

## REHABILITATION HOSPITAL CRITERIA WORK SHEET

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

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

TAG	REGULATION	GUIDANCE TO SURVEYORS	YES	NO	EXPLANATORY STATEMENT
	<b>§412.23 Excluded hospitals:</b>				
	(b) Rehabilitation hospitals. In order to be excluded from the Medicare's Acute Care Hospital Inpatient Prospective Payment System (IPPS) and to be paid under the Inpatient Rehabilitation Facility Prospective Payment System, a rehabilitation hospital must meet the following requirements in addition to all the criteria under subpart B of part 412 of the regulations:				
M75	(1) Have a provider agreement under part 489 to participate as a hospital.	<ul style="list-style-type: none"> <li>• The surveyor should check State Agency (SA) records and/or verify with the Regional Office (RO) to ensure the hospital has an agreement to participate in the Medicare program.</li> </ul>			
M76	(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, a hospital must show that during its most recent consecutive and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), it served an inpatient population that meets the criteria under paragraph (b)(2)(i) or (b)(2)(ii) of this section: (i) For cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, the hospital has served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, the hospital has served an inpatient population of whom at least 60 percent, and for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, the hospital has served an inpatient population of	<ul style="list-style-type: none"> <li>• Has the Fiscal Intermediary verified the rehab hospital meets the 75% rule?</li> </ul>			

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		YES	NO	
	<p>whom at least 65 percent, required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section. A patient with a comorbidity, as defined at §412.602, may be included in the inpatient population that counts towards the required applicable percentage if–</p> <p>(A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;</p> <p>(ii) For cost reporting periods beginning on or after July 1, 2007, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified in paragraph (b)(2)(iii) of this section. A patient with comorbidity as described in paragraph (b)(2)(i) is not included in the inpatient population that counts towards the required 75 percent.</p> <p>(iii) List of conditions</p> <p>(A) Stroke.</p> <p>(B) Spinal cord injury.</p> <p>(C) Congenital deformity.</p> <p>(D) Amputation.</p> <p>(E) Major multiple trauma.</p> <p>(F) Fracture of femur (hip fracture).</p> <p>(G) Brain injury.</p> <p>(H) Neurological disorders.</p> <p>(I) Burns.</p> <p>(J) Active polyarticular rheumatoid arthritis.</p> <p>(K) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living.</p> <p>(L) Severe or advanced osteoarthritis.</p> <p>(M) Knee or hip joint replacement.</p>			

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M77	(3) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment.	<ul style="list-style-type: none"> <li>Review the pre-admission screening protocol and verify the protocol is applied to each potential admission (through record review, etc).</li> </ul>			
M78	(4) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation, nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services.	<ul style="list-style-type: none"> <li>Verify that every patient is under the care of a physician and has signed orders in the chart.</li> <li>If the State issues licenses, verify that all licenses are current and are issued by the State in which qualified personnel are providing services.</li> <li>Determine that the hospital has a means of ensuring that its personnel remain qualified/competent?</li> <li>Refer to State laws and hospital policies to determine the qualifications of personnel providing rehabilitation services.</li> <li>Review medical charts if patients have been admitted.</li> </ul>			
M79	(5) Have a director of rehabilitation who —	Verify the rehab unit has a director of rehab.			
M80	(i) Provides services to the hospital and its inpatients on a full time basis;	The full time hours may be any combination of patient services and administration. A director of rehabilitation hours cannot be substituted by a Physician Assistant. Verify the full time hours through review of personnel time cards/logs, etc.			
M81	(ii) Is a doctor of medicine or osteopathy;	Ensure license is current and issued by the State in which the service is being provided.			
M82	(iii) Is licensed under State law to practice medicine or surgery; and	Ensure license is current and issued by the State in which the service is being provided.			
M83	(iv) Has had, after completing a 1-year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.	Review personnel files.			

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M84	(6) Have a plan of treatment (POT) for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	Ensure that all patients have a POT in their medical record. Verify the physician and other professional personnel participate in the establishment, review, and revision of the POT. (This could be a signature, a record of a conference, or record of consultation.)			
M85	(7) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at every 2 weeks to determine the appropriateness of treatment.	Review hospital policy regarding multidisciplinary team meetings, frequency, and medical record documentation.			
M86	(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 of hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.				

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