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Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2004; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1474–P]

RIN 0938–AL95

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for FY 2004

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year 2004 as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary of Health and Human Services (the Secretary) to publish in the **Federal Register** on or before August 1 before each fiscal year, the classification 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. In addition, in this proposed rule, we are proposing new policies, and changing or clarifying existing policies regarding the prospective payment system (PPS) within the authority granted under sections 1886(j) and 1886(d) of the Act.

DATES: We will consider comments if we receive them at the appropriate addresses, as provided below, no later than 5 p.m. on July 7, 2003.

ADDRESSES: In commenting, please refer to file code CMS–1474–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission or e-mail.

Mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1474–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.) Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Robert Kuhl, (410) 786–4597, Pete Diaz (410) 786–1235 or Nora Hoban, (410) 786–0675.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–9994.

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I. Background

A. Requirements for Updating the Prospective Payment Rates for Inpatient Rehabilitation Facilities (IRFs)

On August 7, 2001, we published a final rule entitled ''Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities (CMS–1069–F)'' in the **Federal Register** (66 FR 41316), that established a PPS for IRFs as authorized under section 1886(j) of the Act and codified at subpart P of part 412 of the Medicare regulations. In the August 7, 2001 final rule, we set forth per discharge Federal prospective payment rates for fiscal year (FY) 2002 that provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS. The provisions of that final rule were effective for cost reporting periods beginning on or after January 1, 2002. (On July 1, 2002, we also published a correcting amendment to the final rule (CMS–1069–F2) in the **Federal Register** (67 FR 44073). Any reference to the August 7, 2001 final rule in this proposed rule includes the provisions effective in the correcting amendment.)

Section 1886(j)(5) of the Act and § 412.628 of the regulations require the Secretary to publish in the **Federal Register**, on or before August 1 of the preceding fiscal year, the classifications and weighting factors for the IRF case-mix groups (CMGs) and a description of the methodology and data used in computing the prospective payment rates for the upcoming fiscal year. On August 1, 2002, we published a notice in the **Federal Register** (67 FR 49928) to update the IRF Federal prospective payment rates from FY 2002 to FY 2003 using the methodology described in § 412.624 of the regulations. As stated in that notice, we used the same classifications and weighting factors for the IRF CMGs that were set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003. The FY 2003 Federal prospective payment rates are effective for discharges on or after October 1, 2002 and before October 1, 2003.

In this proposed rule, we are proposing to update the IRF Federal prospective payment rates from FY 2003 to FY 2004 using the methodology described in § 412.624 of the regulations. See section VI of this proposed rule for further discussion of the proposed FY 2004 Federal prospective payment rates. The proposed FY 2004 Federal prospective payment rates will be effective for discharges on or after October 1, 2003 and before October 1, 2004.

B. General Overview of the Current IRF PPS

Section 4421 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), as amended by section 125 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), provides for the implementation of a per discharge PPS, through new section 1886(j) of the Act, for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the August 7, 2001 final rule (66 FR 41316), we provide below a general description of the IRF PPS.

The IRF PPS, as described in the August 7, 2001 final rule, uses Federal prospective payment rates across 100 distinct CMGs. Ninety-five CMGs were constructed using rehabilitation impairment categories, functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). Five special CMGs were constructed to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors account for the relative difference in resource use across all CMGs. Within each CMG, the weighting factors were ''tiered'' based on the estimated effect that the existence of certain comorbidities have on resource use.

The Federal PPS rates were established using a standardized payment amount (also referred to as the budget neutral conversion factor in the August 7, 2001 final rule (66 FR 41364 through 41367)). For each of the tiers within a CMG, the relative weighting factors were applied to the budget neutral conversion factor to compute the unadjusted Federal prospective payment rates. Adjustments that account for geographic variations in wages (wage index), the percentage of low-income patients (LIPs), and location in a rural area would be applied to the IRF's unadjusted Federal prospective payment rates. In addition, adjustments would be made to account for the early transfer of a patient, interrupted stays, and high cost outliers.

Lastly, the IRF's final prospective payment amount would be determined under the transition methodology prescribed in section 1886(j) of the Act. Specifically, for cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, section 1886(j)(1) of the Act and § 412.626 of the regulations provide that IRFs transition into the prospective payment systems receiving a ''blended payment.'' For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, these blended payments consisted of 66⅔ percent of the Federal IRF PPS rate and 33⅓ percent of the payment that the IRF would have been paid had the IRF PPS not been implemented. However, during the transition period, an IRF with a cost reporting period beginning on or after January 1, 2002 and before October 1, 2002 could have elected to bypass this blended payment

and be paid 100 percent of the Federal IRF PPS rate. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), however, the transition methodology expired, and payments for all IRFs consist of 100 percent of the Federal IRF PPS.

We established a CMS website that contains useful information regarding the IRF PPS. The website URL is *www.cms.hhs.gov/providers/irfpps/default.asp* and may be accessed to download or view publications, software, and other information pertinent to the IRF PPS.

C. Operational Overview of the Current IRF PPS

As described in the August 7, 2001 final rule, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument, the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI). All required data must be electronically encoded into the IRF's PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific PAI data elements to classify (or group) the patient into a distinct CMG and account for the existence of any relevant comorbidities. The GROUPER software produces a 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS website at *www.cms.hhs.gov/providers/irfpps/default.asp).*

Once the patient is discharged, the IRF completes the Medicare claim (UB–92 or its equivalent) using the 5-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI). (Claims submitted to Medicare must comply with the electronic claim requirements contained at *www.cms.hhs.gov/providers/edi/default.asp,* as reported in the Health Insurance Portability and Accountability Act (HIPAA) program claim memoranda issued by CMS and also published at that web site, and as listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in section 3604 of Part 3 of the Medicare Intermediary Manual.) The Medicare FI processes the claim through its software system. This software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths and then applies the applicable adjustments to account for the IRF's wage index, percentage of LIPs, rural location, and outlier payments.

D. Proposals for FY 2004

In this proposed rule, we are proposing to update the data used to compute the IRF wage indices. In the August 7, 2001 final rule, we used FY 1997 acute care hospital wage data to compute the IRF wage indices for FY 2002. The August 1, 2002 notice that set forth the updated FY 2003 IRF Federal prospective payment rates also used 1997 acute care hospital wage data to compute the FY 2003 IRF wage indices.

In this proposed rule, we are proposing to update the IRF wage indices for FY 2004 by using FY 1999 acute care hospital data. We believe that the FY 1999 acute care hospital data are the best available because they are currently the most recent complete final data. However, any adjustments or updates made under section 1886(j)(6) of the Act must be made in a budget neutral manner. Therefore, in section VI of this proposed rule, we are proposing a methodology to update the wage indices for FY 2004 using 1999 acute care hospital data in a budget neutral manner.

In this proposed rule, we are also proposing to update the underlying data used to compute the IRF market basket index. As explained in Appendix D of the August 7, 2001 final rule, we used 1992 cost report data as the underlying data to develop the excluded hospital with capital market basket that formed the basis of the FY 2002 and FY 2003 IRF market basket index. In section VI of this proposed rule, we are proposing to use 1997 cost report data, the most recent data available, to form the basis of the FY 2004 IRF market basket index.

In section II of this proposed rule, we are proposing to modify or clarify certain criteria for a hospital or a hospital unit to be classified as an IRF. As stated in the August 7, 2001 final rule, we did not change the survey and certification procedures applicable to entities seeking classification as an IRF. Currently, to be paid under the IRF PPS, a hospital or unit of a hospital must first be deemed to be excluded from the diagnosis-related group (DRG)-based acute care hospital PPS under the general requirements in subpart B of part 412 of the regulations. Second, the excluded hospital or unit must meet the conditions for payment under the IRF PPS at § 412.604 of the regulations.

Lastly, we are proposing, in various sections of this proposed rule, to modify or clarify existing provisions of the IRF PPS. However, we are not proposing refinements to the FY 2002 case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments, due to the lack of available data to make such changes.

II. Requirements and Conditions for Payment Under the IRF PPS

As issued in the August 7, 2001 final rule, § 412.604 ''Conditions for payment under the prospective payment system for inpatient rehabilitation facilities'' describes the conditions that must be met for an IRF to be paid under the IRF PPS. Section 412.604(a) states the general requirements for payment to be made under the IRF PPS and the effects on Medicare payment if the conditions described therein are not met. Section 412.604(b) states the existing regulatory provisions that must be met for a hospital or unit of a hospital to be excluded from the acute care inpatient hospital PPS and to be classified as an IRF. Section 412.604(c) requires an IRF to complete a patient assessment instrument for each Medicare Part A fee-for-service patient admitted. Section 412.604(d) describes the limitations on IRFs for charging beneficiaries that receive Medicare covered services. Section 412.604(e) describes the requirements associated with furnishing inpatient hospital services directly or under arrangement. Section 412.604(f) states the reporting and recordkeeping requirements that IRFs must meet.

In this section of the proposed rule, we describe proposed changes, if any, to the conditions or underlying requirements of § 412.604.

Section 412.604(a) General Requirements

Under paragraph (a)(2), we propose to change the word ''we'' to ''CMS or its Medicare fiscal intermediary'' to read as follows:

''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, CMS or its Medicare fiscal intermediary 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).''

Section 412.604(b) Inpatient Rehabilitation Facilities Subject to the Prospective Payment System

Section 412.604(b) states that, ''subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the general criteria set forth in § 412.22 and 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).'' The general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in § 412.23(b), § 412.25, and § 412.29 are under subpart B of part 412 of the regulations. In the August 7, 2001 final rule implementing the IRF PPS, we did not make any changes to the exclusion criteria and requirements to be classified as an IRF under subpart B of part 412. Since the implementation of the IRF PPS, a number of questions have been raised on the application of some of these requirements and the necessity of other criteria. Below, we will discuss each requirement as it relates to the classification of an IRF.

A. Background of Subpart B Provisions

Section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) added section 1886 to the Act that established a PPS for acute care inpatient hospital services for cost reporting periods beginning on or after October 1, 1983. Under section 1886(d)(1)(B) of the Act, several types of hospitals and units of hospitals are excluded from the inpatient hospital PPS. Sections 1886(d)(1)(B)(ii) and 1886(d)(1)(B) of the Act specify that rehabilitation hospitals and rehabilitation units of hospitals (as defined by the Secretary) are excluded from the inpatient PPS.

Extensive discussion and public comments on developing the criteria under which a hospital or unit of a hospital can be excluded from the inpatient PPS as an IRF began with the September 1, 1983 publication of the interim final rule with comment period in the **Federal Register** (48 FR 39752). (That interim final rule discussed the provisions necessary to implement section 1886 of the Act.) On January 3, 1984, we published a final rule (49 FR 234) that responded to public comments on the provisions of the September 1, 1983 interim final rule and established the initial set of criteria that must be met by a hospital or unit of a hospital seeking exclusion from the inpatient hospital PPS as an IRF. Since the publication of these earlier rules, the criteria to be an IRF have been revised and codified at subpart B of part 412 of the current Medicare regulations.

Section 412.20 Hospital Services Subject to the Prospective Payment Systems

In the August 7, 2001 final rule, we added § 412.20(b) stating that 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 PPS described in subpart P of this part.

In this proposed rule, we are proposing to redesignate current § 412.20(b) as paragraph (b)(1) of § 412.20 and add paragraph (b)(2) to ensure that inpatient hospital services will not be paid under the IRF PPS if the services are paid by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under part 417 of this chapter. This proposed provision is similar to the provision at § 412.20(b)(3) that prohibits payments under the acute care hospital PPS for similar HMO or CMP services.

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

Section 412.22(h) describes the requirements to be a satellite facility that is excluded from the acute care hospital PPS. The following describes our proposal to eliminate the provision that limits the bed size of a satellite IRF.

In the July 30, 1999 **Federal Register** (64 FR 41540), we revised § 412.22(h) to require that in order to be excluded from the acute care hospital inpatient PPS, a satellite of a hospital: (1) Effective for cost reporting periods beginning on or after October 1, 2002, is not under the control of the governing body or chief executive officer of the hospital in which it is located, and 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; (2) must maintain admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available; (3) cannot commingle beds with beds of the hospital in which it is located; (4) must be serviced by the same FI as the hospital of which it is a part; (5) must be treated as a separate cost center of the hospital of which it is a part; (6) for cost reporting and apportionment purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation; and (7) must report costs in 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. In addition, the satellite facility must independently comply with the qualifying criteria for exclusion from the acute care hospital inpatient PPS. Lastly, the total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital (other than a children's hospital) that was excluded from the acute care hospital inpatient PPS for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period.

In § 412.22(h)(1), we define a satellite as ''a part of a hospital 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.'' Satellite arrangements exist when an existing hospital that is excluded from the acute care hospital inpatient PPS and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e) shares space in a building or on a campus occupied by another hospital in order to establish an additional location for the excluded hospital. The July 30, 1999 acute care hospital inpatient PPS final rule (64 FR 41532–41534) includes a detailed discussion of our policies regarding Medicare payments for satellite facilities of hospitals excluded from the acute care hospital inpatient PPS.

In accordance with section 1886(b) of the Act, as amended by sections 4414 and 4416 of Pub. L. 105–33, we established two different target limits on payments to excluded hospitals, depending upon when the IRF was established. The target amount limit for an IRF with a cost reporting period beginning before October 1, 1997 was set at the 75th percentile of the target amounts of IRFs, as specified in § 413.40(c)(4)(iii), updated to the applicable cost reporting period. For IRFs with a cost reporting period beginning on or after October 1, 1997, under section 4416 of Pub. L. 105–33, the payment amount for the hospital's

first two 12-month cost reporting periods, as specified at § 413.40(f)(2)(ii)(A) and (B), could not exceed 110 percent of the national median of target amounts of IRFs for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the IRF receives payment.

Because we were concerned that a number of pre-1997 excluded hospitals (including IRFs), governed by § 413.40(c)(4)(iii), would seek to create satellite arrangements in order to avoid the effect of the lower payment caps that would apply to new hospitals under § 413.40(f)(2)(ii), we established rules regarding the exclusion of and payments to satellites of existing facilities. If the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) exceeds the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997, the facility would be paid under the acute care hospital inpatient DRG system. Therefore, while an excluded hospital or unit could ''transfer'' bed capacity from a base facility to a satellite, if it increased total bed capacity beyond the level it had in the most recent cost reporting period before October 1, 1997 (see 64 FR 41532–41533, July 30, 1999), the hospital will not be paid as a hospital excluded from the acute care hospital inpatient PPS. However, no similar limitation was imposed with respect to the number of total beds in excluded hospitals and units and satellite facilities of those excluded hospitals and units established after October 1, 1997, since those excluded hospitals and units were subject to the lower payment limits of section 4416 of Pub. L. 105–33, and would, therefore, not benefit from the higher payment cap on target amounts under § 413.40(c)(4) by creating a satellite facility.

On March 22, 2002, we published a proposed rule in the **Federal Register** (67 FR 13416) that set forth the proposed Medicare PPS for long-term care hospitals (LTCHs). Discussion of the comments received on that LTCH proposed rule and our responses were published in a final rule on August 30, 2002 **Federal Register** (67 FR 55954). Specific comments received were discussed on page 56013 of the LTCH final rule that urged us to eliminate the bed-number criteria in § 412.22(h)(2)(i) for pre-1997 IRFs since the applicable PPS is fully phased in. The rationale for the bed-number criteria provision at § 412.22(h)(2)(i) was the potential for circumventing the PPS by creating a satellite location that could have their payment based on a higher TEFRA target amount cap. However, once an IRF's payment under the IRF PPS does not include a TEFRA-based payment (referred to as the facility-specific payment under the transition period described in § 412.626) and is based on 100 percent of the Federal prospective payment rate, we believe that the need for the bed-number criteria does not exist because IRF prospective payments will be the same regardless of when the IRF was established. Because all IRFs will be paid 100 percent of the proposed FY 2004 Federal prospective payment rates, we are proposing to eliminate the bed-number criteria by amending § 412.22(h) for freestanding satellite IRFs. We are also proposing to eliminate the bed-number criteria for IRF satellite units of a hospital by amending § 412.25(e) to conform with the proposed change in § 412.22(h).

Section 412.23 Excluded Hospitals: Classifications

Classification as an IRF—''The 75 Percent Rule''

Under the § 412.23(b)(2) of the regulations, a facility may be classified as an IRF if it can show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitation services for the treatment of one or more of the following conditions:

1. Stroke.
2. Spinal cord injury.
3. Congenital deformity.
4. Amputation.
5. Major multiple trauma.
6. Fracture of femur (hip fracture).
7. Brain injury.
8. Polyarthritis, including rheumatoid arthritis.
9. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
10. Burns.

Under § 412.604(b), the requirement at § 412.23(b)(2) must be met as one of the conditions for payment under the IRF PPS. However, even before the implementation of the IRF PPS, the rehabilitation industry expressed an interest in having CMS re-examine the regulatory criteria used to determine the classification of a unit or hospital as an IRF. Recently this interest has focused on the regulatory requirement at § 412.23(b)(2) commonly known as the ''75 Percent Rule.''

B. Regulatory Background of the 75 Percent Rule

We initially stipulated the ''75 percent'' requirement in the September 1, 1983, interim final rule with comment period entitled ''Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services'' (48 FR 39752). That rule implemented the Social Security Amendments of 1983 (Pub. L. 98–21), changing the method of payment for inpatient hospital services from a cost-based, retrospective reimbursement system to a diagnosis specific PPS. However, the rule stipulated that in accordance with sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act both a rehabilitation unit, which is a distinct part of a hospital, and a rehabilitation hospital were excluded from the inpatient hospital PPS. We noted that sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act also gave the Secretary discretion in defining what is a ''rehabilitation unit'' and a ''rehabilitation hospital.''

In order to define a rehabilitation hospital we consulted with the Joint Commission on Accreditation of Hospitals (JCAH), and other accrediting organizations. (JCAH is currently known as the Joint Commission on Accreditation of Hospital Organizations.) The criteria we included in our definition of a rehabilitation hospital incorporated some of the accreditation requirements of these organizations. The definition also included other criteria, which we believed distinguished a rehabilitation hospital from a hospital that furnished general medical and surgical services as well as some rehabilitation services. One criterion was that ''The hospital must be primarily engaged in furnishing intensive rehabilitation services as demonstrated by patient medical records showing that, during the hospital's most recently completed 12-month cost reporting period, at least 75 percent of the hospital's inpatients were treated for one or more conditions specified in these regulations that typically require intensive inpatient rehabilitation.'' (48 FR 39756) This requirement was originally specified in § 405.471(c)(2)(ii) of the regulations. We included this requirement, as a defining feature of a rehabilitation hospital, because we believed ''that examining the types of conditions for which a hospital's inpatients are treated, and the proportion of patients treated for conditions that typically require intensive inpatient rehabilitation, will help distinguish those hospitals in which the provisions of rehabilitation

services is a primary, rather than a secondary, goal.'' (48 FR 39756) Using a similar line of reasoning, we made compliance with the 75 percent rule one of the characteristics that defined a rehabilitation unit.

The original medical conditions specified in § 405.471(c)(2)(ii) were stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, and polyarthritis, including rheumatoid arthritis. This list of 8 medical conditions was partly based upon the information contained in a document entitled ''Sample Screening Criteria for Review of Admissions to Comprehensive Medical Rehabilitation Hospitals/Units.'' This document was a product of the Committee on Rehabilitation Criteria for PSRO of the American Academy of Physical Medicine and Rehabilitation and the American Congress of Rehabilitation Medicine. In addition, we received input from with the National Association of Rehabilitation Facilities, and the American Hospital Association.

On January 3, 1984, we published a final rule entitled ''Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services'' (49 FR 234). On page 240 of that final rule, we summarized comments that requested inclusion of neurological disorders, burns, chronic pain, pulmonary disorders, and cardiac disorders in the 75 percent rule's list of medical conditions. Our analysis of these comments led us to agree that neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease) and burns should be added to the 75 percent rule's original list of 8 medical conditions. (49 FR 240) We did not agree with comments that we lower from 75 to 60 the percentage of patients that must meet one of the medical conditions. Nor did we agree with comments urging us to use IRF resource consumption, instead of a percentage of patients that must have one or more of the specified medical conditions, to help define what is an IRF. (49 FR 239–240) We also rejected suggestions, which proposed that when an IRF could not meet the 75 percent rule the facility could still be defined as an IRF based on the types of services it furnished.

On August 31, 1984, we published a final rule entitled ''Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1985 Rates'' (49 FR 34728). In that rule we explained how the 75 percent rule applied to a new rehabilitation unit or rehabilitation hospital, or when a rehabilitation unit wanted to expand its size by adding beds.

On March 29, 1985, we published a final rule entitled ''Medicare Program; Prospective Payment System for Hospital Inpatient Services; Redesignation of Rules'' (50 FR 12740). That rule redesignated provisions of § 405.471 that addressed the 75 percent rule into § 412.23.

On August 30, 1991, we published a final rule entitled ''Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1992 Rates'' (56 FR 43196). Since October 1, 1983, the regulations allowed a new rehabilitation hospital or new rehabilitation unit, or an existing excluded rehabilitation unit which was to be expanded by the addition of new beds, to be excluded from the acute care PPS if, in addition to meeting other requirements, it submitted a written certification that during its first cost reporting period it would be in compliance with the 75 percent rule. The August 30, 1991, rule specified that if these facilities were later found to have not complied with the 75 percent rule CMS would determine the amount of actual payment under the exclusion, compute what we would have paid for the facility's services to Medicare patients under the acute care hospital PPS, and recover any difference in accordance with the rules on the recoupment of overpayments.

On September 1, 1992, we published a final rule entitled ''Medicare Program; Changes to Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates'' (57 FR 39746). In the rule we acknowledged that, for various reasons, a new rehabilitation hospital or a new rehabilitation unit might need to begin operations at some time other than at the start of its regular cost reporting period. Therefore, we specified such an IRF could submit a written certification that it would comply with the 75 percent rule for both a partial cost reporting period of up to 11 months, as well as the subsequent full 12-month cost reporting period.

On September 1, 1994, we published a final rule entitled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and FY 1995 Rates'' (59 FR 45330). In that rule, we stated that we had miscellaneous comments requesting that oncology cases, pulmonary disorders, cardiac disorders, and chronic pain be added to the 75 percent rule's list of medical conditions. (59 FR 45393) We responded that although the 75 percent rule had not been addressed in the associated May 27, 1994, proposed rule we would take these miscellaneous comments into consideration if we decided to make changes to the 75 percent rule.

When we published the August 7, 2001 final rule (66 FR 41316), we acknowledged we had received comments requesting that we update the 75 percent rule's list of medical conditions, or eliminate the 75 percent rule. (66 FR 41321) We responded that in our IRF PPS proposed rule we had not proposed changing the 75 percent rule, believed that the existing 75 percent rule was appropriate, and, therefore, would not be revising the 75 percent rule. However, we also stated that data obtained after we implemented the IRF PPS could lead us to reconsider revising the 75 percent rule.

