CHAPTER 12 | DISTINCT PART PHYSICAL REHABILITATION/PROSPECTIVE PAYMENT SYSTEM (PPS) EXCLUDED UNIT

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

☐ N/A. This chapter is not applicable. The facility has no Distinct Part Rehabilitation Unit.

12.00.00 CONDITION OF PARTICIPATION: Distinct Part Rehabilitation Unit/ Prospective Payment System Excluded Unit

☐ Compliant ☐ Not Compliant

This condition is not met as evidenced by:

Rehabilitation units seeking exclusion from the Medicare Prospective Payment System (PPS) must comply with all standards consistent with the following CFR codes:

- §482 – Conditions of Participation for Hospitals;

AND

- §412.25 Excluded hospital units: "Common Requirements" (refer to standards 12.00.02 through 12.00.32)

AND

- §412.29 Excluded Rehabilitation Units: "Additional Requirements" (refer to standards 12.02.00 through 12.02.10).

§485.647

These are the criteria for a PPS excluded rehabilitation unit in a critical access hospital.

Failure to meet the CoP will result in notification to CMS with removal of approval for this unit.

OBSERVATION AND DOCUMENT REVIEW

- Score this CoP Not Compliant if a preponderance of deficiencies are identified in:
  - □ Standards 12.00.02 through 12.00.32.
  - □ Standards 12.02.00 through 12.02.10.
- If PPS excluded unit, is the space containing the rehabilitation beds separate from the beds on other units of the hospital?

12.00.01 For future use

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.00.02 Basis for exclusion	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
In order to be excluded from the prospective payment systems as specified in §412.1(a)(1) and be paid under the inpatient rehabilitation facility prospective payment system as specified in §412.1(a)(3), a rehabilitation unit must meet the following requirements: *Be part of an institution that—* (i) *Has in effect an agreement under §489 to participate as a hospital;* (ii) *Prior to October 1, 2019, is not excluded in its entirety from the prospective payment systems; and* (iii) *Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are paid under the applicable payment system under which the hospital is paid, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater.* *Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an inpatient psychiatric facility unit, the*	ACHC will verify with the CMS Location (Regional Office) that the hospital has a current agreement to participate in the Medicare program and that the hospital is not already excluded in its entirety from PPS.	**INTERVIEW AND DOCUMENT REVIEW** Verify: ▪ The hospital has a current agreement to participate in the Medicare PPS Exclusion program. ▪ The hospital is not already excluded in its entirety from PPS, such as a rehabilitation hospital. □ See standard 01.04.01 for size limitations for the unit and score there.

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hospital must have enough beds that are paid under the applicable payment system under which the hospital is paid to permit the provision of adequate cost information, as required by §413.24(c). §412.25(a) §412.25(a)(1)(i-iii)		
12.00.03 Admission criteria	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
In order to be excluded from the Medicare PPS System, the unit must… ▪ *Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.* §412.25(a)(2)	No additional information.	**DOCUMENT REVIEW** Verify: ▪ Written admission criteria are in place. ▪ Through review of open and closed records, that the approved admission criteria are consistently applied for all patients.

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12.00.04 Separate medical records	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
In order to be excluded for the Medicare PPS System, the unit must… ▪ *Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.* §412.25(a)(3)	Distinct Part Units have separate medical records that are not commingled with other hospital records. These records are readily available for review.	**OBSERVATION** ▪ Confirm that the medical records for the Rehab DPU are not commingled with other hospital records; these are readily available for review.
12.00.05 Availability of clinical records and information	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
In order to be excluded for the Medicare PPS System, the unit must… ▪ *Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.* §412.25(a)(4)	The hospital has a written policy that specifies the clinical information that accompanies the patient when transferred to the exempt rehabilitation unit.	**DOCUMENT REVIEW** Verify: ▪ A policy details the prompt transfer of clinical information for patients transferred to the rehabilitation unit. ▪ Medical records reflect that clinical information is promptly transferred with the record.

