DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICE

FORM APPROVED
OMB NO. 0938-0986

REHABILITATION UNIT CRITERIA WORK SHEET
CMS-437A

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS (City, State, Zip Code)
NUMBER OF BEDS IN THE UNIT	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD	__/__/____ 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 OR FROM THE PAYMENT SYSTEM USED TO PAY CRITICAL ACCESS HOSPITALS.

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
		• Verification of hospital attestations may be done by CMS surveyors or MACs as applicable.	The hospital representative is expected to answer all questions accurately. The representative should verify the answers with the director of rehabilitation, physician, medical records office, or any applicable department to ensure correct responses to this form. A "yes" response means the hospital is in compliance with the applicable regulation.			
	§412.25 Excluded hospital units: Common requirements.					
	(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a rehabilitation unit must meet the following requirements in addition to the all criteria under Subpart B of Part 412 of the regulations:		In the case of § 412.25 and § 412.29, as related to IRF units, the term hospital includes Critical Access Hospitals.			

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A3500	(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 prospective payment systems, and has enough beds that are not excluded to permit the provision of adequate cost.	• The surveyor will verify, through the regional office (RO), that the hospital has an agreement to participate in the Medicare program, and the hospital is not already excluded in its entirety from IPPS, such as a rehabilitation hospital. In other words, the unit seeking exclusions cannot comprise the entire hospital • The hospital must be sufficiently staffed, maintained and IPPS beds utilized that are not part of the rehabilitation unit. • Verification of this information may be done by CMS surveyors or MACs.	Representative to ensure the hospital has a Medicare provider agreement.			
A3501	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	• Verify that the hospital has preadmission criteria for the rehabilitation unit. • Conduct an open and closed record review to determine whether the approved preadmission criteria is applied equally to all patients.	Representative to verify the rehab unit has preadmission criteria.			
A3502	(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 rehabilitation unit medical records are separate and not commingled with other hospital records and are readily available for review.	Representative to verify that the rehab unit houses only the records of the rehab patients.			
A3503	(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 rehabilitation unit clinical records to ensure that the clinical information that should be transferred with the record is actually in the medical record.	Representative to verify the hospital has a policy regarding the transfer of information, and the hospital adheres to the policy.			

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A3504	(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 rehabilitation unit is located? • Does the unit meet special licensing requirements issued by the State?	Representative to verify that all applicable State laws are being met and that all applicable licenses are current.			
A3505	(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.) • Verify that the hospital has written UR standards that are applied to the care offered in the unit.	Representative to verify that the hospital has a UR plan and that the UR standards are being applied to the care offered in the rehab unit.			
A3506	(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 physically separate from the beds in other units of the hospital? • There cannot be any beds that are located within the physical confines of the excluded rehab unit that are not excluded beds. • The IRF unit cannot use its beds for medical /surgical patients or any other type of patient. Those beds are solely for the use of IRF patients. • If the unit doesn't have enough patients to fill those beds, the beds must be left empty or the unit can decrease the number of beds in the unit after the hospital has notified CMS of its intent.	Representative will verify that the beds on the rehab unit do not belong to medical/surgical patients but are dedicated to rehab patients only.			

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A3507	(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.				
A3508	(b) Changes in the size of excluded units. Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.	• Verify that the request the IRF is making to add beds is the first and only request during the cost report year. • A decrease in the number of beds or square footage may occur at any time during the cost report period. In both cases, the change must remain in effect for the remainder of the cost report period • No changes can be made without notifying both CMS RO and the FI/MAC at least 30 days prior to the change.	Representative to verify that if changes were made to the unit, both CMS and the MAC/FI were notified prior to any change.			
	§ 412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment systems. To be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.(1)(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:					
A3509	(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.	• The SA will check these provisions with the RO prior to the survey.	Representative to ensure the hospital has a Medicare provider agreement.			

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A3510	(b) Except in the case of a "new" IRF or "new" IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the criteria outlined in § 412.29 (b)(2).	• The MAC/FI reviews the inpatient population of the IRF. If the hospital has not demonstrated that it served the appropriate inpatient population as defined in § 412.29 (b)(2), the MAC notifies the RO.				
A3511	(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (e)(2) of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.	• In the case of a new IRF unit, the surveyor will verify that the hospital has not previously sought exclusion. • The surveyor will verify that the hospital received approval for the unit under the appropriate State licensure laws. • •The IRF must submit an attestation statement in addition to the Form CMS 437A (Rehabilitation Unit Work Sheet) to the SA as part of their initial application packet. • Until the SA receives both the attestation statement and the Form CMS 437A, the new unit cannot be recommended for approval.	The representative completes this form (Form CMS 437A) as well as a signed attestation statement attesting that the rehab unit's patients it intends to serve meets the requirements outlined in § 412.29(b)(2).			
A3512	(1) **New IRFs.** An IRF hospital or IRF unit is considered new if it has not been paid under the new IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.	• If an IRF unit has been closed for 5 years (more than 60 calendar months), it can open its doors as a new unit. • Verify either through the SA or RO that the IRF unit has been closed for the 5 years before approving the IRF unit as new.	The representative ensures the IRF unit has not been paid under the IRF PPS for at least 5 calendar years.			