C. CMS Evaluation of the 75 Percent Rule

In the spring of 2002 we surveyed the fiscal intermediaries (FIs) in order to ascertain what methods were being used to verify if IRFs were complying with the 75 percent rule. Analysis of the survey data made us aware that inconsistent methods were being used to determine if an IRF was in compliance with the 75 percent rule, and that some IRFs were not being reviewed to determine if they were in compliance with the 75 percent rule. These survey results led us to become concerned that some IRFs may be out of compliance with the regulations. In addition, we were concerned that some FIs might be using methods to verify compliance with the 75 percent rule, which may cause an IRF to incorrectly be found out of compliance with the rule; this would thus cause an IRF to inappropriately lose its classification as an IRF. Therefore, on June 7, 2002, we suspended enforcement of the 75 percent rule until we conducted a careful examination of this area and determined whether changes were needed to the regulation, and the operating procedures that govern how compliance with the regulation is verified.

In addition to our review of FI administrative procedures, we conducted an analysis of CMS administrative data to attempt to estimate overall compliance with the regulation. We examined both IRF–PAI data and claims from the years 1998, 1999, and 2002. Before discussing the results of this analysis, we note that the data does have some limitations. First, it is not possible to discern from the diagnosis data on the IRF–PAI or the claim whether or not there was a medical need to furnish the patient ''intensive rehabilitation.'' The diagnosis is a determination of a

patient's clinical status, but that is different from determining that there is a medical necessity to furnish treatment to a patient in an IRF as opposed to another type of treatment setting. In addition, it was not possible in many cases to map the diagnosis code on the claim data to one of the ten medical conditions listed in § 412.23(b) because a large percentage of claims have an ICD–9–CM diagnosis code that is a general code indicating only care involving the use of rehabilitation procedures instead of a specific diagnosis.

Chart 1 ''Estimates of Compliance with the 75 Percent Rule'' below shows the estimated percent of facilities with 75 percent of cases falling into the 10 conditions (13.35 percent) using 2002 available patient assessment data. Appendix A provides the technical detail regarding the method used to determine the percent of IRFs in calendar year 2002 that complied with the 75 percent rule. We believe our findings may tend to undercount cases falling within the 10 conditions because the IRF–PAI assessment process was first implemented during 2002. We believe that learning the IRF–PAI assessment process probably resulted in IRFs erring when coding the impairment group on the IRF–PAI assessment form. Nevertheless, we believe the analysis is useful for providing an estimate of the overall compliance with this regulatory requirement. Our findings showed that overall about 50 percent of cases fall within the 10 conditions specified in the rule and the number of facilities meeting the requirement based upon Medicare discharges rather than all discharges is very low. In addition, it shows the estimated percent of facilities that meet lower thresholds. Finally, our analysis also found that a facility's Medicare case mix was a good predictor of case mix for non-Medicare IRF patients.

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Chart 1 Estimates on Compliance With the 75 Percent Rule (2002 Data)

		45% Rule	55% Rule	65% Rule	75% Rule
Hospital Characteristic	**Total Number**	**Percent**	**Percent**	**Percent**	**Percent**
Total	**1170**	**71.87**	**44.19**	**25.17**	**13.35**
Census Division					
1. New England	38	76.3	28.9	7.9	2.6
2. Middle Atlantic	170	47.6	22.4	10	4.1
3. South Atlantic	143	74.8	36.4	15.4	7.0
4. East North Central	220	76.8	53.2	29.1	12.3
5. East South Central	66	77.3	36.4	15.2	1.5
6. West North Central	99	78.8	58.6	41.4	27.3
7. West South Central	235	66.4	30.2	11.1	3.4
8. Mountain	78	70.5	51.3	33.3	21.8

Chart 1 Estimates on Compliance With the 75 Percent Rule (2002 Data)					
		45% Rule	55% Rule	65% Rule	75% Rule
Hospital Characteristic	Total Number	Percent	Percent	Percent	Percent
9. Pacific	121	95.9	86.8	71.1	48.8
Unit/Freestanding Facility					
Unit	95456	72.7	47.6	28.3	15.4
Freestanding	214	68.7	28.5	11.2	4.7
Teaching Status					
Teaching	145	71.7	46.2	32.4	18.6
Non-Teaching	845	73.5	43.6	24.6	13.1
Missing	180	65	45	22.2	10.6
Disproportionate Share Hospital (DSH)					
< 0.05	226	67.3	40.7	21.7	10.2
0.05 - 0.1	339	66.1	39.2	21.8	10.9
0.1 - 0.2	313	76	41.9	23.3	13.7
> = 0.2	145	88.3	64.1	43.4	24.1
Missing	147	68	45.6	24.5	12.9
Facility Control					
Voluntary	700	73.4	47.9	28.4	15.3
Proprietary	259	69.1	30.9	12.7	5
Government	135	77.8	48.9	30.4	18.5
Missing	76	57.9	46.1	28.9	15.8
Size					
Small	309	70.2	49.2	28.2	17.2
Medium	502	74.8	44.2	25.8	12.5
Large	201	70.9	35.2	19.6	9.5
Missing	158	67.7	44.9	24.7	13.9
Urban/Rural					
Large Urban	493	71.6	46.7	29.6	15
Other Urban	404	73.8	42.1	22	12.4
Rural	170	74.1	40.6	19.4	10
Missing	103	63.1	45.6	26.2	15.5

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While our estimate of compliance with the 75 percent rule is somewhat limited by the data available, we do believe it clearly demonstrates low compliance of the 75 percent rule by IRFs. Though IRFs are now paid under a PPS, the 75 percent rule still serves the relevant function of distinguishing IRFs from other types of inpatient facilities, thus facilitating compliance with sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act. Making this distinction is also critical to fulfilling the requirements of section

1886(j)(1)(A), which requires Medicare to make payments to IRFs under a PPS specifically designed for the services they furnish. Specifically, the 75 percent rule has the effect of limiting the type of patient that can be cared for in facilities identified as IRFs. This limitation serves to ensure that only patients requiring this type of specialized and more expensive care receive it. The medical conditions listed in the 75 percent rule are conditions in which patients require the services of rehabilitation professionals with specialized skills and experiences that may not be available in other settings.

The largest group of patients treated in rehabilitation hospitals but not considered in this analysis to meet the 75 percent rule is patients with major joint replacements, specifically knee and hip replacements. Joint replacement patients have been more commonly admitted to rehabilitation hospitals in some areas of the country, and nationally, less than one quarter of Medicare beneficiaries are admitted to IRFs after surgery. Although some joint replacement patients may have ''polyarthritis,'' or another of the ten conditions specified in the 75 percent rule requiring intensive inpatient rehabilitation, these cases were generally not counted towards a facility's compliance with the 75 percent rule. Provider representatives also have requested that conditions classified into the cardiac and pulmonary RICs be added to the list of conditions in the 75 percent rule. These two RICs currently represent about 8 percent of beneficiaries serviced in IRFs using the 2002 patient assessment data. We note that many private insurers do not cover acute inpatient rehabilitation care (in IRFs) for many of these patients whose rehabilitation needs can be met in an alternative setting such as a skilled nursing facility. We request comments on any conditions that necessitate the intensive, multidisciplinary care that IRFs are required to provide.

As mentioned previously, we surveyed the FIs to determine the methods they were using to verify compliance with the 75 percent rule. Our analysis of that survey data led us to suspend enforcement of the 75 percent rule. The process for determining compliance with the 75 percent rule needs to be improved. However, we believe that currently there is no need to amend the regulation because it still appropriately functions to help distinguish an IRF from other types of inpatient treatment settings. We will instead be improving the method FIs use to verify compliance with the 75 percent rule, and ensuring that FIs are consistent in how they verify compliance with the 75 percent rule.

When we suspended enforcement of the 75 percent rule we specified that the suspension of enforcement was not applicable to a facility that was first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2). A facility first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2) only has to self-attest that during its next full 12-month cost reporting period it will meet the 75 percent rule. Accordingly, a facility first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2) has never had an FI verify that its patient population actually met the 75 percent rule. Until the medical conditions of this facility's patient population have been evaluated this facility has not proven that for at least one full 12-month cost reporting period it complied with the 75 percent rule and was appropriately classified as an IRF. Therefore, until a facility had proven that it qualified to be classified as an IRF because its patient population actually met the 75 percent rule it could not be eligible for suspension of enforcement of the 75 percent rule.

We will be instructing FIs to re-institute appropriate enforcement action if a FI determines that an IRF has not met the 75 percent rule. We realize that an IRF may need time to come into compliance with the 75 percent rule. An IRF's cost reporting period is the time period used to ascertain compliance with the 75 percent rule. Therefore, we will be instructing the FIs that the FI must use cost reporting periods that begin on or after October 1, 2003, as the time period to ascertain an IRF's compliance with the 75 percent rule.

While this proposed rule does not propose changes to the regulations related to the 75 percent rule, we expect that improved enforcement and compliance with the existing rule will have varying impacts on providers and beneficiaries.

Our analysis, detailed earlier in this section, indicates that approximately 50 percent of cases being cared for in IRFs fall outside of the ten conditions listed in the regulations. In addition, it estimates that potentially 86 percent of IRFs may currently be out of compliance. We again note that this analysis is based on Medicare administrative data (claims and patient assessments) rather than detailed medical record data and, thus, is limited in its ability to accurately classify all patients into one or more of the ten conditions cited in the regulations. Thus, we would expect our estimates of compliance to be higher if more detailed information from the medical records were available to perform the analysis.

We also know from the data that cases observed in IRFs that do not fall in one of the ten conditions have, on the average, lower lengths of stay than those cases that fall into one of the ten conditions. Specifically, the cases that do not fall into one of the ten conditions (approximately 50 percent) account for approximately 40 percent of the Medicare covered days. Conversely, 60 percent of the Medicare covered days fall into one of the ten conditions.

While it is difficult to predict the aggregate impact of improved compliance on provider revenues, we expect that IRFs and/or their parent hospitals (80 percent of IRFs are units of acute care hospitals) will change their behavior in a variety of ways. IRFs may change admission practices to alter their case mix, either Medicare or total patient population, by admitting patients with more intensive rehabilitative needs that fall into the ten conditions. This could have the effect of elevating the facility's revenues because cases requiring more intensive rehabilitation care generally receive higher Medicare payments than less complex cases.

For example, in each of the three years of data examined, lower extremity joint replacements contained by far the largest number of cases not in the ten conditions (44 percent in 2002). Other conditions included cardiac (10.3 percent), pulmonary (4.8 percent) and pain (4.1 percent). IRFs specializing in or treating a significant number of such cases may have to alter their admissions practice to achieve compliance. Treating fewer joint replacement cases (that result in relatively low payments under the IRF PPS) with cases requiring more intensive treatment could actually increase a facility's revenues.

Conversely, some IRFs may not be able to find such cases and may be required to reduce capacity and serve fewer patients in order to achieve compliance, an action that may have the effect of lowering a facility's revenues. Since compliance with the 75 percent rule could be achieved with changes in admission practices for Medicare as well as non-Medicare patients, the impact on Medicare revenues may vary.

The current regulation reflects the fact that a significant number (up to 25 percent) of medically necessary admissions may fall outside of the ten conditions. These cases can continue to be admitted and treated under the regulation. Other cases may appropriately receive rehabilitative care in alternative settings. For certain medically complex cases, it may be

appropriate to lengthen the patient's stay in an acute care setting in order to stabilize their condition to prepare the patient to participate in rehabilitation. Alternative settings for rehabilitative care could include the acute care hospital, skilled nursing facilities, long-term care hospitals, outpatient rehabilitation, and home health care. For this reason, we do not expect to see reduced access to care for Medicare beneficiaries as a result of improved compliance. In addition, because many hospitals having a Medicare certified IRF unit also have one or more other subunits that provide rehabilitation, revenues from these cases may be generated elsewhere within the same hospital.

We have developed a case study (below) to illustrate the differences in Medicare payment for cases that do not fall into one of the ten conditions included in the 75 percent rule. As discussed above, this type of case could be treated in an alternative setting. For this example, we detail Medicare payment amounts for rehabilitation care in four alternative settings (skilled nursing facility, home health, long term care hospital, and outpatient rehabilitation). As noted above, 80 percent of IRFs are units of hospitals. These hospitals may now choose to direct some patients to other settings. As explained above, it is difficult to predict the approach any individual or group of IRFs will follow in achieving compliance with this regulation, however, the case study illustrates some of the potential Medicare payment effects associated with providing similar levels of rehabilitation in different settings.

Case Example

The following case example has been developed to illustrate the payments under Medicare for levels of rehabilitative care received in the various settings that may be a part of a hospital complex for a patient that has a primary diagnosis of a lower extremity joint replacement. The following case example describes one of the most common patient conditions (not included in the 75 percent rule) but is not meant to describe all possible conditions and their related payment effects. The payments for each PPS described in the example are based on case weights and standardized payment rates for 2003.

The clinical description of the case example is as follows:

A 74-year-old woman status post a right total knee arthroplasty (TKA), with a wound infection, fever, and high white blood count are noted on her second postoperative day. A work-up indicates the existence of staphylococcus aureus septicemia. Patient lacks full extension and has only 65 degrees of flexion on her third post-operative day. The management options for this patient include: extension of acute care length of stay; transfer to a long term care hospital; admission to a skilled nursing facility; possibly home health services or outpatient services.

Under the IRF PPS, this patient would be classified into case-mix group 804 (lower extremity joint replacement with some functional capabilities) with an average length of stay of 14 days. Furthermore, the existence of staphylococcus aureus septicemia, a comorbid condition (ICD–9–CM code 038.11), would place this patient into the tier 2 payment category. The corresponding 2003 unadjusted payment amount for this patient would be $10,828.60.

Under the skilled nursing facility (SNF) PPS, this patient is classified into either the very high (RVB) or ultra high (RUB) rehabilitation group based on the hours of therapy she receives per week. We believe that this patient would have a length of stay in the SNF of either 14 days or 20 days. The corresponding 2003 unadjusted payment amount for this patient would be $4,446.82 for RVB and 14 days, $6,670.23 for RVB and 20 days, $6,352.60 for RUB and 14 days, or $7,672.40 for RUB and 20 days.

Under the long-term care hospital PPS, this patient would be classified into patient group 238 and would have a length of stay of either 14 days or 24 or more days. The corresponding 2003 unadjusted payment amount for this patient would be $17,671.22 for 14 days or $28,296.21 for 24 or more days.

Under the home health PPS, this patient would be placed into the High/High/Moderate group. The corresponding 2003 unadjusted payment amount for this patient would be $5,165.26 for home health services delivered for a 60-day period.

Under outpatient therapy, assuming 2 hours of physical therapy and 1 hour of occupational therapy given during 12 days, payment for this patient would be $4,108.16

If the patient remained in the original surgical acute care hospital stay, under the inpatient acute care hospital PPS this patient would be classified in to DRG 209 and payment at the 50th percentile would be $9,047.36. This illustrative example shows that this facility may have lower payments for the care of this patient relative to the IRF PPS payment if this patient is cared for in an SNF or receives home health or outpatient services. However, the facility may have higher payments relative to the IRF PPS payment if this patient is placed in a long-term care hospital unit. Overall, the example does show that this facility could continue to receive Medicare payments for this type of patient in a setting other than their IRF unit, and have the option of changing its IRF admitting practices without any potential negative effect on patient access to rehabilitative care. However, we invite public comment of this issue.

Section 412.29 Excluded Rehabilitation Units: Additional Requirements

Under § 412.29(a), an IRF unit must have met either the requirements for new units or converted units under § 412.30. Section 412.29(a)(2) contains an incorrect reference to the requirements for converted units as ''§ 412.30(b).'' The correct reference to the requirements for converted units is § 412.30(c). Accordingly, we are proposing to make a technical correction by changing the reference in paragraph (a)(2) to state ''Converted units under § 412.30(c).''

Section 412.30 Exclusion of New Rehabilitation Units and Expansion of Units Already Excluded

Under § 412.30(b)(2), a hospital that seeks exclusion of a new IRF unit may provide written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2). Section 412.30(b)(3) contains an incorrect reference to the required written certification described in ''(a)(2)'' of this section. The correct reference to the written certification is described in paragraph (2) of § 412.30(b). Accordingly, we are proposing to make a technical correction by changing the current reference to § 412.23(a)(2) in § 412.23(b)(3) to state ''The written certification described in paragraph (b)(2) * * *''.

Section 412.30(d)(1) defines new bed capacity for the purposes of expanding an existing excluded IRF unit. Section 412.30(d)(2)(i) contains an incorrect reference to the definition of new bed capacity under paragraph ''(c)(1)'' of this section. The correct reference to the definition of new bed capacity is paragraph (d)(1). Accordingly, we are proposing a technical correction to change the current reference to paragraph (c)(1) in paragraph (d)(2)(i) to state ''* * * under paragraph (d)(1) of this section.''

III. Research To Support Case-Mix Refinements to the IRF PPS

A. Research on IRFs

As described in the August 7, 2001 final rule, we contracted with the RAND Corporation (RAND) to analyze IRF data to support our efforts in developing the CMG patient classification system and the IRF PPS. As discussed below, we are continuing our contract with RAND to support us in developing refinements to the classification and PPS, and in developing a system to monitor the effects of the IRF PPS. In addition, under a separate contract, we are developing and defining measures to monitor the quality of care and services provided to Medicare beneficiaries receiving care in an IRF.

B. RAND Research Background

In 1995, the RAND Corporation (RAND) began extensive CMS-sponsored research to assist us in developing a per-discharge based inpatient rehabilitation PPS model using patient classification system known as Functional Independence Measures-Functional Related Groups (FIM-FRGs) using 1994 data. Initial results of RAND's earliest research were revealed in September 1997 and are contained in two reports available through the National Technical Information Service (NTIS). The reports are entitled ''Classification System for Inpatient Rehabilitation Patients—A Review and Proposed Revisions to the Functional Independence Measure-Function Related Groups,'' NTIS order number PB98–105992INZ; and ''Prospective Payment System for Inpatient Rehabilitation,'' NTIS order number PB98–106024INZ.

In summarizing these reports, RAND found in the research based on 1994 data that, with limitations, the FIM-FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor score, cognitive scores, and age remained stable over time. Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM-FRG classifications that explains approximately 50 percent of patient costs and approximately 60 percent to 65 percent of the costs at the facility level. Based on this earlier analysis, RAND concluded that an IRF PPS using this model is feasible.

In July 1999, we contracted with RAND to update the earlier study. The update used their earlier research and included an analysis of FIM data, the FRGs, and the model rehabilitation PPS using more recent data from a greater number of IRFs. The purpose of updating the earlier research was to develop the underlying data necessary to support the Medicare IRF PPS based on case-mix groups for the proposed rule. RAND expanded the scope of their earlier research to include the examination of several payment elements, such as comorbidities, facility-level adjustments, and implementation issues, including evaluation and monitoring. This research was used in our development of the IRF PPS. RAND issued a report on its research which can be found on our Web site at *http:cms.hhs.gov/providers/irfpps/research.asp.*

C. Continuing Research

RAND's data efforts over the past year were concentrated on archiving data from the first phase of the project, constructing the analytic files for monitoring special studies, and preparing for post-IRF data that will be used for monitoring and for refinement. RAND's monitoring effort seeks to measure changes in IRF, post-IRF, and post-acute care after implementation of the IRF PPS. The refinement effort necessitates that the methods used to create the initial set of CMGs weights, and facility adjustments be applied to more recent IRF data.

Section 125(b) of the BBRA provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after the date the IRF prospective payment system is first implemented. Accordingly, to continue RAND's research, data from other health care settings are needed to assess the impact on utilization and beneficiary access to services because the IRF PPS can have an impact among other settings that deliver rehabilitative services. If we only analyzed data from IRFs, our assessment of utilization and access would not be complete. In addition to the data obtained from the IRF Medicare claims, functional measures from the IRF PAI, and cost reports, other data are required that shows the utilization and access of rehabilitative services delivered in other settings, such as skilled nursing facilities, long-term care facilities, home health agencies, and outpatient rehabilitation facilities. Analysis of these data may show changes in utilization of inpatient rehabilitation services and if the types or severity of patients treated in IRFs differs significantly from the data used to create the CMGs, case-mix refinements may be needed.

In the next phase of their research, RAND will be developing and testing possible improvements to the payment system using existing data. This analysis will focus on potential improvements to the methods used to establish the CMGs, facility adjustments (such as teaching, rural, and low-income adjustments), and comorbidities.

In constructing the CMGs for the IRF PPS, one of our primary goals was to create payments that would match payment to resource use as closely as possible. It is important to continue to examine the IRF PPS to ensure that the system remains a good predictor of resource use over time. Further, more complete data will be available in which we can assess the reliability and validity of the IRF PPS. We also expect improvements with certain data elements. For example, prior to implementation of the IRF PPS, IRFs were not required to code comorbidities. As a result of implementing the IRF PPS, we expect that IRFs will improve coding comorbidities because they may affect their payment amount. These improved data will allow us to determine the effects various conditions have on the cost of a case.

RAND will use post-IRF PPS data when it becomes available, as well as existing data to support their research. RAND research includes: analyses of methodological improvements in the creation of CMGs, methodological improvements to the statistical approaches used to derive payment adjustments and characterizing IRFs into groups based on their case mix. As mentioned in Section I of this proposed rule, currently, RAND does not have enough post-IRF PPS data to analyze potential modifications to the classification and payment systems. Further, we will need a sufficient amount of these data to be able to determine our future refinements, if any are needed. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient data will not be available for those facilities whose cost report start date occurs later in the calendar year. Therefore, in this proposed rule, we are not proposing to change the CMG classification system or the facility level and case level adjustments, other than the wage adjustment. The proposed changes for the wage adjustment are discussed in detail in Section VI of this proposed rule.

D. Staff Time Measurement Data

As described in the August 7, 2001 final rule, we contracted with Aspen Systems Corporation (ASPEN) to collect

actual resource use or staff time measurement (STM) data in a sample of IRFs. Data were collected using the MDS–PAC patient assessment instrument. FIM data were collected at the same time. We believe that these data that measure actual nursing and therapy time spent on patient care may be used to enhance our ability to refine the CMGs.

RAND received ASPEN's analytical database in early spring 2002. After a brief period of working with the data, RAND discovered that their study required details that were not in this summary database. Specifically, about half of the cases within the analytic database had data for only the first part of the patient's stay. RAND needed to have data on how staff time use changed during the stay and the analytic database contained only the averages of the observed portions of the patient's stay. RAND needed data on patients during the second part of their stay.

In late July 2002, RAND received the backup data, but did not assess it until late August 2002. Further technical questions about the data still exist and must be answered before the modeling of the data can occur.

E. Monitoring

A greater part of the ongoing work to be performed by RAND is an analysis to develop a potential system of indicators to monitor the impact and performance of the IRF PPS. As part of their analysis, RAND will case-mix adjust these measures and distinguish between those that will track the direct impact of PPS on IRFs and IRF patients, and those that will track changes in the pool of potential IRF patients. We anticipate that RAND will develop a set of possible indicators needed to monitor the IRF PPS, develop potential access to care models and measures, and define a possible measure of outcomes.

F. Need To Develop Quality Indicators for IRFs

The IRF–PAI is the data collection instrument for IRFs. It contains a blend of FIM items and proposed quality and medical needs questions. These quality and medical needs questions (which are currently collected on a voluntary basis) may need to be modified to encapsulate those data necessary for calculation of a quality indicator. One of the primary tasks of the RAND contract is to identify quality indicators pertinent to the inpatient rehabilitation setting and determine what information is necessary to calculate those quality indicators. These tasks include reviewing literature and other sources for existing rehabilitation quality indicators. It also involves identifying organizations involved in measuring or monitoring quality of care in the inpatient rehabilitation setting. RAND will convene a technical expert panel to identify a series of quality indicators that can be measured using the IRF–PAI. In addition, quality indicators and data elements must be developed for calculation as well as the independent testing of the developed indicators.