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12.00.06 State licensure requirements *In order to be excluded for the Medicare PPS System, the unit must…* ▪ *Meet applicable State licensure laws.* §412.25(a)(5)	☐ Compliant ☐ Not Compliant **HOSPITAL LICENSING** ▪ The hospital demonstrates that all applicable state licensure laws are met. ▪ The hospital provides documentation of any and all unmet state licensure requirements including documentation for deficient practices. ▪ The unit meets special licensing requirements issued by the state, as required. **PROFESSIONAL STAFF** The hospital has current licenses for its professional staff. The professional staff are licensed by the state in which the hospital is located.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ Applicable state licensure laws are met, including any special licensing requirements issued by the state. ▪ All professional staff files have current licenses issued by the state in which the unit is located.
12.00.07 Utilization review requirements *In order to be excluded for the Medicare PPS System, the unit must…* ▪ *Have utilization review standards applicable for the type of care offered in the unit.* §412.25(a)(6)	☐ Compliant ☐ Not Compliant The hospital has a utilization review plan that includes the review of rehabilitation services. (No utilization review standards are required if the QIO is conducting review activities.)	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ The hospital has a utilization review plan that includes the review of rehabilitation services, either internally or through the QIO. ▪ The UR standards are applied to the care offered in the rehab unit.

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12.00.08 Distinct unit structure *In order to be excluded for the Medicare PPS System, the unit must…* ▪ *Have beds physically separate from (that is, not commingled with) the hospital's other beds*. §412.25(a)(7)	☐ Compliant ☐ Not Compliant The Distinct Part Unit rehabilitation beds are physically separate from the beds in other units of the hospital. If the unit doesn't have enough patients to fill those beds, the beds must be left empty or the unit can decrease the number of beds in the unit after the hospital has notified CMS of its intent.	This standard is not met as evidenced by: **OBSERVATION** ▪ Verify that the DPU rehabilitation beds are physically separate from the beds in other units of the hospital. □ The beds on the rehab unit do not belong to the medical/surgical patients; these beds are dedicated to rehab patients only.
12.00.09 Distinct unit structure: Fiscal intermediary *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *Be serviced by the same fiscal intermediary as the hospital.* §412.25(a)(8)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU uses the same fiscal intermediary as the hospital.
12.00.10 Distinct unit structure: Separate cost center *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *Be treated as a separate cost center for cost finding and apportionment purposes.* §412.25(a)(9)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU is treated as a separate cost center for cost finding and apportionment purposes.

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12.00.11 Distinct unit structure: Allocate costs *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *Use an accounting system that properly allocates costs.* §412.25(a)(10)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU uses an accounting system that properly allocates costs.
12.00.12 Distinct unit structure: Statistical data *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *Maintain adequate statistical data to support the basis of allocation.* §412.25(a)(11)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU maintains adequate statistical data to support the basis of allocation.
12.00.13 Distinct unit structure: Cost report *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.* §412.25(a)(12)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU reports its costs per the standard.

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12.00.14 Distinct unit structure: Requirements on the first day of the first cost reporting period *In order to be excluded from the Medicare PPS System, the unit must…* ▪ *As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.* §412.25(a)(13)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the DPU is fully equipped and staffed to provide hospital inpatient rehabilitation care.
12.00.15 Change in size of excluded units *Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change.* *The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit.*	☐ Compliant ☐ Not Compliant A request to add or decrease the number of beds or square footage may occur at any time during the cost report period but the change must remain in effect for the remainder of the cost report period. No changes can be made without notifying both CMS Location (regional office) and the FI/MAC at least 30 days prior to the change.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ If the DPU has had a change in the number of beds or a change in square footage during this accreditation cycle, verify that the facility notified the Medicare contractor and CMS in writing at least 30 days prior to the change? □ Did the communication clearly define the unit costs?

