></td><td></td><td></td><td></td><td>Pain</td><td></td><td></td><td></td><td></td><td>Possible Pain</td> </tr> </table> <p>PUSH SCALE®</p> <p>Pressure Ulcers</p> <p>52A. Highest current pressure ulcer stage Admission _____ Discharge _____</p> <p>(Score as: 0 - No pressure ulcer; 1 - Any area of persistent skin redness (Stage 1); 2 - Partial loss of skin layers (Stage 2); 3 - Deep craters in the skin (Stage 3); 4 - Breaks in skin exposing muscle or bone (Stage 4); 5 - Not stageable (necrotic eschar predominant; no prior staging available)</p> <p>52B. Number of current pressure ulcers Admission _____ Discharge _____</p> <p>SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (c through e) and code total score in f.</p> <p>52C. Length multiplied by width (open wound surface area) Admission _____ Discharge _____</p> <p>(Score as 0 - 0 cm²; 1 - < 0.3 cm²; 2 - 0.3 to 0.6 cm²; 3 - 0.7 to 1.0 cm²; 4 - 1.1 to 2.0 cm²; 5 - 2.1 to 3.0 cm²; 6 - 3.1 to 4.0 cm²; 7 - 4.1 to 8.0 cm²; 8 - 8.1 to 12.0 cm²; 9 - 12.1 to 24.0 cm²; 10 - > 24 cm²)</p> <p>52D. Exudate amount Admission _____ Discharge _____ 0 - None; 1 - Light; 2 - Moderate; 3 - Heavy</p> <p>52E. Tissue type Admission _____ Discharge _____ 0 - Closed/resurfaced: The wound is completely covered with epithelium (new skin); 1 - Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 2 - Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance. 3 - Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous. 4 - Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.</p> <p>52F. TOTAL PUSH SCORE (Sum of above three items - C, D and E) Admission _____ Discharge _____</p>		0	1	2	3	4	5	6	7	8	9	10												No					Moderate					Worst	Pain					Pain					Possible Pain
0	1	2	3	4	5	6	7	8	9	10																																				
No					Moderate					Worst																																				
Pain					Pain					Possible Pain																																				
Quality Indicators																																														
<p>RESPIRATORY STATUS</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Admission</th> <th style="width: 20%; text-align: center;">Discharge</th> </tr> </thead> <tbody> <tr> <td>48. Shortness of breath with exertion</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>49. Shortness of breath at rest</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>50. Difficulty coughing and clearing airway (Score items 48 to 50 as 0 - No; 1 - Yes)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Admission	Discharge	48. Shortness of breath with exertion	_____	_____	49. Shortness of breath at rest	_____	_____	50. Difficulty coughing and clearing airway (Score items 48 to 50 as 0 - No; 1 - Yes)	_____	_____	<p>SAFETY</p> <p>53. Total number of falls during the rehabilitation stay _____ Discharge _____</p> <p>54. Balance problem (0 - No; 1 - Yes; e.g., dizziness, vertigo, or light-headedness) Admission _____ Discharge _____</p>																																	
	Admission	Discharge																																												
48. Shortness of breath with exertion	_____	_____																																												
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APPENDIX C—LIST OF COMORBIDITIES

ICD-9-CM code	Abbreviated code title	Tier 1 **	Tier 2 **	Tier 3 **	Excluded RIC ***