IV. The IRF PPS Patient Assessment Process

A. Background

On August 7, 2001, we published the IRF PPS final rule (66 FR 41316), which described how the IRF would use the IRF Patient Assessment Instrument (PAI) to assess an IRF patient. During the fall of 2001, we conducted training on the IRF–PAI assessment process. The training was held in the cities of Baltimore, Maryland, Chicago, Illinois, San Francisco, California, and Atlanta, Georgia. The training was videotaped. During the training sessions we stated that any IRF could obtain the videotapes free of charge. In addition, we stated on the CMS IRF PPS website that any IRF could obtain copies of the videotapes. The IRS–PAI manual, which contains detailed instructions regarding the completion of the IRS–PAI, is also available on the CMS IRF PPS website.

B. Patient Rights

Section 412.608 specifies that prior to performing the IRS–PAI assessment, the IRF must inform the patient of the rights contained in this section. The rights specified in § 412.608 are as follows:

(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.

In addition to the rights specified in § 412.608, a patient has privacy rights under the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)), and 45 CFR 5b.4(a)(3). The Privacy Act and 45 CFR 5b.4(a)(3) require that an individual be informed under what authority, and for what purpose, individually identifiable information is being collected by a Federal agency and maintained in a system of records. In order to ensure compliance with the Privacy Act of 1974, and 45 CFR 5b.4(a)(3), we are proposing that prior to performing the IRS–PAI assessment an IRF clinician must give to each Medicare inpatient two forms. We have published these forms in Appendix B of this proposed rule. In addition, we are proposing that the form entitled ''Privacy Act Statement—Health Care Records'' is a detailed description of the patient's privacy rights under the Privacy Act of 1974. Also, we are proposing that the form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' is the simplified plain language description of the Privacy Act Statement—Health Care Records. Additionally, we are proposing that by giving both of these forms to the patient before beginning the IRS–PAI assessment, the IRF would fulfill the requirement that the patient be informed of the five rights specified in § 412.608. Accordingly we are proposing to amend § 412.608 to read as follows:

Patient's rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient each of these forms—

(1) The form entitled ''Privacy Act Statement—Health Care Records;'' and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.''

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) The Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities is the simplified plain language description of the Privacy Act Statement—Health Care Records.

(d) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

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

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

(iii) 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;

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

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

(e) The patient rights specified in this section are in addition to the patient rights specified in § 482.13 of this chapter.

It should be noted that when the IRF clinician gives the patient the forms entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' and the ''Privacy Act Statement—Health Care Records'' prior to performing an assessment, these forms do not satisfy the privacy provisions contained in the HIPAA Privacy Rule (65 FR 82462 as modified by 67 FR 53182). For example, these forms do not meet the privacy notice requirements of the HIPAA Privacy Rule (see 45 CFR § 164.520). Health plans and health care providers must meet the notice requirements of the HIPAA Privacy Rule by giving a Notice of Privacy Practices to their patients. The Notice of Privacy Practices describes a health plan or health care provider's uses and disclosures of protected health information and the individual rights that patients have with respect to their protected health information.

C. When the IRF–PAI Must Be Completed

According to § 412.606(b), an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients. According to § 412.610(c)(1)(i)(A), the admission assessment covers the first 3 calendar days of the inpatient's current IRF Medicare Part A fee-for-service hospitalization. According to § 412.610(c)(1)(i)(B), the admission assessment reference date is the third day of the 3-day admission assessment time period. Section 412.610(c)(1)(i)(C) specifies that the IRF–PAI for the admission assessment ''Must be completed on the calendar day that follows the admission assessment reference day.''

We are concerned IRFs believe § 412.610(c)(1)(i)(C) means that they may not start to record data on the IRF–PAI before the calendar day that follows the admission assessment reference day, which is not our intent. The ''completion requirement'' of the IRF–PAI means when the IRF's staff must have finished recording on the IRF–PAI the assessment data that the IRF's clinical staff obtained during an assessment of the inpatient that was performed during the admission assessment time period. In other words, the date when the IRF–PAI must be completed is a deadline date when the process of recording data on the IRF–PAI must be finished. The IRF's staff is permitted to enter assessment data on the IRF–PAI prior to the deadline date.

How data are recorded on the IRF–PAI is specified in the IRF–PAI item-by-item guide, which is entitled the ''IRF–PAI Training Manual Revised 01/16/02.'' The instructions contained in the IRF–PAI item-by-item guide are, when possible, very similar to the rules for coding the patient assessment instrument that we used as the model for the IRF–PAI. The model for the IRF–PAI was the patient assessment instrument published by Uniform Data System for Medical Rehabilitation (UDSmr). The UDSmr rules for coding their assessment instrument specified that an item's score should reflect the inpatient's lowest level of functioning. Consequently, in order to be consistent with how an inpatient's functional performance was scored on the UDSmr patient assessment instrument, the IRF–PAI item-by-item guide likewise specifies that a patient's assessment must indicate the patient's lowest level of functioning.

During the admission assessment, an IRF clinician records different types of data on the IRF–PAI. We believe that the sources of the data recorded in the categories of the IRF–PAI entitled ''Identification Information,'' ''Admission Information,'' and ''Payer Information'' makes these data easy and quick to obtain and record. For these categories of data the source of the data may be the patient, the patient's medical record, other patient documents, the patient's family, or a person that has personal knowledge of the patient. In contrast, in order to complete the data for the IRF–PAI categories entitled ''Function Modifiers'' and ''FIM™ Instrument,'' the clinician observes the patient's functional performance over the admission assessment time period, and makes clinical judgments regarding the patient's performance. Consequently, due to how the data for the Function Modifiers and FIM™ categories are obtained, we believe it is the time span that it takes to assess the patient's functional performance that will usually determine how long it takes to complete the admission assessment.

Page III–3 of the IRF–PAI manual states that when determining the level of the patient's functional performance the clinician is to ''record the lowest (most dependent) score.'' We believe that in the time span between the patient's admission to and discharge from the IRF, the patient's functional performance improves. We believe that on the patient's admission day and the next few days a patient's functional performance is poor in comparison to functional performance on subsequent days of the patient's current IRF hospitalization. Therefore, during the part of the admission assessment that is the first or second day of the patient's current IRF hospitalization, we believe that a patient's functional performance will usually be scored as indicating the most dependence.

As stated previously, the IRF's clinical staff is permitted to record assessment data on the IRF–PAI at any time during the admission assessment process. Also, as stated previously, we believe it is the scoring of the patient's functional performance that will determine how long it takes to complete the admission assessment. The combination of: (1) Being able to record assessment data at any time during the admission assessment, (2) the requirement that the lowest level of functional performance be recorded, and (3) that the lowest level of functional performance will usually occur on the first or second day of the admission assessment, makes it possible to finish obtaining and recording all the assessment data before the day that follows the admission assessment reference date. However, in accordance with § 412.610(c)(1)(i)(C), an IRF has until the day following the admission assessment reference day to complete the IRF–PAI.

In order to clarify that § 412.610(c)(1)(i)(C) does not prohibit the IRF from recording any or all of the data on the IRF–PAI before the day that follows the admission assessment reference day, we are proposing to amend § 412.610(c)(1)(i)(C) to read as follows: Must be completed by the calendar day that follows the admission assessment reference day.

D. Transmission of IRF–PAI Data

As specified in § 412.606(b), ''Patient assessment instrument,'' an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients. There are nine categories of IRF–PAI assessment data. The nine categories are entitled ''identification information, admission

information, payer information, medical information, medical needs, function modifiers, the FIM™ instrument, discharge information, and quality indicators''. The data from some of these categories are used to classify a patient into a CMG. It is the CMG classification code, not the IRF–PAI raw data itself, that is part of the claim data the IRF submits to its FI when the IRF submits data in order to be paid for the services it furnished to the inpatient. We believe that an IRF's clinical staff will initially use the paper version of the IRF–PAI to record its assessment data. Then, in accordance with § 412.610(d), the IRF would use the data that it recorded on the paper version of the IRF–PAI to enter the IRF–PAI data into an electronic version of the document. The electronic version of the IRF–PAI uses the patient assessment data to classify a patient into a CMG. Under the IRF PPS, it is the CMG payment code, along with other information that the IRF submits to the fiscal intermediary (FI), that will determine the payment the IRF receives for the services the IRF furnished to a Medicare Part A fee-for-service beneficiary.

Section 412.614, ''Transmission of patient assessment data,'' specifies that an IRF must transmit to us the IRF–PAI assessment data for each Medicare Part A fee-for-service inpatient. It is the electronic version of the IRF–PAI that enables an IRF to transmit the IRF–PAI data to us. We require that IRFs transmit IRF–PAI data so that we have the IRF–PAI data that are associated with the CMG payment code that the IRF submitted to its FI.

In most cases an IRF will submit claims data, including the patient's CMG, to the FI in order to be paid for the services it furnished to a Medicare Part A fee-for-service inpatient. However, there are situations when the IRF would submit claim data to its FI, but the submission of the claim data is not for the purpose of being paid for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient.

In these situations, Medicare operational procedures that were in effect before implementation of the IRF PPS requires an IRF to send claim data to the FI. The purpose of the IRF sending claim data to the FI in these situations is to enable Medicare to monitor a beneficiary's period of entitlement. For instance, an IRF must still send the FI claim data even if the inpatient's non-Medicare primary payer paid for all of the IRF services the IRF furnished to the Medicare Part A fee-for-service inpatient. Another instance when the IRF must still send the FI claim data is when any of the services that an inpatient's non-Medicare primary payer did not pay for also do not qualify for payment under the IRF PPS.

We want to relieve the IRF of the burden of transmitting IRF–PAI data to us when the IRF is not requesting that Medicare pay for any of the services the IRF furnished to a Medicare Part A fee-for-service inpatient. Accordingly, we are proposing to amend § 412.614 by specifying that § 412.614(a) is a general rule that would read as follows:

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

We are also proposing to further amend § 412.614 by adding a new § 412.614(a)(3), which would relieve the IRF of the burden of having to transmit the IRF–PAI data for a Medicare Part A fee-for-service inpatient when Medicare will not be paying the IRF for any of the services the IRF furnished to that inpatient. New § 412.614(a)(3) would read as follows:

Exception to the general rule. When the inpatient rehabilitation facility does not submit claim data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required to, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

E. Proposed Revision of the Definition of Discharge

According to § 412.602, a discharge has occurred when the patient has been formally released from the hospital, or has died in the hospital, or when the patient stops receiving Medicare-covered Part A inpatient rehabilitation services. Our intent in specifying this definition of when a discharge has occurred under the IRF PPS was to try to ensure that Medicare paid an IRF only for furnishing an IRF level of services to the Medicare Part A fee-for-service inpatient. However, in contrast to when a patient is formally released from the IRF or dies, the time when a patient stops receiving Medicare-covered Part A IRF services may be subject to different interpretations resulting in different determinations of when a discharge has occurred. The result of different determinations of when a discharge has occurred is inconsistency in determining the discharge date. This inconsistency could result in different IRFs furnishing the same services for the same period of time, but being paid differently, because the discharge date determines a patient's length-of-stay, and the patient's length-of-stay is one of the factors that determines the amount of the CMG payment. For example, according to § 412.624(f), a patient's length-of-stay as determined by the inpatient's discharge date may affect the amount of the IRF's CMG payment when a patient is transferred from an IRF to another site of care.

In addition, there may be cases when an IRF believes an inpatient no longer has a medical need for Medicare-covered Part A inpatient rehabilitation services, but the IRF believes that the inpatient has a medical need for a SNF level of services. However, due to circumstances beyond the IRF's control, the IRF is unable to formally release the patient, because the IRF cannot place the patient in a SNF setting. In that situation, according to section 1861(v)(1)(G)(i) of the Act and § 424.13(b), a physician may certify or recertify that the patient needs to continue to be hospitalized in the IRF. The effect of the physician's certification or recertification is that under Medicare the patient is not considered discharged until the patient is formally released from the IRF.

In consideration of what can occur when discharge is defined as being when the inpatient stops receiving Medicare-covered Part A inpatient rehabilitation services, we are proposing to amend § 412.602 by revising the definition of ''discharge'' by removing the phrase ''(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services, unless the patient qualifies for continued hospitalization under § 424.13(b) of this chapter; or''. The proposed revised definition would read as follows:

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

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

F. Waiver of the Penalty for Transmitting the IRF–PAI Data Late

Section 412.614(c) ''Transmission dates'' states that the admission and discharge assessment data must be transmitted together. The discharge assessment is completed after the admission assessment has been completed. Therefore, the date when the IRF–PAI data must be transmitted is

determined by when the IRF–PAI discharge assessment is completed.

After the discharge assessment has been completed, § 412.610(d) ''Encoding dates'' specifies that the data must be entered into the electronic version of the IRF–PAI, a process which § 412.602 defines as encoding the data. As specified in § 412.610(d) the IRF has 7 calendar days to encode the discharge assessment. In order for the IRF–PAI data not to be considered as having been transmitted late, § 412.614(d)(2) specifies that the IRF–PAI data must be transmitted to us no later than 10 calendar days from the date specified in § 412.614(c). The date specified in § 412.614(c) is the 7th calendar day of the applicable encoding time period specified in § 412.610(d). The 7th calendar day of the applicable encoding date specified in § 412.610(d) is the end of the discharge assessment encoding time period because none of the data can be transmitted until the discharge assessment has been encoded. The following example, which is very similar to the Chart 3 on page 41332 of the August 7, 2001 final rule (66 FR 41316), is intended to clarify when CMS will determine that the IRF–PAI data was transmitted late.

CHART 2.— EXAMPLE OF APPLYING THE PATIENT ASSESSMENT INSTRUMENT DISCHARGE ASSESSMENT AND TRANSMISSION DATES

Assessment Type	Discharge date	Assessment reference date	IRF–PAI completed by	IRF–PAI encoded by	IRF–PAI data transmitted by	Date when IRF–PAI data transmission is late
Discharge Assessment	10/16/03	10/16/03	10/20/03	10/26/03	11/01/03	11/12/03 *

* Or any day after 11/12/03.

If IRF–PAI data are transmitted later than 10 calendar days from the transmission date specified in § 412.614(c), § 412.614(d)(2) specifies that we will assess a penalty by deducting 25 percent from the CMG payment that is associated with the IRF–PAI data that were transmitted late. However, we believe that an IRF may encounter an extraordinary situation, which is beyond its control, and that extraordinary situation could render the IRF unable to comply with § 412.614(c). The IRF must fully describe in the appropriate inpatient's clinical record, or by use of another documentation method as selected by the IRF, the extraordinary situation which the IRF encountered that resulted in the IRF being unable to comply with § 412.614(c). Although an IRF may believe that the facility has encountered an extraordinary situation, the IRF's belief does not mean that CMS is obligated to also automatically determine that the situation was of an extraordinary nature. CMS has the discretion to determine whether the situation described by the IRF is extraordinary.

The extraordinary situation may be, but does not have to be, due to the occurrence of an unusual event. Examples of unusual events include, but are not limited to, fire, flood, earthquake, or other similar incidents that inflict extensive damage to an IRF. Another example of an extraordinary situation is the inability of an IRF to transmit any IRF–PAI data for an extended time period, because during that entire time period there was a problem with the data transmission system that was beyond the control of the IRF. An example of a data transmission system problem that is beyond the control of the IRF is the inability of an IRF to transmit its IRF–PAI data because the computer used by CMS to receive and process the data is malfunctioning. A further example of a data transmission system problem that is beyond the control of the IRF is the existence of a flaw in the software that was distributed by CMS to IRFs, or a flaw in the software specifications made available by CMS to vendors that prevent the IRF from transmitting its IRF–PAI data. In addition, an extraordinary situation may include a situation in which a facility has correctly followed CMS policies and procedures in order to be classified as an IRF and obtain an IRF provider number, but has experienced a delay in attaining an IRF provider number. In light of these possibilities, we are proposing a new § 412.614(e) to read as follows: ''Exemption to being assessed a penalty for transmitting the IRF–PAI data late.'' CMS may waive the penalty specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.''

G. General Information Regarding the IRF–PAI Assessment Process

We have received many questions regarding the IRF–PAI assessment process policies. We have posted the answers to most of these questions on the IRF PPS website.

1. The IRF PPS Website Address

The current internet address for the IRF PPS website is *http://www.cms.hhs.gov/providers/irfpps/.* Due to changes in CMS internet policies during 2002, the current website address is different from the one we published in the August 7, 2001 final rule.

2. Exceptions to the IRF–PAI Admission and Discharge Assessment Time Period General Rules

Section 412.610(c)(1)(i) states the general rule that the time span covered during the admission assessment is calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service IRF hospitalization. Section 412.610(c)(2)(i) states the general rule that the discharge assessment time period is a span of time that covers 3 calendar days, which includes the inpatient's discharge date, which is the same date as the discharge assessment reference date, and the 2 calendar days

before the discharge date. We want to remind IRFs that, as specified in § 412.610(c)(1)(ii) and § 412.610(c)(2)(iii), we may use the IRF–PAI item-by-item guide and other instructions to identify items that have a different admission or discharge assessment time period. We may specify different admission and discharge assessment time periods in order to capture patient information for payment and quality of care monitoring objectives appropriately.

V. Patient Classification System for the IRF PPS

As previously stated, in this proposed rule we are proposing to use the same case-mix classification system that was set forth in the August 7, 2001 final rule. It is our intention to pursue the development of possible refinements to the case-mix classification system that will continue to improve the ability of the PPS to accurately pay IRFs. We have awarded a contract to the RAND Corporation (RAND) to conduct additional research that will, in the initial stages, provide us with the data necessary to address the feasibility of developing and proposing refinements. When the study has been completed, we plan to review various approaches so that we can propose an appropriate methodology to develop and apply refinements. Any specific refinement proposal resulting from this research will be published in the **Federal Register**.

Table 1, *Proposed Relative Weights for Case-Mix Groups (CMGs),* presents the proposed CMGs, comorbidity tiers, and corresponding Federal relative weights. We also present the average length of stay for each CMG. As we discussed in the August 7, 2001 final rule (66 FR 41353), the average length of stay for each CMG, along with the discharge destination, is used to determine when an IRF discharge meets the definition of a transfer, which results in a per diem case level adjustment (66 FR 41354). Because these data elements are not changing as a result of this proposed rule, Table 1 is identical to Table 1 that was published in the August 7, 2001 final rule (66 FR 41394 through 41396). The proposed relative weights reflect the inclusion of cases with an interruption of stay (patient returns on day of discharge or either of the next 2 days). The methodology we used to construct the data elements in Table 1 is described in detail in the August 7, 2001 final rule (66 FR 41350 through 41353).

VI. Proposed Fiscal Year 2004 Federal Prospective Payment Rates

A. Expiration of the IRF PPS Transition Period

The transition period provision under section 1886(j)(1) of the Act and § 412.626 of the regulations expired for cost reporting periods beginning on or after October 1, 2002 (FY 2003 and beyond). Accordingly, the payment for discharges during FY 2004 will be based entirely on the proposed adjusted FY 2004 IRF Federal PPS rates.

B. Description of the IRF Standardized Payment Amount

In the August 7, 2001 final rule, we established a standard payment amount referred to as the budget neutral conversion factor under § 412.624(c). In accordance with the methodology described in § 412.624(c)(3)(i), the budget neutral conversion factor for FY 2002, as published in the August 7, 2001 final rule, was $11,838.00. Under § 412.624(c)(3)(i), this amount reflects, as appropriate, any adjustments for outlier payments, budget neutrality, and coding and classification changes as described in § 412.624(d).

The budget neutral conversion factor is a standardized payment amount and the amount reflects the budget neutrality adjustment for FY 2002, as described in § 412.624(d)(2). The statute requires a budget neutrality adjustment only for fiscal years 2001 and 2002. Accordingly, we believe it is more consistent with the statute to refer to the standardized payment as the standardized payment conversion factor, rather than refer to it as a budget neutral conversion factor. Thus, after careful consideration, we are proposing to change all references to the budget neutral conversion factor in §§ 412.624(c) and 412.624(d) to the ''standard payment conversion factor.'' We believe that the standard payment conversion factor better describes the standardized payment amount especially in those fiscal years where a budget neutrality adjustment is not made.

Thus, under § 412.624(c)(3)(i), the standard payment conversion factor for FY 2002 of $11,838.00 reflected the budget neutrality adjustment described in § 412.624(d)(2). Under current revised § 412.624(c)(3)(ii), we updated the FY 2002 standard payment conversion factor ($11,838.00) to FY 2003 by applying an increase factor (the IRF market basket index) of 3.0 percent, as described in the August 1, 2002 update notice (67 FR 49931). This yielded the FY 2003 standard payment conversion factor of $12,193.00 that was published in the August 1, 2002 update notice (67 FR 49931). The FY 2003 standard payment conversion factor will be the basis of the updated FY 2004 standard payment conversion factor that will also reflect the adjustments described below.

C. Proposed Adjustments To Determine the Proposed FY 2004 Standard Payment Conversion Factor

1. IRF Market Basket Index

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in IRF services paid for under the IRF PPS, which is referred to as the IRF market basket index. Accordingly, in updating the FY 2004 payment rates set forth in this proposed rule, we propose to apply an appropriate increase factor, that is equal to the IRF market basket, to the FY 2003 IRF standardized payment amount.

Beginning with the implementation of the IRF PPS in FY 2002 and with the FY 2003 IRF PPS update, the 1992-based excluded hospital with capital market basket has been used to determine the IRF market basket factor for updating payments to rehabilitation facilities. The 1992-based market basket reflected the distribution of costs in 1992 for Medicare-participating freestanding rehabilitation, long-term care, psychiatric, cancer, and children's hospitals. This information was derived from the 1992 Medicare cost reports. A full discussion of the methodology and data sources used to construct the 1992-based excluded hospital with capital market basket is available in Appendix D of the IRF PPS August 7, 2001 final rule **Federal Register** (66 FR 41427).

In this proposed rule, we propose to revise and rebase the excluded hospital with capital market basket to a 1997 base year. We believe that proposing to use 1997 data, rather than 1992 data, to construct the IRF market basket will allow us to more appropriately estimate increases in the costs of IRF goods and services from year to year.

The operating portion of the 1997-based excluded hospital with capital market basket is derived from the 1997-based excluded hospital market basket. The methodology used to develop the excluded hospital market basket operating portion was described in the August 1, 2002 **Federal Register** (67 FR 50042–50044). In brief, the operating cost category weights in the 1997-based excluded market basket added to 100.0. These weights were determined from the Medicare cost reports, the 1997 Business Expenditure Survey from the

Bureau of the Census, and the 1997 Annual Input-Output data from the Bureau of Economic Analysis. In using the 1997 data, we made two methodological revisions to the 1997-based excluded hospital market basket: (1) Changing the wage and benefit price proxies to use the Employment Cost Index (ECI) wage and benefit data for hospital workers, and (2) adding a cost category for blood and blood products.

Previously we used a combination of several ECIs, a great part of which are listed in the 1992-based index such as the hospital, professional, and technical workers ECIs. However, the ECI for hospital workers better represents the movement of hospital wages, salaries, and benefits and it is more reflective of current labor market conditions. For the 1992-based market baskets we were unable to find an adequate data source for the blood cost category. For the 1997-based excluded hospital market basket, we were able to obtain this data from Medicare cost reports. As discussed in the IPPS August 1, 2002 final rule (67 FR 50035), BIPA required that we adequately reflect the price of blood and blood products in the hospital market basket when it was rebased and revised, which was done for the FY 2003 IPPS payment rates.