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A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. *Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.* §412.25(b)		
12.00.16 Change in status of hospital units *For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified below in §412.25(c)(1) and (c)(2).* *(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded*	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW AND INTERVIEW** ▪ Has the DPU had a change of status during this accreditation cycle? □ If yes, has the facility notified the fiscal intermediary and the CMS Location in writing at least 30 days before the change?

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

§412.25(c)
§412.25(c)(1-2)

12.00.17 Number of excluded units

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems specified in §412.1(a)(1). A hospital excluded from the prospective payment systems as specified in §412.1(a)(1) may not have an excluded

The hospital may have one PPS excluded rehabilitation unit.

OBSERVATION AND INTERVIEW

- Verify that there is only one PPS excluded rehabilitation unit in this facility.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
unit (psychiatric or rehabilitation) that is excluded on the same basis as the hospital. §412.25(d)		
12.00.18 Satellite facilities: Definition *For purposes of §412.25(e)(2) through (e)(5), a satellite facility is:* (1) *A part of a hospital unit that provides inpatient services 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.* §412.25(e)(1)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify that the satellite facility: ▪ Provides inpatient services consistent with requirement. ▪ Is located consistent with requirement.
12.00.19 Satellite facilities: Criteria *Except as provided below in §412.25(e)(3) and (e)(6), 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 acute care hospital inpatient prospective payment systems for any period:* *(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period*	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the satellite facility meets criteria for exclusion from PPS consistent with requirement. □ The unit's number of state-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of state-licensed and Medicare-certified beds on the last

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beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of state-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997. *(ii) The satellite facility independently complies with—* *(A) For a rehabilitation unit, the requirements under §412.29.* *(B) For a psychiatric unit, the requirements under §412.27(a).* §412.25(e)(2) §412.25(e)(2)(i-ii)(A-B)		day of the unit's last cost reporting period.

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12.00.20 Satellite facility: Separate governing body *The satellite facility meets all the following requirements except as provided in §412.25(e)(2)(iv):* ▪ *It is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.* §412.25(e)(2)(iii)(A)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ The governing body/CEO of the satellite facility is different than that for the hospital. ▪ Care provided is not under control of the hospital medical staff and chief medical officer.
12.00.21 Satellite facility: Admission and discharge records ▪ [The satellite facility] *maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.* §412.25(e)(2)(iii)(B)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** Verify: ▪ The satellite facility maintains admission and discharge records separate from those of the hospital. ▪ These records are readily available.

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12.00.22 Satellite facility: Beds are physically separate ▪ [The satellite facility] *has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.* §412.25(e)(2)(iii)(C)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** ▪ Verify that the beds of the satellite facility are physically separate from the beds of the hospital.
12.00.23 Satellite facility: Fiscal intermediary ▪ [The satellite facility*] is serviced by the same fiscal intermediary as the hospital unit of which it is a part*. §412.25(e)(2)(iii)(D)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the satellite facility uses the same fiscal intermediary as the hospital of which it is a part.
12.00.24 Satellite facility: Separate cost center ▪ [The satellite facility] *is treated as a separate cost center of the hospital unit of which it is a part.* §412.25(e)(2)(iii)(E)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the satellite facility is a separate cost center of the hospital of which it is a part.

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12.00.25 Satellite facility: Accounting system ▪ *For cost reporting and apportionment purposes,* [the satellite facility] *uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation*. §412.25(e)(2)(iii)(F)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the satellite facility uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.
12.00.26 Satellite facility: Hospital cost report ▪ [The satellite facility] *reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.* §412.25(e)(2)(iii)(G)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the satellite facility reports its costs on the cost report of the hospital of which it is a part, using the same fiscal period and same method of apportionment as the hospital.
12.00.27 Satellite facility: Exception ▪ *Effective for cost reporting periods beginning on or after October 1, 2019, the requirements of §412.25 (e)(2)(iii)(A), do not apply to a satellite facility of a unit that is part of a hospital excluded from the prospective payment systems specified in*	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review documents to determine the satellite facility meets this requirement. ▪ Determine whether this unit was structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on

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§412.1(a)(1) that does not furnish services in a building also used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1). ▪ *Except as specified below in §412.25(e)(4) and (e)(5), the provisions of §412.25(e)(2) do not apply to any unit structured as a satellite facility on September 30, 1999 and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.* §412.25(e)(2)(iv) §412.25(e)(3)		that date. □ If yes, has the unit continued to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999?