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A3513	(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds de-licensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.	• If the hospital added beds to its IRF unit, the surveyor or CMS will verify that the hospital had approval (certificate of need or State license) before adding beds, if such approval is required. • The surveyor must verify that the hospital received written CMS RO approval before adding any new beds to its IRF unit. • The surveyor will verify that the hospital's IRF unit didn't have more than one increase in beds during a single cost reporting period. • Surveyors must verify that if the hospital's IRF unit decreased beds, it didn't thereafter add beds unless a full 12 month cost reporting period had elapsed.	• The representative verifies that the hospital received State approval (certification of need or State licensure) if prior approval is required by the State, prior to any IRF unit bed increase. • The representative verifies that the hospital received written approval from the CMS RO before any new beds were added to the IRF unit. • The representative will verify that if the hospital's IRF unit decreased beds, it didn't thereafter add beds unless a full 12 month cost reporting period had elapsed. • The representative will verify that the hospital's IRF unit didn't have more than one increase in beds during a single cost reporting period.			
A3514	(3) **Change of ownership or leasing.** An IRF hospital or IRF unit that undergoes a change of ownership, or leasing as defined in § 489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment systems specified in § 412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may reapply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements under the new IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment	• IRF status is lost if a hospital is acquired and the new owners reject assignment of the previous owner's Medicare provider assignment. • Only entire hospitals may be sold or leased. • IRF units may not be sold or leased separately from the hospital of which it is a part.	The representative of the IRF unit, that has undergone a change of ownership, must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded unit.			

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A3515	(4) **Mergers.** If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF (or the hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.	• As with the change of ownership, the owner of the merged hospital must accept assignment of the hospital's (with the IRF unit) provider agreement to ensure uninterrupted reimbursement. • If the owner of the hospital to be merged doesn't accept assignment of the previous owner(s) Medicare provider agreement, the new owner(s) will not be eligible for reimbursement until the new owner(s) reapplies to the Medicare program to operate a new hospital and have additionally been granted IRF status. • IRF status is lost if a hospital is acquired and the new owner(s) reject assignment of the previous owner's Medicare provider agreement. This also applies to an acquisition that is followed by a merger.	The representative of the IRF unit that has undergone a merger must ensure that the new owner(s) have accepted assignment of the previous Medicare provider agreement. If the new owner(s) have not accepted the assignment, the representative cannot request continued participation as an IPPS-excluded unit.			
A3516	(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.	• Review the hospital's procedures, or other alternative documents or records, to verify the hospital's rehabilitation unit has a preadmission screening procedure in place. • A review of the clinical records should indicate whether the IRF has such a screening procedure and whether it is using the screening procedure. • The purpose of the preadmission screen is to reduce the rate of hospital readmission by ensuring that the patients that are accepted to the IRF will benefit from intensive rehabilitation services.	The representative will ensure the hospital's rehabilitation unit is using the preadmission screening procedure on all patients admitted to the rehab unit.			

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A3517	(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to access the patient both medically and functionally, as well as to modify the courses of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.	• Review the hospital's procedures or other alternative documents or records to verify the hospital has a procedure detailing close medical supervision for patients, including at least 3 face-to-face visits per week. • As part of the clinical record review, look for documentation supporting the physician visits.	The representative will ensure the rehab unit has a procedure or other alternative documents or records verifying the hospital has a procedure detailing close medical supervision that includes the rehabilitation physician making at least 3 face-to-face visits per week.			
A3518	(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus as needed, speech-language pathology, social services, psychological services (including neuropsychological service) and orthotic and prosthetic services.	• Review the licenses of all qualified personnel that are required by the State to be licensed, to verify the licenses are up-to-date. • Qualified personnel would include either personnel that are licensed in the State in which the services are provided or those personnel that are recognized under reciprocity by the State in which the services are provided. • Determine if the hospital has and follows a procedure to evaluate and document that personnel are qualified and that those personnel maintain their qualifications.	The representative verifies that all qualified personnel, which are required by the State to be licensed, have licenses that are up-to-date.			
A3519	(g) Have a director of rehabilitation who —	• Verify the rehab unit has a director of rehabilitation by reviewing personnel logs or rosters and organization charts.	The representative will verify that the rehab unit has a physician Director of Rehabilitation.			
A3520	(1) Provides services to the rehabilitation unit and to unit's 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.	The representative will verify that the physician is spending 20 hours per week providing a combination of patient services and administration the rehab unit.			
A3521	(2) Is a doctor of medicine or osteopathy;	• Review the physician's license to verify the physician is an MD or DO.	The representative will review the physician's license to ensure the physician is an MD or DO.			
A3522	(3) Is licensed under State law to practice medicine or surgery; and	• Ensure license is current and issued by the State.	The representative will review the physician's license is current.			

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A3523	(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 and/or credentialing files to verify the physician's training and experience complies with the regulation.	The representative reviews the director of rehabilitation's level of training and experience.			
A3524	(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	• Conduct a clinical record review to verify that each IRF patient has a plan of treatment and that the plans are updated whenever there is a change in the patient's condition. • The plan of treatment should include the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay. • The anticipated interventions detailed in the overall plan of care should include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/ orthotic therapies required by the patient during the IRF stay.	The representative verifies that the rehab unit has patient plans of treatment.			
A3525	(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans and that team conferences are held at least once per week to determine the appropriateness of treatment.	• Review clinical records to determine whether the interdisciplinary team is meeting once a week to review patient progress toward goal attainment and discharge planning. • Determine if the documentation complies with the regulatory requirements.	The representative will determine whether interdisciplinary teams are meeting once weekly to review patient progress and that documentation is in the medical records.			

COMMENTS