We believe this revision is also appropriate for the excluded hospital with capital market basket because it results in a more precise measure of the cost category for blood and blood products.

When we add the weight for capital costs to the excluded hospital market basket, the sum of the operating and capital weights must still equal 100.0. Because capital costs account for 8.968 percent of total costs for excluded hospitals in 1997, it holds that operating costs must account for 91.032 percent. Each operating cost category weight from the August 1, 2002 **Federal Register** (67 FR 50442–50444) was rebased to the 1997-based excluded hospital market basket by multiplying by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.

The aggregate capital component of the 1997-based excluded hospital market basket (8.968 percent) was determined from the same set of Medicare cost reports used to derive the operating component. The detailed capital cost categories of depreciation, interest, and other capital expenses were also determined using the Medicare cost reports. As explained below, two sets of weights for the capital portion of the revised and rebased market basket needed to be determined. The first set of weights identifies the proportion of capital expenditures attributable to each capital cost category, while the second set represents relative vintage weights for depreciation and interest. The vintage weights identify the proportion of capital expenditures that is attributable to each year over the useful life of capital assets within a cost category (*see* IPPS final rule published in the August 1, 2002 **Federal Register** (67 FR 50046–50047)) for a discussion of how vintage weights are determined).

The cost categories, price proxies, and base-year FY 1992 and proposed FY 1997 weights for the excluded hospital with capital market basket are presented in Chart 3 ''Excluded Hospital With Capital Input Price Index (FY 1992 and Proposed FY 1997) Structure and Weights.'' Chart 4 ''Proposed Excluded Hospital with Capital Input Price Index (FY 1997) Vintage Weights'' presents the vintage weights for the proposed 1997-based excluded hospital with capital market basket.

CHART 3.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX [1] [2] (FY 1992 AND PROPOSED FY 1997) STRUCTURE AND WEIGHTS

Cost category	Price wage variable	Weights (%) base-year 1992	Proposed weights (%) base-year 1997
TOTAL		100.000	100.000
Compensation		57.935	57.579
Wages and Salaries	ECI—Wages and Salaries, Civilian Hospital Workers	47.417	47.335
Employee Benefits	ECI—Benefits, Civilian Hospital Workers to capture total costs (operating and capital), In order to capture total costs (operating and capital), HCFA Occupational Benefit Proxy.	10.519	10.244
Professional fees: Non-Medical	ECI—Compensation: Prof. & Technical Technical	1.908	4.423
Utilities		1.524	1.180
Electricity	WPI—Commercial Electric Power	0.916	0.726
Fuel Oil, Coal, etc.	WPI—Commercial Natural Gas	0.365	0.248
Water and Sewerage	CPI–U—Water & Sewage	0.243	0.206
Professional Liability	HCFA—Professional Liability Premiums	0.983	0.733
All Other Products and Services		28.571	27.117
All Other Products		22.027	17.914
Pharmaceuticals	WPI—Prescription Drugs	2.791	6.318
Food: Direct Purchase	WPI—Processed Foods	2.155	1.122
Food: Contract Service	CPI–U—Food Away from Home	0.998	1.043
Chemicals	WPI—Industrial Chemicals	3.413	2.133
Blood and Blood Products	WPI—Blood and Derivatives		0.748
Medical Instruments	WPI—Med. Inst. & Equipment	2.868	1.795
Photographic Supplies	WPI—Photo Supplies	0.364	0.167
Rubber and Plastics	WPI—Rubber & Plastic Products	4.423	1.366
Paper Products	WPI—Convert. Paper and Paperboard	1.984	1.110
Apparel	WPI—Apparel	0.809	0.478
Machinery and Equipment	WPI—Machinery & Equipment	0.193	0.852
Miscellaneous Products	WPI—Finished Goods excluding Food and Energy	2.029	0.783
All Other Services		6.544	9.203
Telephone	CPI–U—Telephone Services	0.574	0.348
Postage	CPI–U—Postage	0.268	0.702
All Other: Labor	ECI—Compensation: Service Workers	4.945	4.453
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757	3.700

CHART 3.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX [1] [2] (FY 1992 AND PROPOSED FY 1997) STRUCTURE AND WEIGHTS—Continued

Cost category	Price wage variable	Weights (%) base-year 1992	Proposed weights (%) base-year 1997
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Fixed Assets	Boeckh-Institutional Construction:	3.570	3.503
Movable Equipment	WPI—Machinery & Equipment: 11 Year Useful Life	2.041	2.083
Interest Costs		3.212	2.682
Non-profit	Avg. Yield Municipal Bonds: 23 Year Useful Life	2.730	2.280
For-profit	Avg. Yield AAA Bonds: 23 Year Useful Life	0.482	0.402
Other Capital-Related Costs	CPI-U—Residential Rent	0.257	0.699

[1] The operating cost category weights in the excluded hospital market basket described in the August 1, 2002 **Federal Register** (67 FR 50442 through 50444) add to 100.0.
[2] Due to rounding, weights sum to 1.000.

When we add an additional set of cost category weights (total capital weight = 8.968 percent) to this original group, the sum of the weights in the new index must still add to 100.0. Because capital costs account for 8.968 percent of the market basket, then operating costs account for 91.032 percent. Each weight in the 1997-based excluded hospital market basket from the IPPS final rule published in the August 1, 2002 **Federal Register** (67 FR 50442–50444) was multiplied by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.

CHART 4.—PROPOSED EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1997) VINTAGE WEIGHTS

Year from farthest to most recent	Fixed assets (23-year weights)	Movable assets (11-year weights)	Interest: capital-related (23-year weights)
1	0.018	0.063	0.007
2	0.021	0.068	0.009
3	0.023	0.074	0.011
4	0.025	0.080	0.012
5	0.026	0.085	0.014
6	0.028	0.091	0.016
7	0.030	0.096	0.019
8	0.032	0.101	0.022
9	0.035	0.108	0.026
10	0.039	0.114	0.030
11	0.042	0.119	0.035
12	0.044	.....	0.039
13	0.047	.....	0.045
14	0.049	.....	0.049
15	0.051	.....	0.053
16	0.053	.....	0.059
17	0.057	.....	0.065
18	0.060	.....	0.072
19	0.062	.....	0.077
20	0.063	.....	0.081
21	0.065	.....	0.085
22	0.064	.....	0.087
23	0.065	.....	0.090
Total*	1.0000	1.0000	1.0000

* Due to rounding, weights sum to 1.000.

Chart 5 ''Percent Changes in the 1992-based and proposed 1997-based Excluded Hospital with Capital Market Baskets, FY 1999–2004'' compares the 1992-based excluded hospital with capital market basket to the proposed 1997-based excluded hospital with capital market basket. As is shown, the rebased and revised market basket grows slightly faster over the 1999–2001 period than the 1992-based market basket. The major reason for this was the switching of the wage and benefit proxy to the ECI for hospital workers from the previous occupational blend. We believe that the ECI is the most appropriate price proxy for measuring changes in wage data facing IRFs. This wage series reflects actual wage data reported by civilian hospitals to the Bureau of Labor Statistics. The ECIs are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are appropriately not affected by shifts in skill mix. This differs from the proxy used in the FY 1992-based index in which a blended occupational wage index was used. The blended occupational wage proxy used in the FY 1992-based index and the ECI for wages and salaries for hospitals both reflect a fixed distribution of occupations within

a hospital. The major difference between the two proxies is in the treatment of professional and technical wages (legal, accounting, management, and consulting services from outside the facility). In the blended occupational wage proxy, the professional and technical category was blended evenly between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy. The ECI for hospitals reflects hospital-specific occupations. This revision had a similar impact on the hospital PPS and excluded market baskets, as described in the IPPS final rule published in the August 1, 2001 **Federal Register**. The proposed FY 2004 increase in the 1997-based excluded hospital with capital market basket is 3.3 percent.

CHART 5.—PERCENT CHANGES IN THE 1992-BASED AND PROPOSED 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FY 1999–2004

Fiscal Year	Percent Change, FY 1992-based Market Basket	Percent Change, Proposed FY 1997-based Market Basket
Actual Historical % Increase (FY 1999–2001)		
1999	2.3	2.7
2000	3.4	3.1
2001	3.9	4.0
Average historical	3.2	3.3
Forecasts (FY 2002–2004)		
2002	2.7	3.6
2003	3.0	3.5
2004	3.0	3.3
Average forecast	2.9	3.5

Section 1886(j)(3)(c) requires that the increase in the IRF PPS payment rate be based on an ''appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).'' To date, we have used a market basket based on the cost structure of all excluded hospitals to satisfy this requirement, and have discussed in prior rules why we feel this market basket provides a reasonable measure of the price changes facing exempt hospitals.

In its March 2002 Report, the Medicare Payment Advisory Commission (MedPAC) recommended the development of a market basket specific to IRF services. As we mentioned in last year's final rule, we have been researching the feasibility of developing such a market basket. This research included analyzing data sources for cost category weights, specifically the Medicare cost reports, and investigating other data sources on cost, expenditure, and price information specific to IRFs. As described in greater detail below, based on this research, we are not proposing at this time to develop a market basket specific to IRF services.

Our analysis of the Medicare cost reports indicates that the distribution of costs among major cost report categories (wages, pharmaceuticals, capital) for IRFs is not substantially different from the 1997-based excluded hospital with capital market basket we propose to use. In addition, the only data available to us was for these cost categories (wages, pharmaceuticals, and capital) presenting a potential problem since no other major cost category would be based on IRF data.

We conducted a sensitivity analysis of annual percent changes in the market basket when the IRF weights for wages, pharmaceuticals, and capital were substituted into the excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the inpatient PPS hospital market basket. On average, between the years 1995 through 2002, the excluded hospital with capital market basket increased at essentially the same average annual rate (2.9 percent) as the market basket with IRF weights for wages, pharmaceuticals, and capital (2.8 percent). In addition, in almost any individual year the difference was 0.1 percentage point or less, which is less than the 0.25 percentage point criterion that is used under the IPPS update framework to determine whether a forecast error adjustment is warranted.

The 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted has been used in the IPPS update framework since the implementation of the IPPS. It serves as a guideline for the level of forecast accuracy, since any forecast is likely to contain enough imprecision that differences of one tenth or two-tenths of a percentage point are not thought to be significant. Thus, in this case if the forecast error is not at least greater than two-tenths of a percentage point, it is thought to be similar enough to the actual data as not to warrant an adjustment.

Based on the above, we continue to believe that the excluded hospital with capital market basket is doing an adequate job of reflecting the price changes facing IRFs. We will continue to solicit comments about issues particular to IRFs that should be considered in our development of the proposed 1997-based excluded hospital with capital market basket, as well as encourage suggestions for additional data sources that may be available. Our hope is that the additional cost data being collected under the IRF PPS will eventually allow for the development of a market basket derived specifically from IRF data.

As shown in Chart 4, for the payment rates set forth in this proposed rule, the proposed FY 2004 IRF market basket increase factor using 1997 data is 3.3 percent. Thus, we propose to apply the 3.3 percent increase, in addition to the proposed budget neutral wage adjustment factor described below, to the FY 2003 standard payment

conversion factor ($12,193.00) to determine the proposed 2004 standard payment conversion factor.

2. Proposed Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs that are attributable to wages and wage-related costs for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in a geographic area of a rehabilitation facility compared to the national average wage level for such facilities. The statute requires the Secretary to update this wage index adjustment at least every 36 months. The Secretary is required to update this adjustment on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under section 1886(j)(6) of the Act shall be made in a budget neutral manner.

3. Updated Wage Data

For the FY 2004 IRF PPS rates proposed in this proposed rule, we are updating the IRF wage index. In implementing the FY 2002 and FY 2003 IRF PPS, we used FY 1997 acute care hospital wage data to develop the IRF wage indices. We believe that the FY 1999 acute care hospital data are the best available because they are currently the most recent complete final data. Accordingly, we are proposing to update from the FY 1997 acute care hospital wage data to the FY 1999 acute care hospital wage data to develop the proposed wage indices contained in this proposed rule. Tables 3A and 3B contain the proposed FY 2004 wage indices for urban and rural areas respectively.

4. Proposed Updated Labor-Related Share

In implementing the FY 2002 and FY 2003 IRF PPS, we used the 1992 market basket data to determine the labor-related share (72.395 percent). As stated above, we are proposing to update the 1992 market basket data to 1997. Doing so allows us to propose to use the 1997-based excluded hospital market basket with capital costs to determine the FY 2004 labor-related share.

We propose to calculate the FY 2004 labor-related share as the sum of the weights for those cost categories contained in the proposed 1997-based excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services and a 46 percent share of capital-related expenses. The proposed labor-related share for FY 2004 is the sum of the FY 2004 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year (FY 1997) and FY 2004. The proposed sum of the relative importance for FY 2004 for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 69.163 percent, as shown in Chart 6 ''FY 2004 Labor-Related Share Relative Importance.'' The portion of capital that is influenced by local labor markets is estimated to be 46 percent. Because the relative importance of capital is 7.653 percent of the 1997-based excluded hospital with capital market basket in FY 2004, we take 46 percent of 7.653 percent to determine the labor-related share of capital for FY 2004. The result is 3.520 percent, which we then add to the 69.163 percent calculated for operating costs to determine the total labor-related relative importance for FY 2004. The resulting labor-related share that we propose to use for IRFs in FY 2004 is 72.683 percent.

CHART 6.—PROPOSED FY 2004 LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	Relative importance 1992-based market basket FY 2004	Relative importance proposed 1997-based market basket FY 2004
Wages and salaries	50.625	49.032
Employee benefits	11.903	11.050
Professional fees	2.055	4.523
Postage	0.252	
All other labor intensive services	5.242	4.558
Subtotal	70.077	69.163
Labor-related share of capital costs	3.394	3.520
Total	73.471	72.683

Chart 6 above shows that rebasing the excluded hospital with capital market basket lowers the increase in labor share that we are proposing to use in FY 2004 relative to what it would have been had we not rebased the excluded hospital with capital market basket. The proposed labor-related share for FY 2004 of 72.683 percent reflects an increase of 0.29 percent from the FY 2003 labor-related share of 72.395 percent. If we did not rebase the excluded hospital with capital market basket, the labor-related share would have increased from 72.395 percent for FY 2003 to 73.471 percent for FY 2004 by approximately 1.1 percent, rather than the proposed increase of 0.29 percent. As we previously stated, we are proposing a labor-related share of 72.683 percent for the FY 2004 IRF PPS payment rates set forth in the proposed rule.

5. Proposed Budget Neutral Wage Adjustment Update Methodology

As stated above, for FY 2004, we are proposing to update the FY 2003 IRF wage indices by using FY 1999 acute care hospital wage data and update the labor-related share by using the 1997 market basket data. Since any adjustment or updates to the IRF wage index made under section 1886(j)(6) of the Act shall be made in a budget neutral manner as required by statute, we are proposing to amend the regulation at § 412.624(e)(1) to reflect this requirement. We are also proposing to determine a budget neutral wage adjustment factor based on an adjustment or update to the wage data to apply to the standard payment conversion factor.

We propose to use the following steps to ensure that the FY 2004 IRF standard payment conversion factor reflects the update to the wage indices and to the labor-related share in a budget neutral manner:

Step 1. We determine the total amount of the FY 2003 IRF PPS rates using the FY 2003 standardized payment amount and the labor-related share and the wage indices from FY 2003 (as published in the August 1, 2002 notice).

Step 2. We then calculate the total amount of IRF PPS payments using the FY 2003 standardized payment amount and the proposed updated FY 2004 labor-related share and wage indices described above.

Step 3. We divide the amount calculated in step 1 by the amount calculated in step 2, which equals the proposed FY 2004 budget neutral wage adjustment factor of 0.9954.

Step 4. We then apply the FY 2004 budget neutral wage adjustment factor from step 3 to the FY 2003 IRF PPS standard payment conversion factor after the application of the market basket update, described above, to determine the proposed FY 2004 standardized payment amount.

D. Proposed Update of Payment Rates Under the IRF PPS for FY 2004

Once we calculate the proposed IRF market basket increase factor and determine the proposed budget neutral wage adjustment factor, we can determine the proposed updated Federal prospective payments for FY 2004. In accordance with proposed revised § 412.624(c)(3)(i), we apply the proposed IRF market basket increase factor of 3.3 percent to the proposed standard payment conversion factor for FY 2003 ($12,193) which equals $12,595. Then, we apply the proposed budget neutral wage adjustment of .9954 to $12,595, which results in an updated proposed standard payment conversion factor for FY 2004 of $12,537. The proposed FY 2004 standard payment conversion factor is applied to each proposed CMG weight shown in Table 1 to compute the proposed unadjusted IRF prospective payment rates for FY 2004 shown in Table 2.

Table 2, Proposed FY 2004 Federal Prospective Payments for Case-Mix Groups (CMGs) for FY 2004, displays the proposed CMGs, the proposed comorbidity tiers, and the corresponding proposed unadjusted IRF prospective payment rates for FY 2004.

E. Examples of Computing the Total Proposed Adjusted IRF Prospective Payments

In general, under § 412.624(e), we will adjust the Federal prospective payment amount associated with a CMG, shown in Table 2, to account an IRF's geographic wage variation, low-income patients and, if applicable, location in a rural area.

The adjustment for an IRF's geographic wage variation includes the proposed FY 2004 labor-related share adjustment of 72.683 percent and the proposed FY 2004 IRF urban or rural wage indices in Tables 3A and 3B, respectively.

The adjustment for low-income patients is based on the formula to account for the cost of furnishing care to low-income patients as discussed in the August 7, 2001 IRF PPS final rule (67 FR 41360). The formula to calculate the low-income patient or LIP adjustment is as follows:

(1 + DSH) raised to the power of (.4838)

Where:

$$DSH = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non - Medicare Days}}{\text{Total Days}}$$

The adjustment for IRFs located in rural areas is an increase to the Federal prospective payment amount of 19.14 percent. This percentage increase is the same as the one described in the August 7, 2002 IRF PPS final rule (67 FR 41359).

To illustrate the proposed methodology that we will use for adjusting the Federal prospective payments, we provide the following example in Chart 7 below. One beneficiary is in Facility A, an IRF located in rural Maryland, and another beneficiary is in Facility B, an IRF located in the New York City metropolitan statistical area (MSA).

Facility A's disproportionate share hospital (DSH) adjustment is 5 percent, with a low-income patient (LIP) adjustment of (1.0239) and a wage index of (0.8946), and the rural area adjustment (19.14 percent) applies. Facility B's DSH is 15 percent, with a LIP adjustment of (1.0700) and a wage index of (1.4414).

Both Medicare beneficiaries are classified to CMG 0112 (without comorbidities). To calculate each IRF's total proposed adjusted Federal prospective payment, we compute the wage-adjusted Federal prospective payment and multiply the result by the appropriate LIP adjustment and the rural adjustment (if applicable). The following chart illustrates the components of the proposed adjusted payment calculation.

CHART 7.—EXAMPLES OF COMPUTING AN IRF'S PROPOSED FEDERAL PROSPECTIVE PAYMENT

	Facility A	Facility B
Federal Prospective Payment	$25,092.93	$25,092.93
Labor Share	× 0.72683	× 0.72683
Labor Portion of Federal Payment	× 18,238.29	× 18,238.29
Wage Index—(shown in Tables 3A or 3B)	× 0.8946	× 1.4414
Wage-Adjusted Amount	= 16,315.98	= 26,288.67
Non-Labor Amount	+ 6,854.15	+ 6,854.15
Wage-Adjusted Federal Payment	23,170.13	33,142.82
Rural Adjustment	× 1.1914	× 1.0000
Subtotal	27,604.89	33,142.82
LIP Adjustment	× 1.0239	× 1.0700
Total FY'04 Adjusted Federal Prospective Payment	28,264.65	35,462.82

Thus, the proposed adjusted payment for facility A will be $28,264.65, and the proposed adjusted payment for facility B will be $35,462.82.

F. Computing Total Payments Under the IRF PPS for the Transition Period

Under section 1886(j)(1) of the Act and § 412.626, payment for all IRFs with cost reporting periods beginning on or after October 1, 2002 will consist of 100 percent of the proposed FY 2004 adjusted Federal prospective payment (plus any applicable outlier payments under § 412.624(e)(4)) and there will not be any blended payments. Accordingly, the proposed FY 2004 IRF PPS rates set forth in this proposed rule would apply to all discharges on or after October 1, 2003 and before October 1, 2004.

G. IRF-Specific Wage Data

On page 41358 of the August 7, 2001 IRF PPS final rule, we responded to comments regarding the development of a separate wage index for IRFs. Specifically, we responded to these comments as follows:

''At this time, we are unable to develop a separate wage index for rehabilitation facilities. There is a lack of specific IRF wage and staffing data necessary to develop a separate IRF wage index accurately. Further, in order to accumulate the data needed for such an effort, we would need to make modifications to the cost report. In the future, we will continue to research a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages. However, we believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets.''

We still do not have any IRF-specific wage data to determine the feasibility of developing an IRF-specific wage index or of developing an adjustment to refine the acute care hospital wage data to reflect inpatient rehabilitation services. We continue to look into alternative ways to collect, analyze, develop, and audit IRF-specific wage data that would reflect the wages and wage-related costs attributable to rehabilitation facilities. We believe that the best source to collect IRF-specific wage data is the Medicare cost report—the same source for the acute care hospital wage data. These data must be accurate and reliable, thus collecting these data would increase the recordkeeping and reporting burden on IRFs. Initially, this burden would be imposed to collect data just to determine the feasibility of developing an IRF-specific wage index or development of an adjustment to the current IRF wage index.

In addition, as stated earlier in this section of this proposed rule, any adjustment or update to the wage index must be made in a budget neutral manner in accordance with § 1886(j)(6) of the Act. Thus, the PPS rates for any one IRF could be affected in a positive or negative direction, due to the application of the proposed updates to the labor-related share and wage indices in a budget neutral manner. Accordingly, given the current trend of reducing the Medicare cost reporting burden of collecting data and given that any change to the wage index be budget neutral, we are soliciting comments on possible ways to adjust or refine the current IRF wage index, given those restraints.

Since IRFs and hospitals compete in the same labor markets, we propose to continue to use the acute care hospital wage data to develop the IRF wage index as described earlier in this section of this proposed rule.

H. Proposed Adjustment for High-Cost Outliers Under the IRF Prospective Payment System

In this proposed rule, we are proposing changes to the methodology for determining IRF payments for high-cost outliers. The intent of these proposed changes is to ensure outlier payments are paid only for truly high-cost cases. Further, these proposed changes will allow us to create policies that are consistent among the various Medicare prospective payment systems when appropriate.

We have become aware that under the existing acute care hospital inpatient prospective payment system (IPPS), that some hospitals have taken advantage of two system features in the IPPS outlier policy to maximize their outlier payments. The first is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set forth these parameters and the statewide cost-to-charge ratios in the annual notices of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals. In some cases, hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of the cost-to-charge ratio and a higher statewide average cost-to-charge ratio is applied to determine if the acute care hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

We believe the Congress intended that outlier payments under both the IPPS and the IRF PPS would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Under the existing IPPS outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted. Thus, on March 4, 2003, we published a proposed rule (68 FR 10420–10429) ''Proposed Changes in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System,'' with an extensive discussion proposing new regulations to ensure outlier payments are paid for truly high-cost cases under the IPPS.