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.00.28 Satellite facility: Increase/ decrease square footage or decrease beds *In applying the provisions of §412.25 (e)(3), any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility—* *(i) To permit construction or renovation necessary for compliance with changes in federal, state, or local law affecting the physical facility.* (ii) *Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.* §412.25(e)(4) §412.25(e)(4)(i-ii)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility An increase/decrease in the square footage or a decrease in the number of beds is acceptable for the following reasons: 1. To permit construction or renovation necessary for compliance with federal, state, or local law. 2. Due to a catastrophic event.	This standard is not met as evidenced by: **OBSERVATION AND INTERVIEW** If the satellite facility increased/decreased the square footage or decreased the number of beds, verify that these changes were: ▪ To permit construction or renovation necessary for compliance with federal, state, or local law. ▪ Due to a catastrophic event.
12.00.29 Satellite facility: Structure changes after October 1, 2006 *For the cost reporting periods beginning on or after October 1, 2006, in applying the provisions of §412.25(e)(3) —* *(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit*	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **OBSERVATION AND INTERVIEW** ▪ Determine if the unit was a structure of satellite facility on September 30, 1999. If yes: □ Was the increase/decrease in square footage of the satellite facility or the

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only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of §412.25(b)(2) (see above), without affecting the provisions of §412.25(e)(3) (see above); *and* *(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to §412.25(b)(2) (see above), it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.* §412.25(e)(5) §412.25(e)(5)(i-ii)		decrease in the number of beds consistent with the requirement?

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12.00.30 Satellite facility: Inpatient rehabilitation facility *The provisions in §412.25(e)(2)(i)—* ▪ *Do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of §412, effective for cost reporting periods beginning on or after October 1, 2003.* §412.25(e)(6)	☐ Compliant ☐ Not Compliant ☐ Not Applicable (no satellite facility) No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Confirm that the satellite facility is compliant with this requirement.
12.00.31 Changes in classification of hospital units *For purposes of exclusions from the prospective payment system under this section—* ▪ *The classification of a hospital unit is effective for the unit's entire cost reporting period.* ▪ *Any changes in the classification of a hospital unit are made only at the start of a cost reporting period.* §412.25(f)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review documents to verify whether the DPU made any changes in the classification of a unit. If yes: □ Were these changes only made at the start of a cost reporting period?

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12.00.32 CAH units not meeting applicable requirements *If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of §485.647 with respect to a cost reporting period,* ▪ *No payment may be made to the CAH for services furnished in that unit for that period.* ▪ *Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of §485.647.* §412.25(g)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Confirm that the unit is compliant with this requirement.
12.01.00 CONDITION OF PARTICIPATION: Psychiatric and rehabilitation distinct part units *If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of §482, the common requirements of §412.25(a)(2) through (f) for hospital units excluded from the prospective payments systems, and the additional requirements of §412.29 and §412.30 related specifically*	☐ Compliant ☐ Not Compliant No additional information.	This condition is not met as evidenced by: **DOCUMENT REVIEW** ▪ Confirm that the facility is compliant with this requirement.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

to rehabilitation units.

(b) *Eligibility requirements.*

(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.

(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in §485.620(a).

(3) The average annual 96-hour length of stay requirement specified under §485.620(b) does not apply to the 10 beds in the distinct part units specified in §485.647(b)(1), and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in §485.620.