112.4	CANDIDIASIS OF LUNG	1	0	0	15
112.5	DISSEMINATED CANDIDIASIS	1	0	0	.....
112.81	CANDIDAL ENDOCARDITIS	1	0	0	14
112.83	CANDIDAL MENINGITIS	1	0	0	03, 05
112.84	CANDIDAL ESOPHAGITIS	1	0	0	.....
235.1	UNC BEHAV NEO ORAL/PHAR	1	0	0	.....
260.	KWASHIORKOR	1	0	0	.....
261.	NUTRITIONAL MARASMUS	1	0	0	.....
262.	OTH SEVERE MALNUTRITION	1	0	0	.....
478.30	VOCAL CORD PARALYSIS NOS	1	0	0	15
478.31	VOCAL PARAL UNILAT PART	1	0	0	15
478.32	VOCAL PARAL UNILAT TOTAL	1	0	0	15
478.33	VOCAL PARAL BILAT PART	1	0	0	15
478.34	VOCAL PARAL BILAT TOTAL	1	0	0	15
478.6	EDEMA OF LARYNX	1	0	0	15
579.3	INTEST POSTOP NONABSORB	1	0	0	.....
933.1	FOREIGN BODY IN LARYNX	1	0	0	15
934.1	FOREIGN BODY BRONCHUS	1	0	0	15
V440	TRACHEOSTOMY STATUS	1	0	0	15
V461	DEPENDENCE ON RESPIRATOR	1	0	0	15
008.42	PSEUDOMONAS ENTERITIS	0	1	0	.....
008.45	INT INF CLSTRDIUM DFCILE	0	1	0	.....
011.	PULMONARY TUBERCULOSIS*	0	1	0	15
011.0	TB OF LUNG, INFILTRATIVE*	0	1	0	15
011.00	TB LUNG INFILTR-UNSPEC	0	1	0	15
011.01	TB LUNG INFILTR-NO EXAM	0	1	0	15
011.02	TB LUNG INFILTR-EXM UNKN	0	1	0	15
011.03	TB LUNG INFILTR-MICRO DX	0	1	0	15
011.04	TB LUNG INFILTR-CULT DX	0	1	0	15
011.05	TB LUNG INFILTR-HISTO DX	0	1	0	15
011.06	TB LUNG INFILTR-OTH TEST	0	1	0	15
011.1	TB OF LUNG, NODULAR*	0	1	0	15
011.10	TB LUNG NODULAR-UNSPEC	0	1	0	15
011.11	TB LUNG NODULAR-NO EXAM	0	1	0	15
011.12	TB LUNG NODUL-EXAM UNKN	0	1	0	15
011.13	TB LUNG NODULAR-MICRO DX	0	1	0	15
011.14	TB LUNG NODULAR-CULT DX	0	1	0	15
011.15	TB LUNG NODULAR-HISTO DX	0	1	0	15
011.16	TB LUNG NODULAR-OTH TEST	0	1	0	15
011.2	TB OF LUNG W CAVITATION*	0	1	0	15
011.20	TB LUNG W CAVITY-UNSPEC	0	1	0	15
011.21	TB LUNG W CAVITY-NO EXAM	0	1	0	15
011.22	TB LUNG CAVITY-EXAM UNKN	0	1	0	15
011.23	TB LUNG W CAVIT-MICRO DX	0	1	0	15
011.24	TB LUNG W CAVITY-CULT DX	0	1	0	15
011.25	TB LUNG W CAVIT-HISTO DX	0	1	0	15
011.26	TB LUNG W CAVIT-OTH TEST	0	1	0	15
011.3	TUBERCULOSIS OF BRONCHUS*	0	1	0	15
011.30	TB OF BRONCHUS-UNSPEC	0	1	0	15
011.31	TB OF BRONCHUS-NO EXAM	0	1	0	15
011.32	TB OF BRONCHUS-EXAM UNKN	0	1	0	15
011.33	TB OF BRONCHUS-MICRO DX	0	1	0	15
011.34	TB OF BRONCHUS-CULT DX	0	1	0	15
011.35	TB OF BRONCHUS-HISTO DX	0	1	0	15
011.36	TB OF BRONCHUS-OTH TEST	0	1	0	15
011.4	TB FIBROSIS OF LUNG*	0	1	0	15
011.40	TB LUNG FIBROSIS-UNSPEC	0	1	0	15
011.41	TB LUNG FIBROSIS-NO EXAM	0	1	0	15
011.42	TB LUNG FIBROS-EXAM UNKN	0	1	0	15
011.43	TB LUNG FIBROS-MICRO DX	0	1	0	15
011.44	TB LUNG FIBROSIS-CULT DX	0	1	0	15
011.45	TB LUNG FIBROS-HISTO DX	0	1	0	15
011.46	TB LUNG FIBROS-OTH TEST	0	1	0	15
011.5	TB BRONCHIECTASIS*	0	1	0	15
011.50	TB BRONCHIECTASIS-UNSPEC	0	1	0	15
011.51	TB BRONCHIECT-NO EXAM	0	1	0	15
011.52	TB BRONCHIECT-EXAM UNKN	0	1	0	15
011.53	TB BRONCHIECT-MICRO DX	0	1	0	15
011.54	TB BRONCHIECT-CULT DX	0	1	0	15
011.55	TB BRONCHIECT-HISTO DX	0	1	0	15
011.56	TB BRONCHIECT-OTH TEST	0	1	0	15