We believe the use of parameters is appropriate for determining cost-to-charge ratios to ensure these values are reasonable and outlier payments can be made in the most equitable manner possible. Further, we believe the methodology of computing IRF outlier payments is susceptible to the same payment enhancement practices identified under the IPPS and, therefore, merit similar proposed revisions. Accordingly, as discussed below, we are proposing in this proposed rule to make revisions to the IRF outlier payment methodology.

1. Current Outlier Payment Provision Under the IRF PPS

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. In the August 7, 2001 IRF PPS final rule, we codified at § 412.624(e)(4) of the regulations the provision to make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the IRF PPS in

determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients.

Under § 412.624(e)(4), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount ($11,211 which is then adjusted for each IRF by the facilities wage adjustment, its LIP adjustment, and its rural adjustment, if applicable). We calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.624(e)(4), we pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount).

On November 1, 2001, we published a Program Memorandum (Transmittal A–01–131) with detailed intermediary instructions for calculating the cost-to-charge ratios for the purposes of determining outlier payments under the IRF PPS. We stated the following:

''Intermediaries will use the latest available settled cost report and associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs and for IRFs that are distinct part units of acute care hospitals. Intermediaries will calculate updated ratios each time a subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments will not be made. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the intermediary should ensure that the underlying costs and charges are properly reported. We are evaluating the use of upper and lower cost-to-charge ratio thresholds (similar with the outlier policy for acute care hospitals) in the future to ensure that the distribution of outlier payments remains equitable.''

For this proposed rule, we are proposing to continue to use the $11,211 threshold amount. This threshold amount was used in the FY 2003 IRF PPS payment rates and we believe it remains appropriate because the data should not contain any of the inappropriate payment enhancement practices that would result with the implementation of an outlier policy. The data used to construct the existing IRF-PPS outlier threshold consists of cost and charge data that was not influenced by the incentives the current IRF PPS outlier policy may create. Specifically, we used the IRF cost and charge data from the previous cost-based reimbursement system to establish the outlier threshold. These data were not inappropriately influenced by incentives to inflate charges that are created with the existence of an outlier policy; there is not a need for an outlier policy cost-based reimbursement because IRFs, with some limits, would be paid their costs. This is unlike the outlier situation in IPPS, which used post-PPS data to update its annual threshold amount. The IPPS data reflected the practices that we believe erroneously created inappropriate outlier payments.

We propose to continue to make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount ($11,211 which is then adjusted for each IRF by the facility's wage adjustment, its LIP adjustment, and its rural adjustment, if applicable). We propose to continue to calculate the estimated cost of a case by multiplying an IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. However, we are proposing to apply a ceiling to an IRF's cost-to-charge ratios which is discussed below. In accordance with § 412.624(e)(4), we will continue to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted IRF PPS payment for the CMG and the adjusted threshold amount). In addition, under the existing methodology described in the preamble to the August 7, 2001 IRF PPS final rule (66 FR 41363), we will continue to assign the applicable national average for new IRFs.

2. Proposed Changes to the IRF Outlier Payment Methodology

Statistical Accuracy of Cost-to-Charge ratios

We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IRF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IRFs to underserve patients who require more costly care. Further, using a statistical measure of accuracy to address aberrant cost-to-charge ratios will also allow us to be consistent with the proposed outlier policy changes for the acute care hospital IPPS discussed in the March 4, 2003 Cost Outlier proposed rule, (68 FR 10420). Therefore in this proposed rule, we are proposing the following:

(1) To apply a ceiling to IRF's cost-to-charge ratio if a facility's cost-to-charge ratio is above a ceiling. We will calculate two national ceilings, one for IRFs located in rural areas and one for facilities located in urban areas. We propose to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratio for both urban and rural IRFs. (Because of the small number of IRF's compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed under the IPPS, would not be statistically valid. Thus, we propose to use national average cost-to-charge ratios in place of statewide averages.) To determine the rural and urban ceiling, we propose to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (rural and urban). We believe this method results in statistically valid ceilings. If an IRF's cost-to-charge ratio is above the applicable ceiling it is considered to be statistically inaccurate and we propose to assign the national (either rural or urban) average cost-to-charge ratio to the IRF. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because such data are most likely erroneous and therefore should not be relied upon. We propose to update the ceiling and averages using this methodology every year and we will publish these amounts in future program memoranda;

(2) Not assign the applicable national average cost-to-charge ratio when an IRF's cost-to-charge ratio falls below a floor. We are proposing this policy because, as is the case for acute care hospitals, we believe IRFs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we propose the use of a floor, the IRF's cost-to-charge ratio would be raised to the applicable national average. This application of the national average could result in inappropriately higher outlier payments. Accordingly, we are proposing to apply the IRF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. Applying an IRF's actual cost-to-charge ratio to charges in the future to determine the cost of a case

will result in more appropriate outlier payments because it does not overstate the actual cost-to-charge ratio. Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing that to use an IRF's actual cost-to-charge ratio no matter how low their ratio fall.

3. Proposed Adjustment of IRF Outlier Payments

Under the existing methodology for computing IRF outlier payments as described in the preamble of the August 7, 2001 IRF PPS final rule (66 FR 41363) and in the November 1, 2001 Program Memorandum discussed above, we specify that the cost-to-charge ratio used to compute estimated costs are obtained from the most recent settled Medicare cost report. Further, we provided for no retroactive adjustment to the outlier payments to account for differences between the cost-to-charge ratio from the latest settled cost report and the actual cost-to-charge ratio for the cost reporting period in which the outlier payment is made. This policy is consistent with the existing outlier payment policy for acute care hospitals under the IPPS. However, as discussed in the IPPS March 4, 2003 Cost Outlier proposed rule (68 FR 10423), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities exist in the current IPPS outlier policy. Because we believe the IRF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we are proposing the following:

(1) As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under proposed § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report, whichever is later to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. As is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change.

(2) As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an ''overpayment.'' We also may adjust outlier payments for the time value of money for cases that are ''underpaid'' to the IRF. In these cases, the adjustment will result in additional payments to the IRF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

4. Proposed Change to the Methodology for Calculating the Federal Prospective Payment Rates

Section 412.624(e)(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 CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Additional payments made under this section will be subject to the adjustments at § 412.84(i) except that national averages will be used instead of statewide averages. Additional payments made under this section will also be subject to adjustments at § 412.84(m).

VII. Provisions of the Proposed Rule

Overall, in this proposed rule, we are proposing to update the IRF Federal prospective payment rates from FY 2003 to FY 2004 using the methodology described in § 412.624 of the regulations. Our proposed FY 2004 Federal prospective payment rates would be effective for discharges on or after October 1, 2003 and before October 1, 2004.

We are proposing to update the IRF wage indices for FY 2004 by using FY 1999 acute care hospital data. However, any adjustments or updates made under section 1886(j)(6) of the Act must be made in a budget neutral manner. Therefore, we are proposing a methodology to update the wage indices for FY 2004 using 1999 acute care hospital data in a budget neutral manner.

We are also proposing to modify certain criteria for a hospital or a hospital unit to be classified as an IRF.

Section 412.20 Hospital services subject to the prospective payment systems

We are proposing to redesignate current § 412.20(b) and add a new paragraph (b)(2) that states inpatient hospital services will not be paid for under the IRF PPS if the services are paid by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under part 417.

Section 412.22 Excluded hospitals and hospital units: General rules

We are proposing to eliminate application of the bed-number criteria in § 412.22(h)(2)(i) for freestanding satellite IRFs by revising § 412.22(h)(2) and by adding § 412.22(h)(7).

Section 412.25 Excluded hospital units: Common requirements

We are also proposing to eliminate application of the bed-number criteria for IRF satellite units of a hospital in § 412.25(e)(2)(i) by revising § 412.25(e)(2) and by adding § 412.25(e)(5) to conform with the proposed change in § 412.22(h)(2)(i).

Section 412.29 Excluded rehabilitation units: Additional requirements

Under § 412.29(a), an IRF unit must have met either the requirements for new units or converted units under § 412.30 in order to be excluded from the inpatient acute care PPS. Section 412.29(a)(2) contains an incorrect reference to the requirements for converted units under ''§ 412.30(b).'' The correct reference to the requirements for converted units is § 412.30(c). Accordingly, we are proposing to make a technical correction by changing the reference in § 412.29(a)(2) to state ''Converted units under § 412.30(c).''

Section 412.30 Exclusion of new rehabilitation units and expansion of units already excluded

Section 412.30(b)(3) contains an incorrect reference to the required written certification described in

paragraph ''(a)(2)'' of this section. The correct reference to the written certification is described in paragraph (2) of § 412.30(b). Accordingly, we are proposing to make a technical correction by changing the current reference to paragraph (a)(2) in paragraph (b)(3) to state ''The written certification described in paragraph (b)(2) * * *''.

Section 412.30(d)(2)(i) contains an incorrect reference to the definition of new bed capacity under paragraph ''(c)(1)'' of this section. The correct reference to the definition of new bed capacity is paragraph (d)(1). Accordingly, we are proposing a technical correction to change the current reference to paragraph (c)(1) in paragraph (d)(2)(i) to state ''* * * under paragraph (d)(1) of this section.''

Revision of the Definition of Discharge in § 412.602

According to § 412.602, a discharge has occurred when the patient has been formally released from the hospital, or has died in the hospital, or when the patient stops receiving Medicare—covered Part A inpatient rehabilitation services. We are proposing to amend § 412.602 by revising the definition of ''Discharge.'' Accordingly, the revised definition would read as follows:

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

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

General Requirements for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities in § 412.604

In § 412.604, ''General requirements,'' in paragraph (a)(2) introductory text, we are proposing to change the word ''we'' to ''CMS or its Medicare fiscal intermediary'' to read as follows:

''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, CMS or its Medicare fiscal intermediary may, as appropriate—''

Addition of Requirement To Give Patient the Privacy Act Statement in § 412.608

Section 412.608 specifies that before performing the IRF–PAI assessment, the IRF must inform the patient of the rights contained in this section. The rights specified in § 412.608 are—

(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.

In addition to the rights specified in § 412.608, a patient has privacy rights under the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)), and 45 CFR 5b.4(a)(3). The Privacy Act and 45 CFR 5b.4(a)(3) require that an individual be informed under what authority, and for what purpose, individually identifiable information is being collected by a Federal agency and maintained in a system of records. In order to ensure that an IRF complies with the Privacy Act of 1974, and 45 CFR 5b.4(a)(3), we are proposing that before performing the IRF–PAI assessment, an IRF clinician must give each Medicare inpatient two forms. We have published these forms in Appendix B ''Inpatient Rehabilitation Facility Patient Privacy Forms'' of this proposed rule. In addition, we are proposing that the form entitled ''Privacy Act Statement—Health Care Records'' is a detailed description of patient privacy rights under the Privacy Act of 1974. Also, we are proposing that the form entitled ''Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities'' is the plain language equivalent of the Privacy Act Statement—Health Care Records. Additionally, we are proposing that by giving both of these forms to a patient before starting the IRF–PAI assessment, the IRF would fulfill the requirement that the patient be informed of the five rights specified in § 412.608. Accordingly, we are proposing to amend § 412.608 to read as follows:

Section 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 inpatient rehabilitation facility must give a Medicare inpatient each of these forms—

(1) The Privacy Act Statement—Health Care Records; and

(2) The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) Privacy Act Statement—Health Care Records.

(b) The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF–PAI) Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities is the plain language equivalent of the Privacy Act Statement—Health Care Records.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility has informed the Medicare patient of—

(1) His or her privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data.

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

(iii) 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.

(iv) The right to refuse to answer patient assessment questions.

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

(d) The patient rights specified in this section are in addition to the patient rights specified in § 482.13 of this chapter.

By complying with the requirements specified in revised § 412.608 the IRF has not met the separate requirement in 45 CFR 164.520 entitled ''Notice of privacy practices for protected health information.'' Section 164.520 requires that a health plan or health care provider give patients a Notice of Privacy Practices that must describe the health plan's or health care provider's own uses and disclosures of protected health information, and the individual rights that patients have with respect to their protected health information.

When the IRF–PAI Must Be Completed (§ 412.610)

According to § 412.606(b), an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients. Section 412.610(c)(1)(i)(C) specifies that the IRF–PAI for the admission assessment ''Must be completed on the calendar day that follows the admission assessment reference day.'' In order to clarify that

§ 412.610(c)(1)(i)(C) does not prohibit the IRF from recording any or all of the data on the IRF–PAI before the day that follows the admission assessment reference day, we are proposing to amend § 412.610(c)(1)(i)(C) to read as follows: Must be completed by the calendar day that follows the admission assessment reference day.

Transmission of IRF–PAI Data (§ 412.614)

As specified in § 412.606(b), ''Patient assessment instrument,'' an IRF must use the IRF–PAI to assess Medicare Part A fee-for-service inpatients.

Section 412.614, ''Transmission of patient assessment data,'' specifies that an IRF must transmit to us the IRF–PAI assessment data for each Medicare Part A fee-for-service inpatient. It is the electronic version of the IRF–PAI that enables an IRF to transmit the IRF–PAI data to us. We require that IRFs transmit IRF–PAI data so that we have the IRF–PAI data that are associated with the CMG payment code that the IRF submitted to its FI. We are proposing to amend § 412.614 by specifying that § 412.614(a) is a general rule that would read as follows:

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

We are proposing to amend § 412.614 by adding a new § 412.614(a)(3), which would relieve the IRF of having to transmit the IRF–PAI data for a Medicare Part A fee-for-service inpatient when Medicare will not be paying the IRF for any of the services the IRF furnished to that inpatient. New § 412.614(a)(3) would read as follows:

Exception to the general rule. When the inpatient rehabilitation facility does not submit claims data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

We are proposing a new § 412.614(e) to read as follows: ''Exemption to being assessed a penalty for transmitting the IRF-PAI data late. CMS may waive the penalty specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(2) of this section. An extraordinary situation may be, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.''

Proposed Update of Area Wage Data

In § 412.624(e), ''Calculation of the adjusted Federal prospective payment,'' in paragraph (1), ''Adjustment for area wage levels,'' we are proposing that adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. We are also proposing to determine a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

Proposed Adjustment for High-Cost Outliers Under the IRF Prospective Payment System (§ 412.624)

As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use more recent data when determining an IRF's cost-to-charge ratio. Specifically, under proposed § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report, whichever is later, to obtain the applicable IRF cost-to-charge ratio. In addition, as proposed under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. (Because of the small number of IRFs compared to the number of acute care hospitals, we believe that statewide averages for IRFs, as proposed under the IPPS, would not be statistically valid. Thus, we are proposing to use national average cost-to-charge ratios in place of statewide averages.) As is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change.

As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 4, 2003 proposed rule (68 FR 10420), we are proposing under § 412.624(e)(4), by cross-referencing proposed § 412.84(m), that IRF outlier payments may be adjusted to account for the time value of money which is the value of money during the time period it was inappropriately held by the IRF as an ''overpayment.'' We also may adjust outlier payments for the time value of money for cases that ''underpaid'' to the IRF. In these cases, the adjustment will result in additional payments to the IRF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are therefore soliciting public comment on each of these issues for the proposed information collection requirements discussed below.

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

Under this section, before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient the form entitled

''Privacy Act Statement—Health Care Records'' and the simplified plain language description of the Privacy Act Statement—Health Care Records, which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities;'' the inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in the section.

The burden associated with this section is the time it will take to document that the patient has been given the requisite forms. We estimate that it will take no more than a minute per patient. There will be an estimated 390,000 admissions per year, for a total of 6,500 hours per year.

Section 412.614 Transmission of Patient Assessment Data

1. The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient.

These information collection requirements associated with the IRF PPS are currently approved by OMB through July 31, 2005 under OMB number 0938–0842.

2. Under paragraph (e), *Exemption to being assessed a penalty for transmitting the IRF-PAI data late,* CMS may waive the penalty specified in paragraph (d) of this section. To assist CMS in determining if a waiver is appropriate the inpatient rehabilitation facility must fully document the circumstances surrounding the occurrence.

Given that it is estimated that fewer than 10 instances will occur on an annual basis to necessitate a waiver, this requirement is not subject to the PRA as stipulated under 5 CFR 1320.3(c).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in § 412.604, § 412.608 and § 412.614. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies to CMS within 60 days of this publication date directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Office of Regulations Development and Issuances, Reports Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Attn: Julie Brown, CMS–1474–P; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: e-mail: *baguilar@omb.eop.gov;* or faxed to OMB at (202) 395–6974.

IX. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

X. Regulatory Impact Analysis

A. Introduction

The August 7, 2001 IRS PPS final rule (66 FR 41316) established the IRF PPS for the payment of inpatient hospital services furnished by a rehabilitation hospital or rehabilitation unit of a hospital with cost reporting periods beginning on or after January 1, 2002. We incorporated a number of elements into the IRF PPS, such as case-level adjustments, a wage adjustment, an adjustment for the percentage of low-income patients, a rural adjustment, and outlier payments. The August 1, 2002 IRF PPS notice (67 FR 49928) set forth updates of the IRF PPS rates contained in the August 7, 2001 IRF PPS final rule. The purpose of the updates set forth in the August 1, 2002 IRF PPS notice was to provide an update to the IRF payment rates for discharges during FY 2003. This proposed rule proposes updated IRF PPS rates for discharges that occur during FY 2004.

In constructing these impacts, we do not attempt to predict behavioral responses, and we do not make adjustments for future changes in such variables as discharges or case-mix. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, or new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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).

In this proposed rule, we are proposing to use an updated FY 2004 IRF market basket index and an updated FY 2004 IRF labor-related share and wage indices to update the IRF PPS rates to FY 2004, as described in section VI of this proposed rule. By updating the IRF PPS rates to FY 2004, as proposed in this proposed rule, we estimate that the overall cost to the Medicare program for IRF services in FY 2004 will increase by $204.2 million over FY 2003 levels. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 have no overall effect on estimated costs to the Medicare program. Therefore, this estimated cost to the Medicare program is due to the application of the proposed updated IRF market basket of 3.3 percent. Because the cost to the Medicare program is greater than $100 million, this proposed rule is considered a major rule as defined above.

2. Regulatory Flexibility Act (RFA) and Impact on Small Hospitals

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, small entities include small businesses, nonprofit organizations, and governmental agencies. Most hospitals

are considered small entities, either by nonprofit status or by having receipts of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's regulation that set forth size standards for health care industries at 65 FR 69432.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs are considered small entities for the purpose of the analysis that follows. 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.

This proposed rule proposes a 3.3 percent increase to the Federal PPS rates. We do not expect an incremental increase of 3.3 percent to the Medicare Federal rates to have a significant effect on the overall revenues of IRFs. Most IRFs are units of hospitals that provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. In addition, IRFs provide services to (and generate revenues from) patients other than Medicare beneficiaries. Accordingly, we certify that this proposed rule will not have a significant impact on small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed 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 603 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 (MSA) and has fewer than 100 beds.

This proposed rule will not have a significant impact on the operations of small rural hospitals. As indicated above, this proposed rule proposes a 3.3 percent increase to the Federal PPS rates. In addition, we do not expect an incremental increase of 3.3 percent to the Federal rates to have a significant effect on overall revenues or operations since most rural hospitals provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. Accordingly, we certify that this proposed rule will not have a significant impact on the operations of small rural hospitals.

3. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates 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 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least $110 million. This proposed rule will not have a substantial effect on the governments mentioned nor will it affect private sector costs.

4. Executive Order 13132

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

5. Overall Impact

For the reasons stated above, we have not prepared an analysis under the RFA and section 1102(b) of the Act because we have determined that this proposed rule will not have a significant impact on small entities or the operations of small rural hospitals.

B. Anticipated Effects of the Proposed Rule

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

1. Budgetary Impact

Section 1886(j)(3)(C) of the Act requires annual updates to the IRF PPS payment rates. Section 1886 (j)(6) of the Act requires the Secretary to adjust or update the labor-related share and the wage indices or the labor-related share and the wage indices the applicable to IRFs not later than October 1, 2001 and at least every 36 months thereafter. We project that updating the IRF PPS for discharges occurring on or after October 1, 2003 and before October 1, 2004 will cost the Medicare program $204.2 million. The proposed update to the IRF labor-related share and wage indices if finalized will be made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 would have no overall effect on estimated costs to the Medicare program. Therefore, this estimated cost to the Medicare program is due to the application of the proposed updated IRF market basket of 3.3 percent.

2. Impact on Providers

For the impact analyses shown in the August 7, 2001 IRF PPS final rule, we simulated payments for 1,024 facilities. To construct the impact analyses set forth in this proposed rule, we use the latest available data. These data include the same facilities that were used in constructing the impact analyses displayed in the August 7, 2001 IRF PPS final rule (66 FR 41364–41365, and 41372). We do not have enough post-IRF PPS data to develop the overall budgetary impact and the impact on providers. Further, we will need a sufficient amount of these data to be able to rely on them as the basis for the impact analysis. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient Medicare claims data will not be available for those facilities whose cost report start date occurs later in the calendar year. We do not have enough post-IRF PPS data to develop the overall budgetary impact and the impact on providers. Further, we will need a sufficient amount of these data to be able to rely on them as the basis for the impact analysis. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient Medicare claims data will not be available for those facilities whose cost report start date occurs later in the calendar year. The estimated monetary changes among the various classifications of IRFs for discharges occurring on or after October 1, 2003 and before October 1, 2004 is reflected in Chart 8 ''Projected Impact of Proposed FY 2004 Update'' of this proposed rule.

3. Calculation of the Estimated FY 2003 IRF Prospective Payments

To estimate payments under the IRF PPS for FY 2003, we multiplied each facility's case-mix index by the facility's number of Medicare discharges, the FY 2003 standardized payment amount, the applicable FY 2003 labor-related share and wage indices, a low-income patient adjustment, and a rural adjustment (if applicable). The adjustments include the following:

The wage adjustment, calculated as follows: (.27605 + (.72395 × FY 2003 Wage Index)).

The disproportionate share adjustment, calculated as follows:

(1 + Disproportionate Share Percentage) raised to the power of .4838).

The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

4. Calculation of the Proposed Estimated FY 2004 IRF Prospective Payments

To calculate proposed FY 2004 payments, we use the payment rates described in this proposed rule that reflect the proposed 3.3 percent market basket increase factor using the proposed FY 2004 labor-related share

and wage indices, a low-income patient adjustment, and a rural adjustment (if applicable). The proposed adjustments include the following:

The proposed wage adjustment, calculated as follows: (.27605 + (.72683 × FY 2004 Wage Index)).

The proposed disproportionate share adjustment, calculated as follows: (1 + Disproportionate Share Percentage) raised to the power of .4838).

The proposed rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

Chart 8 ''Projected Impact of Proposed FY 2004 Update'' illustrates the aggregate impact of the proposed estimated FY 2004 updated payments among the various classifications of facilities compared to the estimated IRF PPS payment rates applicable for FY 2003.

The first column, Facility Classification, identifies the type of facility. The second column identifies the number of facilities for each classification type, and the third column lists the number of cases. The fourth column indicates the impact of the proposed budget neutral wage adjustment. The last column reflects the combined changes including the proposed update to the FY 2003 payment rates by proposed 3.3 percent and the proposed budget neutral wage adjustment (including the proposed FY 2004 labor-related share and the proposed FY 2004 wage indices).