§485.647(a)(2)
§485.647(b)
§485.647(b)(1-3)

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.02.00 Additional requirements *Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.* ▪ *To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:* §412.29	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ Score as noncompliant if a preponderance of standards 12.02.01 through 12.02.10 fail to meet requirements.
12.02.01 Provider agreement *An inpatient rehabilitation unit must:* ▪ *Have (or be part of a hospital that has) a provider agreement under §489 to participate as a hospital.* §412.29(a)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify the facility has an agreement to participate in the Medicare program.

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12.02.02 Inpatient population requirement *Except in the case of a "new" IRF or "new" IRF beds, as defined below in §412.29(c), an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:* *(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified below at §412.29 (b)(2).* *A patient with a comorbidity, as defined at §412.602, may be included in the inpatient population that counts toward the required applicable percentage if—* *(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in §412.29 (b)(2);* *(ii) The patient has a comorbidity that*	☐ Compliant ☐ Not Compliant ☐ N/A. This is a new IRF or new IRF beds. No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that for the most recent consecutive 12-months, 60% of the patients were admitted for intensive rehabilitation services as defined in the standard.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

falls in one of the conditions specified in §412.29 (b)(2); and

(iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of §412 and that cannot be appropriately performed in another care setting covered under this title.

(2) List of conditions

(i) Stroke

(ii) Spinal cord injury

(iii) Congenital deformity

(iv) Amputation

(v) Major multiple trauma

(vi) Fracture of femur (hip fracture)

(vii) Brain injury

(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease

(ix) Burns

(x) Active polyarticular rheumatoid arthritis, psoriatic arthritis, and

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

rehabilitation.

(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria: (A) *The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.* (B) *The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.* (C) *The patient is age 85 or older at the time of admission to the IRF.* §412.29(b) §412.29(b)(1) §412.29(b)(1)(i-ii) §412.29(b)(2) §412.29(b)(2)(i-xiii)(C)		

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.02.03 Written certification for new IRFs *In the case of new IRFs (as defined in §412.29(c)(1)) or new IRF beds (as defined in §412.29(c)(2)), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of §412.29(b).* *This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.* *(1) **New IRFs**.* *An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of §412 for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.* *(2) **New IRF beds**.* *Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost*	☐ Compliant ☐ Not Compliant ☐ N/A The rehabilitation facility has submitted a written attestation statement as well as Form CMS 4378 (rehabilitation hospital worksheet) to the state agency as a part of the application packet, or as determined by CMS to maintain the IPPS excluded status. **NEW IRFS** If an IRF unit has been closed for five years, it can open its doors as a new unit. **NEW IRF BEDS** If the hospital added beds to its IRF unit, the hospital must have approval (certificate of need or state license) before adding beds, if such approval is required. The hospital must receive written CMS Location approval before adding any new beds to its IRF unit. The hospital's IRF may not have more than one increase in beds during a single cost reporting period. If the hospital's IRF unit decreased beds, it did not thereafter add beds unless a full 12-month cost reporting period had elapsed. **CHANGE OF OWNERSHIP OR LEASING** IRF status is lost if a hospital is acquired and the new owners reject assignment of the previous owner's Medicare provider assignment. Only entire hospitals may be sold or leased. IRF units may not be sold or leased separately from the hospital of which it is a part.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Note: This requirement applies only for "new" inpatient rehabilitation facilities or "new" rehabilitation beds. For new units, verify that: ▪ The rehabilitation unit has not been paid under PPS for at least five calendar years. ▪ The attestation statement and IRF unit worksheet have been submitted to the state agency. For new IRF beds, verify that: ▪ The hospital received state approval (certificate of need or state licensure), if approval is required by the state, prior to IRF unit bed increase. ▪ The hospital received written approval from the CMS Location before any new beds were added to the IRF unit. ▪ If the IRF unit decreased beds, it did not add beds unless a full 12-month cost reporting period had elapsed. ▪ The IRF unit did not have more than one increase in beds during a single cost reporting period.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
reporting period. *A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit.* *Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified.* *New IRF beds are included in the compliance review calculations under §412.29 (b) from the time that they are added to the IRF.* *(3) **Change of ownership or leasing**.* *An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in §489.18f, retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the*	**MERGERS** As with the change of ownership, the owner of the merged hospital must accept assignment of the hospital's (with the IRF unit) provider agreement to ensure uninterrupted reimbursement. If the owner of the hospital to be merged doesn't accept assignment of the previous owner(s) Medicare provider agreement, the new owner(s) will not be eligible for reimbursement until the new owner(s) reapplies to the Medicare program to operate a new hospital and has been granted IRF status.	If the hospital has undergone a change of ownership or a merger: ▪ Ensure that the new owners have accepted assignment of the previous Medicare provider agreement, if assignment was not accepted, the facility cannot request continued participation as a PPS excluded rehab unit.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

