FORM APPROVED
OMB NO. 0938-0358

REHABILITATION UNIT CRITERIA WORK SHEET

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

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

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
	§412.25 Excluded hospital units: Common requirements.				
	(a) Basis for exclusion. In order to be excluded from the Medicare's Acute Care Hospital Prospective Payment System (PPS) and to be paid under the Inpatient Rehabilitation Facility Prospective Payment System, a rehabilitation unit must meet the following requirements in addition to the all criteria under subpart B of part 412 of the regulations:				
M50	(1) Be part of an institution that — has in effect an agreement under part 489 to participate as a hospital and is not excluded in its entirety from the Acute Care Hospital PPS.	• Has the Fiscal Intermediary (FI) verified the rehab unit meets the 75% rule? • The surveyor should check State Agency (SA) records and/or verify with the Regional Office (RO) to ensure the hospital has an agreement to participate in the Medicare program and to ensure that the hospital is not already excluded in its entirety from PPS, such as a rehabilitation hospital. In other words, the unit seeking exclusion cannot comprise the entire hospital.			
M51	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	Verify that the hospital has admission criteria and review same. Verify through open and closed record review that the approved admission criteria is being followed for all patients.			
M52	(3) Have admission & discharge records that are separately identified from those of the hospital in which it is located and are readily available.	Verify that medical records are separate and not commingled with other hospital records and are readily available for review.			

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M53	(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.	Verify that the hospital has a policy detailing the *prompt* transfer of information and that it is being followed. Review records to ensure that the clinical information that should be transferred with the record is actually in the medical record.			
M54	(5) Meet applicable State licensure laws.	• Verify and document that all applicable State licensure laws are met. • Document all unmet State licensure requirements. • Verify the hospital has current licenses for its professional staff. • Are the licenses issued by the State in which the hospital is located? • Does the unit meet special licensing requirements issued by the State?			
M55	(6) Have utilization review standards applicable for the type of care offered in the unit.	Verify that the hospital has a utilization review plan that includes the review of rehab services (No utilization review (UR) standards are required if the QIO is conducting review activities.)			
M56	(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds. **NOTE:** §412.25(a) (8)-(12) are verified by the FI.	Is the space containing the rehab beds separate from the beds in other units of the hospital?			
M57	(13) As part of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.	Prior to scheduling the survey, verify with the FI that the unit is operational: fully staffed and equipped. (It is not required that the unit has inpatients on the day of the survey, but must demonstrate capability of caring for patients.)			

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	§412.29 Excluded rehabilitation units. Additional requirements. In order to be excluded from the Acute Care Hospital PPS, a rehabilitation unit must meet the following requirements:				
M58	(a) Have met either the requirements for: (1) New units under §412.30(b); or (2) Converted units under §412.30(c); or (3) Is excluded for the current cost-reporting period.	The SA will check these provisions with the RO prior to the survey.			
M59	(b) Have in effect a pre-admission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment.	Review the pre-admission screening protocol.			
M60	(c) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services.	• Verify that every patient is under the care of a physician and has authenticated orders in the chart. • If the State issues licenses, verify that all licenses are current & are issued by the State in which qualified personnel are providing services. • Determine that the hospital has a means of ensuring that its personnel remain qualified/competent. • Refer to State laws and hospital policies to determine the qualifications of personnel providing rehabilitation services. • Review medical charts if patients have been admitted.			
M61	(d) Have a plan of treatment (POT) for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	Ensure that all patients have a POT in their medical record. Verify the physician and other professional personnel participate in the establishment, review, and revision of the POT. (This could be a signature, a record of a conference, or record of consultation.)			

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M62	(e) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.	Review hospital policy regarding multidisciplinary team meetings, frequency, and medical record documentation.			
M63	(f) Have a director of rehabilitation who —	Verify the rehab unit has a director of rehab.			
M64	(1) Provides services to the unit and to its inpatients for at least 20 hours per week;	The 20 hours may be any combination of patient services and administration. Hours cannot be substituted by a Physician Assistant or by any other qualified professional. Verify the 20 hours through review of personnel time cards/logs, etc.			
M65	(2) Is a doctor of medicine or osteopathy;	Ensure license is current and issued by the State in which the service is being provided.			
M66	(3) Is licensed under State law to practice medicine or surgery; and	Ensure license is current and issued by the State in which the service is being provided.			
M67	(4) Has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.	Review personnel files.			

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	§412.30 Exclusion of new distinct part rehabilitation units and expansion of units already excluded.				
M68	(a) **Bed capacity in units.** A decrease in bed capacity must remain in effect for at least a full 12-month cost reporting period before an equal or lesser number of beds can be added to the hospital's licensure and certification and considered "new" under §412.30(b) below.	The SA must verify a previous decrease in State licensed hospital beds. The RO will verify any corresponding reduction in the number of beds for Medicare certification purposes.			
M69	(b) **New units.** A hospital unit is considered a new unit if the hospital has not previously sought exclusion for any rehabilitation unit; and has obtained approval under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit. For a hospital seeking exclusion of a new rehabilitation unit, the hospital may provide a written certification that at least 75 percent of the inpatient population it intends the unit to serve will require intensive rehabilitation services for treatment of one or more of the following conditions instead of showing that it has treated such a population during its most recent 12-month cost reporting period: (i) Stroke. (ii) Spinal cord injury (iii) Congenital deformity (iv) Amputation (v) Major multiple trauma. (vi) Fracture of femur (hip fracture). (vii) Brain injury. (viii) Polyarthritis, including rheumatoid arthritis. (ix) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular distrophy, and Parkinson's disease. (x) Burns.	• SA/RO to verify that the hospital has not previously sought exclusion. • SA to verify that hospital received approval for unit under State licensure. • SA to verify that the hospital has provided written certification to the RO/FI. • The regulations at §412.30 state that a hospital unit is considered a converted unit if it doesn't qualify as a new unit. Therefore, existing excluded units are treated as converted units for purposes of reverification of the 75% rule.			

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M70	(c) **Converted units** A hospital unit is considered a converted unit if it does not qualify as a new unit and it must have treated, for the hospital's most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitation services for the treatment of one or more conditions listed under §412.23(b)(2).	Verify through the RO that the hospital unit provided intensive rehab services to 75% of the unit's population for the most recent 12-month cost reporting period. (The FI is responsible for verifying this criteria.)			
M71	(d) **Expansion of Excluded Rehabilitation Units** (1) The beds that a hospital seeks to add to its excluded rehabilitation unit are considered new only if the State-licensed & Medicare certified bed capacity increases at the start of the cost reporting period (for which the hospital seeks to increase the size of its excluded rehabilitation unit) or at any time after the start of the preceding cost report period; and the hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit. (2) A hospital may increase the size of its excluded rehabilitation unit through conversion of existing bed capacity only if it shows that, for all of the hospital's most recent cost reporting period of at least 12 months, the beds have been used to treat an inpatient population meeting the requirements of §412.23(b)(2).	• Verify the hospital obtained State approval for an increase in its bed capacity. • FI to verify hospital has met the 75% rule for all of the most recent cost reporting period.			

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0358. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.