CHART 8.—PROJECTED IMPACT OF PROPOSED FY 2004 UPDATE

Facility classification	Number of facilities	Number of cases	Proposed budget neutral wage adjustment	Proposed total change
Total				
	1,024	347,809	0.0%	3.3%
Urban unit	725	206,926	−0.5	2.8
Rural unit	131	26,507	0.2	3.5
Urban hospital	156	109,691	0.9	4.3
Rural hospital	12	4,685	−1.3	1.9
Total urban	881	316,617	0.0	3.3
Total rural	143	31,192	0.0	3.2
Urban by Region				
New England	32	15,039	0.1	3.5
Middle Atlantic	133	64,042	−1.5	1.8
South Atlantic	112	52,980	0.5	3.8
East North Central	171	55,071	−0.5	2.7
East South Central	41	23,434	0.9	4.2
West North Central	70	18,087	0.6	3.9
West South Central	154	52,346	1.5	4.8
Mountain	56	14,655	1.1	4.4
Pacific	112	20,963	−0.7	2.6
Rural by Region				
New England	4	829	−0.2	3.1
Middle Atlantic	10	2,424	−1.3	1.9
South Atlantic	20	6,192	−0.8	2.5
East North Central	29	5,152	−0.5	2.8
East South Central	10	3,590	0.2	3.5
West North Central	22	3,820	1.7	4.9
West South Central	32	7,317	0.6	3.9
Mountain	9	1,042	−0.3	3.0
Pacific	7	826	−1.2	2.1

As Chart 8 illustrates, all IRFs are expected to benefit from the proposed 3.3 percent market basket increase that would be applied to FY 2003 IRF PPS payment rates to develop the proposed FY 2004 rates. However, there may be distributional impacts among various IRFs due to the application of the proposed updates to the labor-related share and proposed wage indices in a budget neutral manner.

To summarize, we have proposed that all facilities would receive a 3.3 percent increase in their unadjusted IRF PPS payments. The estimated positive impact among all IRFs reflected in Chart 8 are due to the effect of the proposed update to the IRF market basket index. We also note that, while no changes in the regulations are being proposed, we discuss the potential effects of improved compliance with the 75 percent rule in section II of this proposed rule.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget (OMB).

List of Subjects in 42 CFR Part 412

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV, part 412, as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

2. In § 412.20, the following changes are made:

A. Redesignate paragraph (b) as paragraph (b)(1).

B. Add paragraph (b)(2) to read as follows:

§ 412.20 Hospital services subject to the prospective payment systems.

* * * * *

(b) * * *

(2) CMS will not pay for services under Subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an inpatient rehabilitation facility for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

* * * * *

3. In § 412.22, the following changes are made:

A. Revise paragraph (h)(2) introductory text.

B. Add and reserve paragraph (h)(6).

C. Add paragraph (h)(7).

The revisions and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) * * *

(2) Except as provided in paragraphs (h)(3) and (h)(7) 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 acute care hospital inpatient prospective payment systems for any period:

* * * * *

(6) [Reserved]

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

4. In § 412.25, the following changes are made:

A. Revise paragraph (e)(2) introductory text.

B. Add paragraph (e)(5).

The revision and addition read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(e) * * *

(2) Except as provided in paragraphs (e)(3) and (e)(5) 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 acute care hospital inpatient prospective payment systems for any period:

* * * * *

(5) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

* * * * *

5. In § 412.29, revise paragraph (a)(2) to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

(a) * * *

(2) Converted units under § 412.30(c).

* * * * *

6. In § 412.30, the following changes are made:

A. Revise paragraph (b)(3).

B. Revise paragraph (d)(2)(i).

§ 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

(b) * * *

(3) The written certification described in paragraph (b)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care.

* * * * *

(d) * * *

(2) *Conversion of existing bed capacity.* (i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (d)(1) of this section.

* * * * *

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

7. In § 412.602, republish the introductory text and revise the definition of ''Discharge'' to read as follows:

§ 412.602 Definitions.

As used in this subpart—

* * * * *

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

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

* * * * *

8. In § 412.604, revise paragraph (a)(2) introductory text to read as follows:

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

(a) * * *

(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, CMS or its Medicare fiscal intermediary may, as appropriate—

* * * * *

9. Section 412.608 is revised to read as follows:

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

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient each of these forms—

(1) The form entitled ''Privacy Act Statement—Health Care Records;'' and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.''

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) The Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities is the simplified plain language description of the Privacy Act Statement—Health Care Records.

(d) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

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

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

(iii) 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;

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

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

(e) The patient rights specified in this section are in addition to the patient rights specified in § 482.13 of this chapter.

10. In § 412.610, revise paragraph (c)(1)(i)(C) to read as follows:

§ 412.610 Assessment schedule.

* * * * *

(c) * * *

(1) * * *

(i) * * *

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

* * * * *

11. In § 412.614, the following changes are made:

A. Redesignate paragraphs (a)(1) and (a)(2) as (a)(1)(i) and (a)(1)(ii), respectively.

B. Redesignate the introductory text to paragraph (a) as (a)(1) and add a heading to newly designated paragraph (a)(1).

C. Add a new paragraph (a)(2).

D. Add a new paragraph (e).

The revision and additions read as follows:

§ 412.614 Transmission of patient assessment data.

(a) *Data format.* (1) *General rule.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient—

* * * * *

(2) *Exception to the general rule.* When the inpatient rehabilitation facility does not submit claim data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required to, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

* * * * *

(e) *Exemption to being assessed a penalty for transmitting the IRF-PAI data late.* CMS may waive the penalty specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

12. In § 412.624, the following changes are made:

A. Revise paragraph (c).

B. Revise paragraph (d).

C. Revise paragraph (e)(1).

D. Revise paragraph (e)(4).

The revisions read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

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

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

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

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

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

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

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

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

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

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

(e) * * *

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

* * * * *

(4) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation

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 CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Additional payments made under this section will be subject to the adjustments at § 412.84(i) and at § 412.84(m), except that national averages will be used instead of statewide averages. Additional payments made under this section will also be subject to adjustments at § 412.84(m).

* * * * *

Dated: March 18, 2003.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 6, 2003.

Tommy G. Thompson,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations:

Appendix A—Methodology to Determine Compliance with the 75 Percent Rule

Section 412.23(b)(2) specifies that during the most recent cost reporting period 75 percent of an IRF's inpatient population must have had a medical condition that can be matched to one of ten medical conditions specified in this section. This requirement is commonly termed the ''75 percent rule.''

CMS used the IRF–PAI database to estimate the percentage of IRFs that submitted IRF–PAI data during the first eight months of calendar year 2002 that met the 75 percent rule. Under the existing IRF PPS regulations, an IRF must send CMS an IRF–PAI data record that contains data about each Medicare Part A fee-for-service inpatient admitted to the IRF. The IRF–PAI is submitted by the IRF after the inpatient has been discharged.

Section II of the preamble contains Chart 1 ''Estimates of Compliance with the 75 Percent Rule.'' Chart 1 illustrates the estimated percentage of IRFs whose Medicare inpatient populations had medical conditions considered to be consistent with one or more of the medical conditions in § 412.23(b)(2). In addition, Chart 1 also shows the estimated percentage of IRFs that met lower thresholds.

For example, in the ''65% rule'' column of Chart 1 shows the percentage of IRFs that submitted IRF–PAI data during the first eight months of calendar year 2002 that had 65 percent of their Medicare inpatient population included in at least one of the ten medical conditions specified in § 412.23(b)(2).

An IRF–PAI data record was counted as meeting one of the ten medical conditions specified in § 412.23(b)(2) if its impairment group code given in IRF–PAI item 21 is listed in one of the codes listed in Table 4 ''Acceptable Impairment Group Codes'' below, or if any of its diagnoses (IRF–PAI items 22 and 24a through 24j) are listed in Table 5 ''Acceptable ICD–9–CM Codes'' below. (This list may not be all inclusive, but represents a conservative list of diagnoses more likely to be consistent with the ten diagnoses.)

Table 4 illustrates that the pairing of some impairment group codes with specific etiologic diagnosis ICD–9–CM codes within the same IRF–PAI data record resulted in that data record not being counted as meeting one of the ten medical conditions specified in § 412.23(b)(2). For example, if an IRF–PAI data record specified both the impairment group code 02.1 (non-traumatic brain injury) and the etiologic diagnosis ICD–9–CM code 215.0 (other benign neoplasms of connective and other soft tissue of head and neck) then that admission was not counted as meeting one of the medical conditions specified in § 412.23(b)(2). However, regardless of the impairment group code specified in an IRF–PAI data record the data record for the admission was counted as meeting one of the ten medical conditions specified in § 412.23(b)(2) if IRF–PAI items 22 and 24a through 24j contained an ICD–9–CM code as specified in Table 5 ''Acceptable ICD–9–CM Codes'' below. The data analyzed represents 8 months of IRF–PAI data records.

Appendix B—Inpatient Rehabilitation Facility Patient Privacy Forms

BILLING CODE 4120–01–P

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU NOTICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154,), 1861(z), 1864, 1865, 1866, 1871, 1886(j) of the Social Security Act.

Medicare participating inpatient rehabilitation facilities must do a complete assessment that accurately reflects your current clinical status and includes information that can be used to show your progress toward your rehabilitation goals. The inpatient rehabilitation facility must use the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IFR-PAI) as part of that assessment, when evaluating your clinical status. The IRF-PAI must be used to assess every Medicare Part A fee-for-service inpatient, and it may be used to assess other types of inpatients. This information will be used by the Centers for Medicare & Medicaid Services (CMS) to be sure that the inpatient rehabilitation facility is paid appropriately for the services that they furnish you, and to help evaluate that the inpatient rehabilitation facility meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information to the inpatient rehabilitation facility for the assessment. Information provided to the federal government for this assessment is protected under the Federal Privacy Act of 1974 and the IRF-PAI System of Records. You have the right to see, copy, review, and request correction of inaccurate or missing personal health information in the IRF-PAI System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the IRF-PAI System No. 09-70-1518. Your health care information in the IRF-PAI System of Records will be used for the following purposes:

- support the IRF prospective payment system (PPS) for payment of the IRF Medicare Part A fee-for services furnished by the IRF to Medicare beneficiaries;
- help validate and refine the Medicare IRF-PPS
- study and help ensure the quality of care provided by IRFs;
- enable CMS and its agents to provide IRFs with data for their quality assurance and ultimately quality improvement activities;
- support agencies of the State government , deeming organizations or accrediting agencies to determine, evaluate and assess overall effectiveness and quality of IRF services provided in the State;
- provide information to consumers to allow them to make better informed selections of providers;
- support regulatory and policy functions performed within the IRF or by a contractor or consultant;
- support constituent requests made to a Congressional representative;
- support litigation involving the facility;
- support research on the utilization and quality of inpatient rehabilitation services; as well as, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health for understanding and improving payment systems.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the IRF-PAI System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of protected health information authorized by these routine uses may be made only if, and as, permitted or required by the 'Standards for Privacy of Individually Identifiable Health Information.' Disclosures of the information may be to:

1. To agency contractors or consultants who have been contracted by the agency to assist in the performance of a service related to this system of records and who need to have access to the records in order to perform the activity;
2. To a Peer Review Organization (PRO) in order to assist the PRO to perform Title XI and Title XVIII functions relating to assessing and improving IRF quality of care. PROs will work with IRFs to implement quality improvement programs, provide consultation to CMS, its contractors, and to State agencies;
3. To another Federal or State agency:
    a. To contribute to the accuracy of CMS's proper payment of Medicare benefits,
    b. To enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, or
    c. To improve the state survey process for investigation of complains related to health and safety or quality of care and to implement a more outcome oriented survey and certification program.

4. To an individual or organization for a research, evaluation, or epidemiological projects related to the prevention of disease or disability, the restoration or maintenance of health epidemiological or for understanding and improving payment projects.
5. To a member of Congress or to a congressional staff member in response to a inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.
6. To the Department of Justice (DOJ), court or adjudicatory body when:
    a. The agency or any component thereof; or
    b. Any employee of the agency in his or her official capacity; or
    c. Any employee of the agency in his or her individual capacity where the employee; or
    d. The United States Government; is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.
7. To a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.
8. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in whole or part by Federal funds, when disclosure is deemed reasonable necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat frauds or abuse in such programs;
9. To a national accrediting organization that has been approved for deeming authority for Medicare requirements for inpatient rehabilitation services (i.e., the Joint Commission for the Accreditation of Healthcare Organizations, the American Osteopathic Association and the Commission of Accreditation of Rehabilitation Facilities). Data will be released to these organizations only for those facilities that participate in Medicare by virtue of their accreditation status.
10. To insurance companies, third party administrators (TPA), employers, self-insurers, manage care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (i.e., health maintenance organizations (HMO) or a competitive medical plan (CMP)) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:
    a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a third party administrator;
    b. Utilize the information solely for the purpose of processing the individual's insurance claims; and
    c. Safeguard the confidentiality of the data and prevent unauthorized access.

IV. EFFECT ON YOU IF YOU DO NOT PROVIDE INFORMATION

The inpatient rehabilitation facility needs the information contained in the IRF-PAI in order to comply with the Medicare regulations. Your inpatient rehabilitation facility will also use the IRF-PAI to assist in providing you with quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it difficult to evaluate if the facility is giving you quality services. If you choose not to provide information, there is no federal requirement for the inpatient rehabilitation facility to refuse you services.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal health information which that Federal agency maintains in its IRF-PAI System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the IRF-PAI System of Records Manager.

TTY for the hearing and speech impaired: 1-800-820-1202

Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities

This notice is a summary of the information contained in the attached "Privacy Act Statement-Health Care Records"

As a hospital rehabilitation inpatient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**

  We are required by federal law to collect health information to make sure:
  1) you get quality health care, and
  2) payment for Medicare patients is correct.

- **You have the right to have your personal health care information kept confidential and secure.**

  - You will be asked to tell us information about yourself so that we can provide the most appropriate, comprehensive services for you.
  - We keep anything we learn about you confidential and secure. This means only those who are legally permitted to use or obtain the information collected during this assessment will see it.

- **You have the right to refuse to answer questions.**

  You do not have to answer any questions to get services.

- **You have the right to look at your personal health information.**

  - We know how important it is that the information we collect about you is correct.
  - You may ask to review the information you provided. If you think we made a mistake, you can ask us to correct it.

In addition, you may ask the Centers for Medicare & Medicaid Services to see, review, copy or request correction of inaccurate or missing personal identifying health information which this Federal agency maintains in its IRF-PAI System of Records. For CONTACT INFORMATION or a detailed description of your privacy rights, refer to the attached PRIVACY ACT STATEMENT – HEALTH CARE RECORDS.
Note: The rights listed above are in concert with the rights listed in the hospital conditions of participation and the rights established under the Federal Privacy Rule.

This is a Medicare & Medicaid Approved Notice.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TABLES

Table 1. – Proposed Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M = motor, C = cognitive, A = age)	Proposed 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
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

CMG	CMG Description (M = motor, C = cognitive, A = age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
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

CMG	CMG Description (M = motor, C = cognitive, A = age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
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

CMG	CMG Description (M = motor, C = cognitive, A = age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
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
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

CMG	CMG Description (M = motor, C = cognitive, A = age)	Proposed Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
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.—PROPOSED FISCAL YEAR 2004 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	$5,990.21	$5,364.61	$5,112.61	$4,838.05
0102	8,156.61	7,305.34	6,961.83	6,588.23
0103	10,400.74	9,315.04	8,876.24	8,399.83
0104	11,292.13	10,113.65	9,637.24	9,120.71
0105	14,215.77	12,731.38	12,132.11	11,481.44
0106	17,490.45	15,663.80	14,925.37	14,125.51
0107	20,258.64	18,143.63	17,288.61	16,360.86
0108	21,911.02	19,624.26	18,699.02	17,696.06
0109	23,696.30	21,222.74	20,222.28	19,137.82
0110	25,418.89	22,766.05	21,692.87	20,529.44
0111	26,188.66	23,455.59	22,349.82	21,151.27
0112	31,069.34	27,826.00	26,514.63	25,092.93
0113	28,051.67	25,124.27	23,939.52	22,655.72
0114	34,228.68	30,655.62	29,211.35	27,644.22
0201	9,639.75	9,121.96	8,429.92	7,735.37
0202	14,017.69	13,265.46	12,258.74	11,249.50
0203	16,394.71	15,514.61	14,337.38	13,157.64
0204	20,728.78	19,615.48	18,127.34	16,635.42
0205	31,468.02	29,778.02	27,517.59	25,253.40
0301	12,104.53	10,329.28	9,898.01	9,020.41
0302	17,148.19	14,633.26	14,021.45	12,780.28
0303	23,509.49	20,061.80	19,224.33	17,521.80
0304	34,992.19	29,859.52	28,614.59	26,078.34
0401	11,636.90	10,927.30	10,307.97	8,660.60
0402	17,816.42	16,729.45	15,781.65	13,259.19
0403	29,443.29	27,646.72	26,079.59	21,912.27
0404	44,164.30	41,470.09	39,119.39	32,867.16
0501	9,515.63	8,744.60	7,810.59	6,723.63
0502	11,857.55	10,895.96	9,732.52	8,378.52
0503	14,559.29	13,379.55	11,951.58	10,287.91
0504	21,010.86	19,307.07	17,247.23	14,846.39
0505	31,736.31	29,162.46	26,049.50	22,425.04
0601	11,025.09	8,462.52	8,285.74	7,458.30
0602	15,018.14	11,527.83	11,287.12	10,161.29
0603	19,266.95	14,788.72	14,480.30	13,034.78
0604	25,130.54	19,289.52	18,887.08	17,001.51
0701	8,794.75	8,783.46	8,412.37	7,472.09
0702	11,614.33	11,598.03	11,109.09	9,866.67
0703	13,761.93	13,743.13	13,163.91	11,692.06
0704	15,656.28	15,634.97	14,975.52	13,300.57
0705	18,504.70	18,479.63	17,701.08	15,721.47
0801	6,154.44	5,887.40	5,664.24	4,876.92
0802	7,104.75	6,796.34	6,539.33	5,629.14
0803	8,720.78	8,342.16	8,026.23	6,909.17
0804	11,639.41	11,134.16	10,712.92	9,222.26
0805	12,570.91	12,026.80	11,570.45	9,960.69
0806	17,151.95	16,408.50	15,786.67	13,590.17
0901	8,760.90	8,011.18	7,553.58	6,535.57
0902	11,905.19	10,887.18	10,264.09	8,881.25
0903	15,028.17	13,741.87	12,955.80	11,210.64
0904	20,400.30	18,655.15	17,588.24	15,217.48
1001	9,805.23	9,805.23	8,967.76	8,177.92
1002	12,534.55	12,534.55	11,463.89	10,454.65
1003	15,331.57	15,331.57	14,022.70	12,787.80
1004	17,882.86	17,882.86	16,355.85	14,915.34
1005	22,050.18	22,050.18	20,167.11	18,391.87
1101	15,823.02	9,632.22	8,962.74	8,313.32

TABLE 2.—PROPOSED FISCAL YEAR 2004 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
1102	24,489.89	14,909.07	13,871.00	12,866.78
1103	33,277.12	20,258.64	18,848.22	17,482.93
1201	9,050.50	6,806.37	6,397.66	5,762.03
1202	11,639.41	8,754.63	8,228.07	7,410.66
1203	13,503.67	10,156.27	9,545.72	8,597.92
1204	17,489.20	13,153.88	12,362.79	11,135.42
1205	22,408.74	16,853.57	15,839.32	14,267.17
1301	9,677.36	8,176.67	8,066.34	6,978.13
1302	12,389.12	10,467.19	10,326.78	8,933.91
1303	16,463.67	13,909.87	13,721.81	11,871.34
1304	23,396.66	19,768.44	19,501.40	16,871.12
1401	9,014.15	8,065.09	7,173.71	6,464.11
1402	12,414.20	11,105.33	9,879.20	8,902.57
1403	16,266.84	14,553.02	12,944.51	11,665.73
1404	22,583.01	20,203.47	17,971.88	16,195.37
1501	10,069.77	9,569.54	8,683.17	8,293.27
1502	12,873.05	12,233.66	11,101.57	10,602.59
1503	16,601.57	15,776.64	14,316.07	13,672.92
1504	25,823.84	24,541.29	22,269.58	21,269.12
1601	10,916.02	10,439.61	9,886.73	8,278.22
1602	16,699.36	15,970.96	15,127.22	12,666.19
1701	12,532.05	11,310.94	10,202.66	9,032.95
1702	18,498.43	16,695.60	15,058.26	13,331.91
1703	26,791.70	24,181.48	21,809.47	19,309.58
1801	9,333.84	9,333.84	8,602.93	7,875.78
1802	13,382.06	13,382.06	12,333.96	11,292.13
1803	20,498.09	20,498.09	18,892.10	17,297.38
1804	36,532.99	36,532.99	33,672.04	30,827.38
1901	14,524.18	12,539.57	12,262.50	11,127.89
1902	27,007.33	23,316.42	22,802.40	20,692.42
1903	39,289.89	33,920.27	33,171.81	30,102.73
2001	10,494.77	9,020.41	8,406.10	7,558.59
2002	13,860.97	11,912.71	11,101.57	9,982.01
2003	18,353.00	15,772.88	14,699.70	13,217.82
2004	21,904.75	18,826.90	17,544.36	15,775.38
2005	26,075.83	22,411.25	20,885.49	18,779.26
2101	12,984.63	11,816.18	10,514.83	10,514.83
2102	28,218.41	25,678.41	22,850.05	22,850.05
5001	.....	.....	.....	2,069.87
5101	.....	.....	.....	5,364.61
5102	.....	.....	.....	15,533.42
5103	.....	.....	.....	6,815.15
5104	.....	.....	.....	21,438.37

TABLE 3A.—PROPOSED URBAN WAGE INDEX

MSA	Urban area (constituent counties or county equivalents)	Wage index
0040	Abilene, TX	0.7792
	Taylor, TX	
0060	Aguadilla, PR	0.4587
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080	Akron, OH	0.9600
	Portage, OH	
	Summit, OH	
0120	Albany, GA	1.0594
	Dougherty, GA	
	Lee, GA	
0160	Albany-Schenectady-Troy, NY.	0.8384
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200	Albuquerque, NM	0.9315
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220	Alexandria, LA	0.7859
	Rapides, LA	
0240	Allentown-Bethlehem-Easton, PA.	0.9735
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
0280	Altoona, PA	0.9225
	Blair, PA	
0320	Amarillo, TX	0.9034
	Potter, TX	
	Randall, TX	
0380	Anchorage, AK	1.2358
	Anchorage, AK	
0440	Ann Arbor, MI	1.1103
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450	Anniston,AL	0.8044
	Calhoun, AL	
0460	Appleton-Oshkosh-Neenah, WI.	0.8997
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470	Arecibo, PR	0.4337