IRF prospective payment system.

If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program.

If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412.1(a)(1).

*(4) **Mergers**.*

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF. §412.29(c) §412.29(c)(1-4)		
12.02.04 Preadmission screening An inpatient rehabilitation unit must: ▪ *Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program.* *This procedure must ensure that the preadmission screening for each Medicare Part A Fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.* §412.29(d)	☐ Compliant ☐ Not Compliant The purpose of the preadmission screening tool is to reduce the rate of hospital readmission by ensuring the patients accepted to the IRF will benefit from the intensive rehabilitation services. The IRF consistently applies the screening procedure.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review five patient records from the unit to verify: □ The unit has preadmission screening procedures that address whether the patient is likely to benefit significantly from an intensive inpatient program or assessment. □ The medical records indicate that the preadmission screen is applied to all patients admitted to the rehabilitation unit.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.02.05 Medical supervision	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
An inpatient rehabilitation unit must: ▪ *Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.* ***Beginning with the second week, as defined in §412.622, of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.*** §412.29(e)	Hospital policy defines: 1. Required medical supervision for patients. 2. Special training and experience requirements for inpatient rehabilitation medical staff.	**DOCUMENT REVIEW** Verify: ▪ Hospital policy addresses the required elements. ▪ Each record contains documentation of a minimum of three face-to-face visits per week. **In week 1, these visits are** by a licensed physician with specialized training and experience in inpatient rehabilitation. **Beginning the second week, a qualified non-physician practitioner (NPP) may perform one of the three required assessments, consistent with state scope of practice law.**

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.02.06 Personnel qualifications An inpatient rehabilitation unit must: ▪ *Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.* §412.29(f)	☐ Compliant ☐ Not Compliant All licenses of the professional staff are current and are issued by the state in which the personnel are providing services. The hospital has and follows a procedure to evaluate and document that personnel are qualified and competent, consistent with state law.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ Policies establish the qualifications for personnel providing rehabilitation services. ▪ Licenses for the professional staff are current and issued by the state in which the personnel are providing services. ▪ The hospital ensures that its personnel are qualified and competent.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.02.07 Director – requirements	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
An inpatient rehabilitation unit must have a director of rehabilitation who— *(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;* *(2) Is a doctor of medicine or* doctor of osteopathic medicine; *(3) Is licensed under State law to practice medicine or surgery; and* *(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.* §412.29(g) §412.29(g)(1-4)	The medical director of the rehabilitation unit provides at least 20 service hours per week. The 20 hours may be any combination of patient services and administration. These 20 hours cannot be delegated to a physician assistant or any other qualified professional.	**DOCUMENT REVIEW AND FILE REVIEW** Verify: ▪ The rehabilitation unit has a medical director of rehabilitation. The director is an MD or DO. ▪ The medical director's license is current and issued by the state in which the service is being provided. ▪ The medical director has met the criteria for internship plus two years of training or experience. ▪ The medical director provides at least 20 service hours per week providing a combination of patient services and administration for the rehab unit.
12.02.08 Plan of treatment	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
The inpatient rehabilitation unit must: ▪ *Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.*	Each plan of treatment includes the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay. Interventions detailed in the overall plan of care include: ▪ Expected intensity (number of hours per day). ▪ Frequency (number of days per week). ▪ Duration (total number of days during the IRF stay) of physical,	**DOCUMENT REVIEW** Review a sample of closed records. Sample volumes as appropriate to evaluate both inpatient and outpatient records to verify: ▪ Each patient has a plan of treatment in their medical record. ▪ A physician and other professional

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
§412.29(h)	occupational, speech-language pathology, and prosthetic/ orthotic therapies required by the patient. The treatment plan includes measurable long term and short-term goals with estimated time frames for achieving these to assist the patient in regaining independence, reducing pain, and/or adapting to limitations in activities of daily living.	personnel participate in the establishment, review and revision of the plan of treatment. (This could be a signature, a record of a conference, or record of consultation.)
12.02.09 Coordinated multidisciplinary team approach *The inpatient rehabilitation unit must:* ▪ *Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.* §412.29(i)	☐ Compliant ☐ Not Compliant The facility has a written policy that addresses the functioning of the interdisciplinary team approach, including: 1. Planning patient care. 2. Establishing goals. 3. Discharge planning. 4. Documentation requirements. 5. Frequency of team meetings.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ Policies address the required elements. ▪ Medical records contain periodic clinical entries related to achievement of goals, consistent with facility policy. ▪ An interdisciplinary team approach is used for the rehabilitation of each patient. ▪ At least weekly team conferences are held to determine appropriateness of treatment in relation to goal achievement.
12.02.10 Retroactive adjustments *If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the*	☐ Compliant ☐ Not Compliant ☐ N/A. This is a new IRF or new IRF beds. New IRFs must meet the requirements of this section to receive retroactive payment.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Confirm that facility policies address the required elements.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
prospective payment system specified in §412.1(a)(3) for a cost reporting period under §412.29(c), but the inpatient population actually treated during that period does not meet the requirements of §412.29(b), Medicare adjusts payments to the IRF retroactively in accordance with the provisions in §412.130. §412.29(j)		
12.03.00 Multidisciplinary team The Rehabilitation Program uses an integrated, multidisciplinary approach to patient care. The Program's core team may include, but is not necessarily limited to: ▪ Physician ▪ Rehabilitation RN ▪ Speech Therapist ▪ Occupational Therapist ▪ Social Worker ▪ Physical Therapist ▪ Therapeutic Recreational Specialist for inpatient facilities §412.29(i)	☐ Compliant ☐ Not Compliant The disciplines represented in the core team will vary depending upon the mission and objective of the facility. Other healthcare workers may be included as appropriate, such as: ▪ Psychologist ▪ Psychiatrist ▪ Neuropsychologist ▪ Orthotist ▪ Prosthetist ▪ Exercise physiologist ▪ Vocational rehabilitation counselor ▪ Audiologist	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review the organizational chart for the integrated, multidisciplinary rehabilitation services program to verify that it meets the requirement.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
12.03.01 Organizational plan There should be a written description of the Rehabilitation Program which includes, but need not be limited to the following: ▪ The scope of services provided and how these services relate to each other. ▪ Services specific to inpatient or outpatient programs including: □ Admission criteria □ The assessment and evaluation process □ A program evaluation system including treatment criteria and outcome measures, e.g., functional index measurement (FIM) and referral/discharge procedures. §412.25(a)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify the plan for the Rehabilitation Program is available for review. The plan includes all elements in the standard.
12.03.02 Quality assessment performance improvement (QAPI) Rehabilitation services are integrated into the facility-wide QAPI plan. §485.641(b)(1) §485.641(b)(2) §482.21(c)(2)	☐ Compliant ☐ Not Compliant No additional information.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review the QAPI plan and minutes to verify that rehabilitation services are integrated. ▪ Rehabilitation services-related data is collected and used to improve the

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
		quality of patient care and patient safety. Improvements are monitored to insure improvement in outcomes/results.