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480	Asheville, NC	0.9876
	Buncombe, NC	
	Madison, NC	
0500	Athens, GA	1.0211
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520	Atlanta, GA	0.9991
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Henry, GA	
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560	Atlantic City-Cape May, NJ.	1.1017
	Atlantic City, NJ	
	Cape May, NJ	
0580	Auburn-Opelika, AL.	0.8325
	Lee, AL	
0600	Augusta-Aiken, GA–SC.	1.0264
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640	Austin-San Marcos, TX.	0.9637
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680	Bakersfield, CA	0.9899
	Kern, CA	
0720	Baltimore, MD	0.9929
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	
0733	Bangor, ME	0.9664
	Penobscot, ME	
0743	Barnstable-Yarmouth, MA.	1.3202
	Barnstable, MA	
0760	Baton Rouge, LA	0.8294
	Ascension, LA	
	East Baton Rouge	
	Livingston, LA	
	West Baton Rouge, LA	
0840	Beaumont-Port Arthur, TX.	0.8324
	Hardin, TX	
	Jefferson, TX	
	Orange, TX	
0860	Bellingham, WA	1.2282
	Whatcom, WA	
0870	Benton Harbor, MI	0.9042
	Berrien, MI	
0875	Bergen-Passaic, NJ.	1.2150
	Bergen, NJ	
	Passaic, NJ	
0880	Billings, MT	0.9022
	Yellowstone, MT	
0920	Biloxi-Gulfport-Pascagoula, MS.	0.8757
	Hancock, MS	
	Harrison, MS	
	Jackson, MS	
0960	Binghamton, NY	0.8341
	Broome, NY	
	Tioga, NY	
1000	Birmingham, AL	0.9222
	Blount, AL	
	Jefferson, AL	
	St. Clair, AL	
	Shelby, AL	
1010	Bismarck, ND	0.7972
	Burleigh, ND	
	Morton, ND	
1020	Bloomington, IN	0.8907
	Monroe, IN	
1040	Bloomington-Normal, IL.	0.9109
	McLean, IL	
1080	Boise City, ID	0.9310
	Ada, ID	
	Canyon, ID	
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH.	1.1235
	Bristol, MA	
	Essex, MA	
	Middlesex, MA	
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
	Worcester, MA	
	Hillsborough, NH	
	Merrimack, NH	
	Rockingham, NH	
	Strafford, NH	
1125	Boulder-Longmont, CO.	0.9689
	Boulder, CO	
1145	Brazoria, TX	0.8535
	Brazoria, TX	
1150	Bremerton, WA	1.0944
	Kitsap, WA	
1240	Brownsville-Harlingen-San Benito, TX.	0.8880
	Cameron, TX	
1260	Bryan-College Station, TX.	0.8821
	Brazos, TX	
1280	Buffalo-Niagara Falls, NY.	0.9365
	Erie, NY	
	Niagara, NY	
1303	Burlington, VT	1.0052
	Chittenden, VT	
	Franklin, VT	
	Grand Isle, VT	
1310	Caguas, PR	0.4371
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320	Canton-Massillon, OH.	0.8932
	Carroll, OH	
	Stark, OH	
1350	Casper, WY	0.9690
	Natrona, WY	
1360	Cedar Rapids, IA	0.9056
	Linn, IA	
1400	Champaign-Urbana, IL.	1.0635
	Champaign, IL	
1440	Charleston-North Charleston, SC.	0.9235
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480	Charleston, WV	0.8898
	Kanawha, WV	
	Putnam, WV	
1520	Charlotte-Gastonia-Rock Hill, NC–SC.	0.9850
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Stanly, NC	
	Union, NC	
	York, SC	
1540	Charlottesville, VA	1.0438
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560	Chattanooga, TN–GA.	0.8976
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
1580	Cheyenne, WY	0.8628
	Laramie, WY	
1600	Chicago, IL	1.1044
	Cook, IL	

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	De Kalb, IL	
	Du Page, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	Lake, IL	
	McHenry, IL	
	Will, IL	
1620	Chico-Paradise, CA.	0.9745
	Butte, CA	
1640	Cincinnati, OH–KY–IN.	0.9381
	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.	0.8406
	Christian, KY	
	Montgomery, TN	
1680	Cleveland-Lorain-Elyria, OH.	0.9670
	Ashtabula, OH	
	Geauga, OH	
	Cuyahoga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
1720	Colorado Springs, CO.	0.9916
	El Paso, CO	
1740	Columbia, MO	0.8496
	Boone, MO	
1760	Columbia, SC	0.9307
	Lexington, SC	
	Richland, SC	
1800	Columbus, GA–AL	0.8374
	Russell, AL	
	Chattanoochee, GA	
	Harris, GA	
	Muscogee, GA	
1840	Columbus, OH	0.9751
	Delaware, OH	
	Fairfield, OH	
	Franklin, OH	
	Licking, OH	
	Madison, OH	
	Pickaway, OH	
1880	Corpus Christi, TX	0.8729
	Nueces, TX	
	San Patricio, TX	
1890	Corvallis, OR	1.1453
	Benton, OR	
1900	Cumberland, MD–WV.	0.7847
	Allegany, MD	
	Mineral, WV	
1920	Dallas, TX	0.9998
	Collin, TX	
	Dallas, TX	
	Denton, TX	
	Ellis, TX	
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950	Danville, VA	0.8859
	Danville City, VA	
	Pittsylvania, VA	
1960	Davenport-Moline-Rock Island, IA–IL.	0.8835
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000	Dayton-Springfield, OH.	0.9282
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020	Daytona Beach, FL.	0.9062
	Flagler, FL	
	Volusia, FL	
2030	Decatur, AL	0.8973
	Lawrence, AL	
	Morgan, AL	
2040	Decatur, IL	0.8055
	Macon, IL	
2080	Denver, CO	1.0601
	Adams, CO	
	Arapahoe, CO	
	Broomfield, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120	Des Moines, IA	0.8791
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160	Detroit, MI	1.0448
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180	Dothan, AL	0.8137
	Dale, AL	
	Houston, AL	
2190	Dover, DE	0.9356
	Kent, DE	
2200	Dubuque, IA	0.8795
	Dubuque, IA	
2240	Duluth-Superior, MN–WI.	1.0368
	St. Louis, MN	
	Douglas, WI	
2281	Dutchess County, NY.	1.0684
	Dutchess, NY	
2290	Eau Claire, WI	0.8952
	Chippewa, WI	
	Eau Claire, WI	
2320	El Paso, TX	0.9265
	El Paso, TX	
2330	Elkhart-Goshen, IN	0.9722
	Elkhart, IN	
2335	Elmira, NY	0.8416
	Chemung, NY	
2340	Enid, OK	0.8376
	Garfield, OK	
2360	Erie, PA	0.8925
	Erie, PA	
2400	Eugene-Springfield, OR.	1.0944
	Lane, OR	
2440	Evansville-Henderson, IN–KY.	0.8177
	Posey, IN	
	Vanderburgh, IN	
	Warrick, IN	
	Henderson, KY	
2520	Fargo-Moorhead, ND–MN.	0.9684
	Clay, MN	
	Cass, ND	
2560	Fayetteville, NC	0.8889
	Cumberland, NC	
2580	Fayetteville-Springdale-Rogers, AR.	0.8100
	Benton, AR	
	Washington, AR	
2620	Flagstaff, AZ–UT	1.0682
	Coconino, AZ	
	Kane, UT	
2640	Flint, MI	1.1135
	Genesee, MI	
2650	Florence, AL	0.7792
	Colbert, AL	
	Lauderdale, AL	
2655	Florence, SC	0.8780
	Florence, SC	
2670	Fort Collins-Loveland, CO.	1.0066
	Larimer, CO	
2680	Ft. Lauderdale, FL	1.0297
	Broward, FL	
2700	Fort Myers-Cape Coral, FL.	0.9680
	Lee, FL	
2710	Fort Pierce-Port St. Lucie, FL.	0.9823
	Martin, FL	
	St. Lucie, FL	
2720	Fort Smith, AR–OK.	0.7895
	Crawford, AR	
	Sebastian, AR	
	Sequoyah, OK	
2750	Fort Walton Beach, FL.	0.9693
	Okaloosa, FL	
2760	Fort Wayne, IN	0.9457
	Adams, IN	
	Allen, IN	
	De Kalb, IN	
	Huntington, IN	
	Wells, IN	
	Whitley, IN	
2800	Forth Worth-Arlington, TX.	0.9446

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Hood, TX	
	Johnson, TX	
	Parker, TX	
	Tarrant, TX	
2840	Fresno, CA	1.0216
	Fresno, CA	
	Madera, CA	
2880	Gadsden, AL	0.8505
	Etowah, AL	
2900	Gainesville, FL	0.9871
	Alachua, FL	
2920	Galveston-Texas City, TX.	0.9465
	Galveston, TX	
2960	Gary, IN	0.9584
	Lake, IN	
	Porter, IN	
2975	Glens Falls, NY	0.8281
	Warren, NY	
	Washington, NY	
2980	Goldsboro, NC	0.8892
	Wayne, NC	
2985	Grand Forks, ND–MN.	0.8897
	Polk, MN	
	Grand Forks, ND	
2995	Grand Junction, CO.	0.9456
	Mesa, CO	
3000	Grand Rapids-Muskegon-Holland, MI.	0.9525
	Allegan, MI	
	Kent, MI	
	Muskegon, MI	
	Ottawa, MI	
3040	Great Falls, MT	0.8950
	Cascade, MT	
3060	Greeley, CO	0.9237
	Weld, CO	
3080	Green Bay, WI	0.9502
	Brown, WI	
3120	Greensboro-Winston-Salem-High Point, NC.	0.9282
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150	Greenville, NC	0.9100
	Pitt, NC	
3160	Greenville-Spartanburg-Anderson, SC.	0.9122
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180	Hagerstown, MD	0.9268
	Washington, MD	
3200	Hamilton-Middletown, OH.	0.9418
	Butler, OH	
3240	Harrisburg-Lebanon-Carlisle, PA.	0.9223
	Cumberland, PA	
	Dauphin, PA	
	Lebanon, PA	
	Perry, PA	
3283	Hartford, CT	1.1549
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285	Hattiesburg, MS	0.7659
	Forrest, MS	
	Lamar, MS	
3290	Hickory-Morganton-Lenoir, NC.	0.9028
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320	Honolulu, HI	1.1457
	Honolulu, HI	
3350	Houma, LA	0.8385
	Lafourche, LA	
	Terrebonne, LA	
3360	Houston, TX	0.9892
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	
	Montgomery, TX	
	Waller, TX	
3400	Huntington-Ashland, WV–KY–OH.	0.9636
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440	Huntsville, AL	0.8903
	Limestone, AL	
	Madison, AL	
3480	Indianapolis, IN	0.9717
	Boone, IN	
	Hamilton, IN	
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500	Iowa City, IA	0.9587
	Johnson, IA	
3520	Jackson, MI	0.9532
	Jackson, MI	
3560	Jackson, MS	0.8607
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580	Jackson, TN	0.9275
	Chester, TN	
	Madison, TN	
3600	Jacksonville, FL	0.9381
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605	Jacksonville, NC	0.8239
	Onslow, NC	
3610	Jamestown, NY	0.7976
	Chautaqua, NY	
3620	Janesville-Beloit, WI.	0.9849
	Rock, WI	
3640	Jersey City, NJ	1.1190
	Hudson, NJ	
3660	Johnson City-Kingsport-Bristol, TN–VA.	0.8268
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott, VA	
	Washington, VA	
3680	Johnstown, PA	0.8329
	Cambria, PA	
	Somerset, PA	
3700	Jonesboro, AR	0.7749
	Craighead, AR	
3710	Joplin, MO	0.8613
	Jasper, MO	
	Newton, MO	
3720	Kalamazoo-Battlecreek, MI.	1.0595
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740	Kankakee, IL	1.0790
	Kankakee, IL	
3760	Kansas City, KS–MO.	0.9736
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800	Kenosha, WI	0.9686
	Kenosha, WI	
3810	Killeen-Temple, TX	1.0399
	Bell, TX	
	Coryell, TX	
3840	Knoxville, TN	0.8970
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850	Kokomo, IN	0.8971
	Howard, IN	
	Tipton, IN	
3870	La Crosse, WI–MN	0.9400

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Houston, MN	
	La Crosse, WI	
3880	Lafayette, LA	0.8475
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920	Lafayette, IN	0.9278
	Clinton, IN	
	Tippecanoe, IN	
3960	Lake Charles, LA	0.7965
	Calcasieu, LA	
3980	Lakeland-Winter Haven, FL.	0.9357
	Polk, FL	
4000	Lancaster, PA	0.9078
	Lancaster, PA	
4040	Lansing-East Lansing, MI.	0.9726
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080	Laredo, TX	0.8472
	Webb, TX	
4100	Las Cruces, NM	0.8745
	Dona Ana, NM	
4120	Las Vegas, NV–AZ.	1.1521
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150	Lawrence, KS	0.7923
	Douglas, KS	
4200	Lawton, OK	0.8315
	Comanche, OK	
4243	Lewiston-Auburn, ME.	0.9179
	Androscoggin, ME	
4280	Lexington, KY	0.8581
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320	Lima, OH	0.9483
	Allen, OH	
	Auglaize, OH	
4360	Lincoln, NE	0.9892
	Lancaster, NE	
4400	Little Rock-North Little, AR.	0.9097
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420	Longview-Marshall, TX.	0.8629
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480	Los Angeles-Long Beach, CA.	1.2001
	Los Angeles, CA	
4520	Louisville, KY–IN	0.9276
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600	Lubbock, TX	0.9646
	Lubbock, TX	
4640	Lynchburg, VA	0.9219
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680	Macon, GA	0.9204
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720	Madison, WI	1.0467
	Dane, WI	
4800	Mansfield, OH	0.8900
	Crawford, OH	
	Richland, OH	
4840	Mayaguez, PR	0.4914
	Anasco, PR	
	Cabo Rojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR	
4880	McAllen-Edinburg-Mission, TX.	0.8428
	Hidalgo, TX	
4890	Medford-Ashland, OR.	1.0498
	Jackson, OR	
4900	Melbourne-Titusville-Palm Bay, FL.	1.0253
	Brevard, FL	
4920	Memphis, TN–AR–MS.	0.8920
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940	Merced, CA	0.9837
	Merced, CA	
5000	Miami, FL	0.9802
	Dade, FL	
5015	Middlesex-Somerset-Hunterdon, NJ.	1.1213
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080	Milwaukee-Waukesha, WI.	0.9893
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120	Minneapolis-St. Paul, MN–WI.	1.0903
	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	
5140	Missoula, MT	0.9157
	Missoula, MT	
5160	Mobile, AL	0.8108
	Baldwin, AL	
	Mobile, AL	
5170	Modesto, CA	1.0498
	Stanislaus, CA	
5190	Monmouth-Ocean, NJ.	1.0674
	Monmouth, NJ	
	Ocean, NJ	
5200	Monroe, LA	0.8137
	Ouachita, LA	
5240	Montgomery, AL	0.7734
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
5280	Muncie, IN	0.9284
	Delaware, IN	
5330	Myrtle Beach, SC	0.8976
	Horry, SC	
5345	Naples, FL	0.9754
	Collier, FL	
5360	Nashville, TN	0.9578
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Robertson, TN	
	Rutherford, TN	
	Sumner, TN	
	Williamson, TN	
	Wilson, TN	
5380	Nassau-Suffolk, NY.	1.3357
	Nassau, NY	
	Suffolk, NY	
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT.	1.2408
	Fairfield, CT	
	New Haven, CT	
5523	New London-Norwich, CT.	1.1767
	New London, CT	
5560	New Orleans, LA	0.9046
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	St. Tammany, LA	
5600	New York, NY	1.4414
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640	Newark, NJ	1.1381
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660	Newburgh, NY–PA	1.1387
	Orange, NY	
	Pike, PA	
5720	Norfolk-Virginia Beach-Newport News, VA–NC.	0.8574
	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	
5775	Oakland, CA	1.5072
	Alameda, CA	
	Contra Costa, CA	
5790	Ocala, FL	0.9402
	Marion, FL	
5800	Odessa-Midland, TX.	0.9397
	Ector, TX	
	Midland, TX	
5880	Oklahoma City, OK.	0.8900
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910	Olympia, WA	1.0960
	Thurston, WA	
5920	Omaha, NE–IA	0.9978
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945	Orange County, CA.	1.1474
	Orange, CA	
5960	Orlando, FL	0.9640
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990	Owensboro, KY	0.8344
	Daviess, KY	
6015	Panama City, FL	0.8865
	Bay, FL	
6020	Parkersburg-Marietta, WV–OH.	0.8127
	Washington, OH	
	Wood, WV	
6080	Pensacola, FL	0.8645
	Escambia, FL	
	Santa Rosa, FL	
6120	Peoria-Pekin, IL	0.8739
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160	Philadelphia, PA–NJ.	1.0713
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200	Phoenix-Mesa, AZ	0.9820
	Maricopa, AZ	
	Pinal, AZ	
6240	Pine Bluff, AR	0.7962
	Jefferson, AR	
6280	Pittsburgh, PA	0.9365
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323	Pittsfield, MA	1.0235
	Berkshire, MA	
6340	Pocatello, ID	0.9372
	Bannock, ID	
6360	Ponce, PR	0.5169
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403	Portland, ME	0.9794
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440	Portland-Vancouver, OR–WA.	1.0667
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483	Providence-Warwick-Pawtucket, RI.	1.0854
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520	Provo-Orem, UT	0.9984
	Utah, UT	
6560	Pueblo, CO	0.8820
	Pueblo, CO	
6580	Punta Gorda, FL	0.9218
	Charlotte, FL	
6600	Racine, WI	0.9334
	Racine, WI	
6640	Raleigh-Durham-Chapel Hill, NC.	0.9990
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660	Rapid City, SD	0.8846
	Pennington, SD	
6680	Reading, PA	0.9295
	Berks, PA	
6690	Redding, CA	1.1135
	Shasta, CA	
6720	Reno, NV	1.0648
	Washoe, NV	
6740	Richland-Kennewick-Pasco, WA.	1.1491
	Benton, WA	
	Franklin, WA	
6760	Richmond-Petersburg, VA.	0.9477
	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.	1.1365
	Riverside, CA	
	San Bernardino, CA	
6800	Roanoke, VA	0.8614
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820	Rochester, MN	1.2139
	Olmsted, MN	

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
6840	Rochester, NY	0.9194
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880	Rockford, IL	0.9625
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895	Rocky Mount, NC	0.9228
	Edgecombe, NC	
	Nash, NC	
6920	Sacramento, CA	1.1500
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960	Saginaw-Bay City-Midland, MI.	0.9650
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980	St. Cloud, MN	0.9700
	Benton, MN	
	Stearns, MN	
7000	St. Joseph, MO	0.8021
	Andrews, MO	
	Buchanan, MO	
7040	St. Louis, MO–IL	0.8855
	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	1.0367
	Marion, OR	
	Polk, OR	
7120	Salinas, CA	1.4623
	Monterey, CA	
7160	Salt Lake City-Ogden, UT.	0.9945
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200	San Angelo, TX	0.8374
	Tom Green, TX	
7240	San Antonio, TX	0.8753
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320	San Diego, CA	1.1131
	San Diego, CA	
7360	San Francisco, CA	1.4142
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400	San Jose, CA	1.4145
	Santa Clara, CA	
7440	San Juan-Bayamon, PR.	0.4741
	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.	1.1271
	San Luis Obispo, CA	
7480	Santa Barbara-Santa Maria-Lompoc, CA.	1.0481
	Santa Barbara, CA	
7485	Santa Cruz-Watsonville, CA.	1.3646
	Santa Cruz, CA	
7490	Santa Fe, NM	1.0712
	Los Alamos, NM	
	Santa Fe, NM	
7500	Santa Rosa, CA	1.3046
	Sonoma, CA	
7510	Sarasota-Bradenton, FL.	0.9425
	Manatee, FL	
	Sarasota, FL	
7520	Savannah, GA	0.9376
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560	Scranton-Wilkes-Barre-Hazleton, PA.	0.8599
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600	Seattle-Bellevue-Everett, WA.	1.1474
	Island, WA	
	King, WA	
	Snohomish, WA	
7610	Sharon, PA	0.7869
	Mercer, PA	
7620	Sheboygan, WI	0.8697
	Sheboygan, WI	
7640	Sherman-Denison, TX.	0.9255
	Grayson, TX	
7680	Shreveport-Bossier City, LA.	0.8987
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720	Sioux City, IA–NE	0.9046
	Woodbury, IA	
	Dakota, NE	
7760	Sioux Falls, SD	0.9257
	Lincoln, SD	
	Minnehaha, SD	
7800	South Bend, IN	0.9802
	St. Joseph, IN	
7840	Spokane, WA	1.0852
	Spokane, WA	
7880	Springfield, IL	0.8659
	Menard, IL	
	Sangamon, IL	
7920	Springfield, MO	0.8424
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003	Springfield, MA	1.0927
	Hampden, MA	
	Hampshire, MA	
8050	State College, PA	0.8941
	Centre, PA	
8080	Steubenville-Weirton, OH–WV.	0.8804
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120	Stockton-Lodi, CA	1.0506
	San Joaquin, CA	
8140	Sumter, SC	0.8273
	Sumter, SC	
8160	Syracuse, NY	0.9714
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200	Tacoma, WA	1.0940
	Pierce, WA	
8240	Tallahassee, FL	0.8504
	Gadsden, FL	
	Leon, FL	
8280	Tampa-St. Petersburg-Clearwater, FL.	0.9065
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320	Terre Haute, IN	0.8599
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
8360	Texarkana, AR-Texarkana, TX.	0.8088
	Miller, AR	
	Bowie, TX	
8400	Toledo, OH	0.9810
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440	Topeka, KS	0.9199
	Shawnee, KS	
8480	Trenton, NJ	1.0432
	Mercer, NJ	
8520	Tucson, AZ	0.8911
	Pima, AZ	
8560	Tulsa, OK	0.8332
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600	Tuscaloosa, AL	0.8130
	Tuscaloosa, AL	
8640	Tyler, TX	0.9521
	Smith, TX	
8680	Utica-Rome, NY	0.8465
	Herkimer, NY	
	Oneida, NY	
8720	Vallejo-Fairfield-Napa, CA.	1.3354
	Napa, CA	
	Solano, CA	
8735	Ventura, CA	1.1096
	Ventura, CA	
8750	Victoria, TX	0.8756
	Victoria, TX	
8760	Vineland-Millville-Bridgeton, NJ.	1.0031
	Cumberland, NJ	
8780	Visalia-Tulare-Porterville, CA.	0.9429
	Tulare, CA	
8800	Waco, TX	0.8073
	McLennan, TX	
8840	Washington, DC–MD–VA–WV.	1.0851
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	

TABLE 3A.—PROPOSED URBAN WAGE INDEX—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	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.	0.8069
	Black Hawk, IA	
8940	Wausau, WI	0.9782
	Marathon, WI	
8960	West Palm Beach-Boca Raton, FL.	0.9939
	Palm Beach, FL	
9000	Wheeling, OH–WV	0.7670
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040	Wichita, KS	0.9520
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080	Wichita Falls, TX	0.8498
	Archer, TX	
	Wichita, TX	
9140	Williamsport, PA	0.8544
	Lycoming, PA	
9160	Wilmington-Newark, DE–MD.	1.1173
	New Castle, DE	
	Cecil, MD	
9200	Wilmington, NC	0.9640
	New Hanover, NC	
	Brunswick, NC	
9260	Yakima, WA	1.0569
	Yakima, WA	
9270	Yolo, CA	0.9434
	Yolo, CA	
9280	York, PA	0.9026
	York, PA	
9320	Youngstown-Warren, OH.	0.9358
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340	Yuba City, CA	1.0276
	Sutter, CA	
	Yuba, CA	
9360	Yuma, AZ	0.8589
	Yuma, AZ	

TABLE 3B.—PROPOSED RURAL WAGE INDEX

Nonurban area	Wage index
Alabama	0.7660
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Guam	0.9611
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079
Louisiana	0.7567
Maine	0.8874
Maryland	0.8946
Massachusetts	1.1288
Michigan	0.9000
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8021
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island [1]	
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7821
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Virgin Islands	0.7845
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

[1] All counties within the State are classified urban.

TABLE 4.—ACCEPTABLE IMPAIRMENT GROUP CODES

Impairment group codes	Excluded etiological diagnoses	Associated rehabilitation impairment category
01.1 Left body involvement (right brain)	None	01 Stroke.

TABLE 4.—ACCEPTABLE IMPAIRMENT GROUP CODES—Continued

Impairment group codes	Excluded etiological diagnoses	Associated rehabilitation impairment category
01.2 Right body involvement (left brain)	None	
01.3 Bilateral Involvement	None	
01.4 No Paresis	None	
01.9 Other Stroke	None	
02.21 Open Injury	None	02 Traumatic brain injury.
02.22 Closed Injury	None	
02.1 Non-traumatic	331.0	03 Nontraumatic brain injury.
	331.2	
	215.0	
02.9 Other Brain	None	
04.210 Paraplegia, Unspecified	None	04 Traumatic spinal cord injury.
04.211 Paraplegia, Incomplete	None	
04.212 Paraplegia, Complete	None	
04.220 Quadriplegia, Unspecified	None	
04.2211 Quadriplegia, Incomplete C1–4	None	
04.2212 Quadriplegia, Incomplete C5–8	None	
04.2221 Quadriplegia, Complete C1–4	None	
04.2222 Quadriplegia, Complete C5–8	None	
04.230 Other traumatic spinal cord dysfunction	None	
04.110 Paraplegia, unspecified	None	05 Nontraumatic spinal cord injury.
04.111 Paraplegia, incomplete	None	
04.112 Paraplegia, complete	None	
04.120 Quadriplegia, unspecified	None	
04.1211 Quadriplegia, Incomplete C1–4	None	
04.1212 Quadriplegia, Incomplete C5–8	None	
04.1221 Quadriplegia, Complete C1–4	None	
04.1222 Quadriplegia, Complete C5–8	None	
04.130 Other non-traumatic spinal cord dysfunction	None	
03.1 Multiple Sclerosis	None	06 Neurological.
03.2 Parkinsonism	None	
03.3 Polyneuropathy	None	
03.5 Cerebral Palsy	None	
03.8 Neuromuscular Disorders	None	
03.9 Other Neurologic	None	
08.11 Status post unilateral hip fracture	None	07 Fracture of lower extremity.
08.12 Status post bilateral hip fractures	None	
08.3 Status post pelvic fracture	None	
05.3 Unilateral lower extremity above the knee (AK)	None	10 Amputation, lower extremity.
05.4 Unilateral lower extremity below the knee (BK)	None	
05.5 Bilateral lower extremity above the knee (AK/AK)	None	
05.6 Bilateral lower extremity above/below the knee (AK/BK)	None	
05.7 Bilateral lower extremity below the knee (BK/BK)	None	
05.1 Unilateral upper extremity above the elbow (AE)	None	11 Amputation, other.
05.2 Unilateral upper extremity below the elbow (BE)	None	
05.9 Other amputation	None	
06.1 Rheumatoid Arthritis	701.1	13 Rheumatoid, other arthritis.
	710.1	
06.9 Other arthritis	701.1	
	710.1	
08.4 Status post major multiple fractures	None	17 Major multiple trauma, no brain injury or spinal cord injury.
14.9 Other multiple trauma	None	
14.1 Brain and spinal cord injury	None	18 Major multiple trauma, with brain or spinal cord injury.
14.2 Brain and multiple fractures/amputation	None	
14.3 Spinal cord and multiple fractures/amputation	None	
3.4 Guillian Barre	None	19 Guillian Barre.
12.1 Spina Bifida	None	20 Miscellaneous.
12.9 Other congenital	None	
11 Burns	None	21 Burns.

TABLE 5.—ACCEPTABLE ICD–9–CM CODES

Code	Label
036.0	MENINGOCOCCALMENINGITIS
047.8	VIRAL MENINGITIS NEC
047.9	VIRAL MENINGITIS NOS

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
049.0	LYMPHOCYTICCHORIOMENINGG
049.9	VIRAL ENCEPHALITIS NOS

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
052.0	POSTVARICELLAENCEPHALIT
053.0	HERPES ZOSTER MENINGITIS
054.3	HERPETICENCEPHALITIS

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
054.5	HERPETICSEPTICEMIA
054.72	H SIMPLEX MENINGITIS
055.0	POSTMEASLESENCEPHALITIS
072.1	MUMPSMENINGITIS
072.2	MUMPSENCEPHALITIS
094.2	SYPHILITICMENINGITIS
112.83	CANDIDALMENINGITIS
114.2	COCCIDIOIDALMENINGITIS
115.01	HISTOPLASM CAPSUL MENING
115.11	HISTOPLASM DUBOIS MENING
115.91	HISTOPLASMOSISMENINGIT
130.0	TOXOPLASMMENINGOENCEP-H
139.0	LATE EFF VIRAL ENCEPHAL
320.0	HEMOPHILUSMENINGITIS
320.1	PNEUMOCOCCALMENINGITIS
320.2	STREPTOCOCCALMENINGITIS
320.3	STAPHYLOCOCCMENINGITIS
320.7	MENING IN OTH BACT DIS
320.81	ANAEROBICMENINGITIS
320.82	MNINGTS GRAM–NEG BCT NEC
320.89	MENINGITIS OTH SPCF BACT
320.9	BACTERIAL MENINGITIS NOS
321.0	CRYPTOCOCCALMENINGITIS
321.1	MENING IN OTH FUNGAL DIS
321.2	MENING IN OTH VIRAL DIS
321.3	TRYPANOSOMIASISMENINGIT
321.4	MENINGIT D/T SARCOIDOSIS
321.8	MENING IN OTH NONBAC DIS
322.0	NONPYOGENICMENINGITIS
322.2	CHRONICMENINGITIS
322.9	MENINGITISNOS
323.0	ENCEPHALIT IN VIRAL DIS
323.6	POSTINFECTENCEPHALITIS
323.8	ENCEPHALITISNEC
323.9	ENCEPHALITISNOS
324.0	INTRACRANIALABSCESS
324.1	INTRASPINALABSCESS
324.9	CNS ABSCESS NOS
334.0	FRIEDREICHSATAXIA
334.1	HERED SPASTIC PARAPLEGIA
334.2	PRIMARY CEREBELLAR DEGEN
334.3	CEREBELLAR ATAXIA NEC
334.4	CEREBEL ATAX IN OTH DIS
334.8	SPINOCEREBELLAR DIS NEC
334.9	SPINOCEREBELLAR DIS NOS
335.0	WERDNIG–HOFFMANNDISEASE
335.10	SPINAL MUSCL ATROPHY NOS
335.11	KUGELBERG–WELANDERDIS
335.19	SPINAL MUSCL ATROPHY NEC
335.20	AMYOTROPHICSCLEROSIS
335.21	PROG MUSCULAR ATROPHY
335.22	PROGRESSIVE BULBAR PALSY
335.23	PSEUDOBULBARPALSY
335.24	PRIM LATERAL SCLEROSIS
335.29	MOTOR NEURON DISEASE NEC
335.8	ANT HORN CELL DIS NEC
335.9	ANT HORN CELL DIS NOS
336.0	SYRINGOMYELIA
336.1	VASCULARMYELOPATHIES
336.2	COMB DEG CORD IN OTH DIS
336.3	MYELOPATHY IN OTH DIS
336.8	MYELOPATHYNEC
336.9	SPINAL CORD DISEASE NOS
342.01	FLCCD HMIPLGA DOMNT SIDE
342.02	FLCCD HMIPLG NONDMNT SDE
342.10	SPSTC HMIPLGA UNSPF SIDE
342.11	SPSTC HMIPLGA DOMNT SIDE
342.12	SPSTC HMIPLG NONDMNT SDE
342.80	OT SP HMIPLGA UNSPF SIDE
342.81	OT SP HMIPLGA DOMNT SIDE
342.82	OT SP HMIPLG NONDMNT SDE
342.90	UNSP HEMIPLGA UNSPF SIDE
342.91	UNSP HEMIPLGA DOMNT SIDE
342.92	UNSP HMIPLGA NONDMNT SDE
343.0	CONGENITALDIPLEGIA
343.1	CONGENITALHEMIPLEGIA
343.2	CONGENITALQUADRIPLEGIA
343.3	CONGENITALMONOPLEGIA
343.4	INFANTILEHEMIPLEGIA
343.8	CEREBRAL PALSY NEC
343.9	CEREBRAL PALSY NOS
344.00	QUADRIPLEGIA, UNSPECIFD
344.01	QUADRPLG C1–C4, COM-PLETE
344.02	QUADRPLG C1–C4, INCOMPLT
344.03	QUADRPLG C5–C7, COM-PLETE
344.04	QUADRPLG C5–C7, INCOMPLT
344.09	OTHERQUADRIPLEGIA
344.1	PARAPLEGIANOS
344.2	DIPLEGIA OF UPPER LIMBS
344.30	MONPLGA LWR LMB UNSP SDE
344.31	MONPLGA LWR LMB DMNT SDE
344.32	MNPLG LWR LMB NONDMNT SD
344.40	MONPLGA UPR LMB UNSP SDE
344.41	MONPLGA UPR LMB DMNT SDE
344.42	MNPLG UPR LMB NONDMNT SD
344.5	MONOPLEGIANOS
344.60	CAUDA EQUINA SYND NOS
344.61	NEUROGENICBLADDER
344.81	LOCKED–INSTATE
344.89	OTH SPCF PARALYTIC SYND
344.9	PARALYSISNOS
348.1	ANOXIC BRAIN DAMAGE
348.4	COMPRESSION OF BRAIN
356.1	PERONEAL MUSCLE ATRO-PHY
356.2	HERED SENSORY NEUROP-ATHY
356.4	IDIO PROG POLYNEUROPATHY
359.0	CONG HERED MUSC DYSTRPHY
359.1	HERED PROG MUSC DYSTRPHY
359.5	MYOPATHY IN ENDOCRIN DIS
359.6	INFL MYOPATHY IN OTH DIS
359.8*	MYOPATHY NEC
359.9	MYOPATHYNOS
430	SUBARACHNOIDHEMORRHAG-E
431	INTRACEREBRALHEMORRHA-GE
432.0	NONTRAUM EXTRADURAL HEM
432.1	SUBDURALHEMORRHAGE
432.9	INTRACRANIAL HEMORR NOS
433.01	OCL BSLR ART W INFRCT
433.11	OCL CRTD ART W INFRCT
433.21	OCL VRTB ART W INFRCT
433.31	OCL MLT BI ART W INFRCT
433.81	OCL SPCF ART W INFRCT
433.91	OCL ART NOS W INFRCT
434.01	CRBL THRMBS W INFRCT
434.11	CRBL EMBLSM W INFRCT
434.91	CRBL ART OCL NOS W INFRC
438.11	LATE EFF CV DIS–APHASIA
438.20	LATE EF–HEMPLGA SIDE NOS
438.21	LATE EF–HEMPLGA DOM SIDE
438.22	LATE EF–HEMIPLGA NON–DOM
438.30	LATE EF–MPLGA UP LMB NOS
438.31	LATE EF–MPLGA UP LMB DOM
438.32	LT EF–MPLGA UPLMB NONDOM
438.40	LTE EF–MPLGA LOW LMB NOS
438.41	LTE EF–MPLGA LOW LMB DOM
438.42	LT EF–MPLGA LOWLMB NONDM
438.50	LT EF OTH PARAL SIDE NOS
438.51	LT EF OTH PARAL DOM SIDE
438.52	LT EF OTH PARALS NON–DOM
438.53	LT EF OTH PARALS–BILAT
710.0	SYST LUPUS ERYTHEMATOSUS
710.4	POLYMYOSITIS
714.0	RHEUMATOIDARTHRITIS
714.1	FELTYSSYNDROME
714.2	SYST RHEUM ARTHRITIS NEC
714.30	JUV RHEUM ARTHRITIS NOS
714.31	POLYART JUV RHEUM ARTHR
714.4	CHR POSTRHEUM ARTHRITIS
716.29	ALLERGARTHRITIS–MULT
720.0	ANKYLOSINGSPONDYLITIS
806.00	C1–C4 FX–CL/CORD INJ NOS
806.01	C1–C4 FX–CL/COM CORD LES
806.02	C1–C4 FX–CL/ANT CORD SYN
806.03	C1–C4 FX–CL/CEN CORD SYN
806.04	C1–C4 FX–CL/CORD INJ NEC
806.05	C5–C7 FX–CL/CORD INJ NOS
806.06	C5–C7 FX–CL/COM CORD LES
806.07	C5–C7 FX–CL/ANT CORD SYN
806.08	C5–C7 FX–CL/CEN CORD SYN
806.09	C5–C7 FX–CL/CORD INJ NEC
806.10	C1–C4 FX–OP/CORD INJ NOS
806.11	C1–C4 FX–OP/COM CORD LES
806.12	C1–C4 FX–OP/ANT CORD SYN
806.13	C1–C4 FX–OP/CEN CORD SYN
806.14	C1–C4 FX–OP/CORD INJ NEC
806.15	C5–C7 FX–OP/CORD INJ NOS
806.16	C5–C7 FX–OP/COM CORD LES

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
806.17	C5–C7 FX–OP/ANT CORD SYN
806.18	C5–C7 FX–OP/CEN CORD SYN
806.19	C5–C7 FX–OP/CORD INJ NEC
806.20	T1–T6 FX–CL/CORD INJ NOS
806.21	T1–T6 FX–CL/COM CORD LES
806.22	T1–T6 FX–CL/ANT CORD SYN
806.23	T1–T6 FX–CL/CEN CORD SYN
806.24	T1–T6 FX–CL/CORD INJ NEC
806.25	T7–T12 FX–CL/CRD INJ NOS
806.26	T7–T12 FX–CL/COM CRD LES
806.27	T7–T12 FX–CL/ANT CRD SYN
806.28	T7–T12 FX–CL/CEN CRD SYN
806.29	T7–T12 FX–CL/CRD INJ NEC
806.30	T1–T6 FX–OP/CORD INJ NOS
806.31	T1–T6 FX–OP/COM CORD LES
806.32	T1–T6 FX–OP/ANT CORD SYN
806.33	T1–T6 FX–OP/CEN CORD SYN
806.34	T1–T6 FX–OP/CORD INJ NEC
806.35	T7–T12 FX–OP/CRD INJ NOS
806.36	T7–T12 FX–OP/COM CRD LES
806.37	T7–T12 FX–OP/ANT CRD SYN
806.38	T7–T12 FX–OP/CEN CRD SYN
806.39	T7–T12 FX–OP/CRD INJ NEC
806.4	CL LUMBAR FX W CORD INJ
806.5	OPN LUMBAR FX W CORD INJ
806.60	FX SACRUM–CL/CRD INJ NOS
806.61	FX SACR–CL/CAUDA EQU LES
806.62	FX SACR–CL/CAUDA INJ NEC
806.69	FX SACRUM–CL/CRD INJ NEC
806.70	FX SACRUM–OP/CRD INJ NOS
806.71	FX SACR–OP/CAUDA EQU LES
806.72	FX SACR–OP/CAUDA INJ NEC
806.79	FX SACRUM–OP/CRD INJ NEC
806.8	VERT FX NOS–CL W CRD INJ
806.9	VERT FX NOS–OP W CRD INJ
850.2	CONCUSSION–MODERATECOMA
850.3	CONCUSSION–PROLONGCOMA
850.4	CONCUSSION–DEEPCOMA
851.02	CORTEX CONTUS–BRIEF COMA
851.03	CORTEX CONTUS–MOD COMA
851.04	CORTX CONTUS–PROLNG COMA
851.05	CORTEX CONTUS–DEEP COMA
851.12	OPN CORT CONTUS–BRF COMA
851.13	OPN CORT CONTUS–MOD COMA
851.14	OPN CORT CONTU–PROL COMA
851.15	OPN CORT CONTU–DEEP COMA
851.22	CORTEX LACERA–BRIEF COMA
851.23	CORTEX LACERAT–MOD COMA
851.24	CORTEX LACERAT–PROL COMA
851.25	CORTEX LACERAT–DEEP COMA
851.32	OPN CORTX LAC–BRIEF COMA
851.33	OPN CORTX LACER–MOD COMA
851.34	OPN CORTX LAC–PROLN COMA

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
851.35	OPN CORTEX LAC–DEEP COMA
851.42	CEREBELL CONTUS–BRF COMA
851.43	CEREBELL CONTUS–MOD COMA
851.44	CEREBEL CONTUS–PROL COMA
851.45	CEREBEL CONTUS–DEEP COMA
851.52	OPN CEREBE CONT–BRF COMA
851.53	OPN CEREBE CONT–MOD COMA
851.54	OPN CEREBE CONT–PROL COM
851.55	OPN CEREBE CONT–DEEP COM
851.62	CEREBEL LACER–BRIEF COMA
851.63	CEREBEL LACERAT–MOD COMA
851.64	CEREBEL LACER–PROLN COMA
851.65	CEREBELL LACER–DEEP COMA
851.72	OPN CEREBEL LAC–BRF COMA
851.73	OPN CEREBEL LAC–MOD COMA
851.74	OPN CEREBE LAC–PROL COMA
851.75	OPN CEREBE LAC–DEEP COMA
851.82	BRAIN LAC NEC–BRIEF COMA
851.83	BRAIN LACER NEC–MOD COMA
851.84	BRAIN LAC NEC–PROLN COMA
851.85	BRAIN LAC NEC–DEEP COMA
851.92	OPN BRAIN LAC–BRIEF COMA
851.93	OPN BRAIN LACER–MOD COMA
851.94	OPN BRAIN LAC–PROLN COMA
851.95	OPEN BRAIN LAC–DEEP COMA
852.03	SUBARACH HEM–MOD COMA
852.04	SUBARACH HEM–PROLNG COMA
852.05	SUBARACH HEM–DEEP COMA
852.06	SUBARACH HEM–COMA NOS
852.13	OP SUBARACH HEM–MOD COMA
852.14	OP SUBARACH HEM–PROL COM
852.15	OP SUBARACH HEM–DEEP COM
852.23	SUBDURAL HEMORR–MOD COMA
852.24	SUBDURAL HEM–PROLNG COMA
852.25	SUBDURAL HEM–DEEP COMA
852.26	SUBDURAL HEMORR–COMA NOS
852.33	OPN SUBDUR HEM–MOD COMA
852.34	OPN SUBDUR HEM–PROL COMA
852.35	OPN SUBDUR HEM–DEEP COMA

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
852.43	EXTRADURAL HEM–MOD COMA
852.44	EXTRADUR HEM–PROLN COMA
852.45	EXTRADURAL HEM–DEEP COMA
852.53	EXTRADURAL HEM–MOD COMA
852.54	EXTRADUR HEM–PROLN COMA
852.55	EXTRADUR HEM–DEEP COMA
853.03	BRAIN HEM NEC–MOD COMA
853.04	BRAIN HEM NEC–PROLN COMA
853.05	BRAIN HEM NEC–DEEP COMA
853.06	BRAIN HEM NEC–COMA NOS
853.13	BRAIN HEM OPEN–MOD COMA
853.14	BRAIN HEM OPN–PROLN COMA
853.15	BRAIN HEM OPEN–DEEP COMA
854.03	BRAIN INJ NEC–MOD COMA
854.04	BRAIN INJ NEC–PROLN COMA
854.05	BRAIN INJ NEC–DEEP COMA
854.06	BRAIN INJ NEC–COMA NOS
854.13	OPN BRAIN INJ–MOD COMA
854.14	OPN BRAIN INJ–PROLN COMA
854.15	OPN BRAIN INJ–DEEP COMA
887.0	AMPUT BELOW ELB, UNILAT
887.1	AMP BELOW ELB, UNIL–COMP
887.3	AMPUT ABV ELB, UNIL–COMP
887.4	AMPUTAT ARM, UNILAT NOS
887.5	AMPUT ARM, UNIL NOS–COMP
887.6	AMPUTATION ARM, BILAT
887.7	AMPUTAT ARM, BILAT–COMPL
897.0	AMPUT BELOW KNEE, UNILAT
897.1	AMPUTAT BK, UNILAT–COMPL
897.2	AMPUT ABOVE KNEE, UNILAT
897.3	AMPUT ABV KN, UNIL–COMPL
897.4	AMPUTAT LEG, UNILAT NOS
897.5	AMPUT LEG, UNIL NOS–COMP
897.6	AMPUTATION LEG, BILAT
897.7	AMPUTAT LEG, BILAT–COMPL
905.9	LATE EFF TRAUMAT AMPUTAT
907.0	LT EFF INTRACRANIAL INJ
907.2	LATE EFF SPINAL CORD INJ
952.00	C1–C4 SPIN CORD INJ NOS
952.01	COMPLETE LES CORD/C1–C4
952.02	ANTERIOR CORD SYND/C1–C4
952.03	CENTRAL CORD SYND/C1–C4
952.04	C1–C4 SPIN CORD INJ NEC
952.05	C5–C7 SPIN CORD INJ NOS
952.06	COMPLETE LES CORD/C5–C7
952.07	ANTERIOR CORD SYND/C5–C7
952.08	CENTRAL CORD SYND/C5–C7
952.09	C5–C7 SPIN CORD INJ NEC
952.10	T1–T6 SPIN CORD INJ NOS
952.11	COMPLETE LES CORD/T1–T6
952.12	ANTERIOR CORD SYND/T1–T6
952.13	CENTRAL CORD SYND/T1–T6
952.14	T1–T6 SPIN CORD INJ NEC
952.15	T7–T12 SPIN CORD INJ NOS
952.16	COMPLETE LES CORD/T7–T12
952.17	ANTERIOR CORD SYN/T7–T12
952.18	CENTRAL CORD SYN/T7–T12

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
952.19	T7–T12 SPIN CORD INJ NEC
952.2	LUMBAR SPINAL CORD INJUR
952.3	SACRAL SPINAL CORD INJUR
952.4	CAUDA EQUINA INJURY
952.8	SPIN CORD INJ–MULT SITE
952.9	SPINAL CORD INJURY NOS
997.60	AMPUTAT STUMP COMPL NOS
997.61	NEUROMA AMPUTATION STUMP

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
997.62	INFECTION AMPUTAT STUMP
997.69	AMPUTAT STUMP COMPL NEC
V49.63	STATUS AMPUT HAND
V49.64	STATUS AMPUT WRIST
V49.65	STATUS AMPUT BELOW ELBOW
V49.66	STATUS AMPUT ABOVE ELBOW
V49.67	STATUS AMPUT SHOULDER

TABLE 5.—ACCEPTABLE ICD–9–CM CODES—Continued

Code	Label
V49.75	STATUS AMPUT BELOW KNEE
V49.76	STATUS AMPUT ABOVE KNEE
V49.77	STATUS AMPUT HIP

*Note code 359.8 has been replaced by 359.81 and 359.89

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