REHABILITATION HOSPITAL CRITERIA WORK SHEET
CMS-437B

Name of IRF Hospital:	CCN#:	Date of Last Survey:
IRF Hospital's Street Address:		Number of Beds in IRF Hospital:

City	State	Zip Code	Telephone Number:

Dates of Cost Reporting Periods for Which Exclusion from the Medicare IPPS Payment System Is Requested:

1. Day/Month/Year to Day/Month/Year
2. Day/Month/Year to Day/Month/Year
3. Day/Month/Year to Day/Month/Year

Tag	Regulation	Guidance	Actions Required to Determine If Requirements Met	YES	NO	N/A
	§412.23- Excluded hospital units: Classifications.					
	§412.23(b) - Rehabilitation hospitals. An inpatient rehabilitation hospital must meet the requirements specified in §412.29 of this subpart to be excluded from the prospective payment systems specified in §412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in §412.1(a)(3) of this subpart and in subpart P of this part.					

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	§412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system. To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:					
A3600	**§412.29(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 facility will verify, through the regional office (RO), that the hospital has an agreement to participate in the Medicare program.	The IRF hospital representative shall verify that the IRF hospital has a Medicare provider agreement.			
A3601	**§412.29(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 of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraphs (b)(1) and (b)(2) of this section.	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)(1) and §412.29 (b)(2), the MAC notifies the RO.	For existing IRF hospitals that ***are not new*** and ***have not*** added **new** IRF beds during the past 12 months: The IRF hospital representative shall verify that at least 60% of the inpatient population served by the IRF hospital during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor) required intensive			

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A3601 (Cont.)			rehabilitation services for treatment of one or more of the conditions specified in §412.29(b)(1) and §412.29(b)(2).			
A3602	**§412.29(c)** In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(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 report period or in the case of new IRF beds, until the end of the cost report period during which the new beds are added to the IRF.	The IRF must submit a written attestation statement as well as form CMS 437B (rehabilitation hospital worksheet) to the SA as part of their initial application packet or as determined by CMS to maintain their IPPS excluded status. Until the SA receives both the attestation statement and the form CMS 437B the new rehabilitation hospital cannot be recommended for approval.	**For new IRF hospitals and IRF hospitals that have added new beds during the past 12 months:** The IRF hospital representative must provide a written attestation statement which certifies that 60% of the inpatient population it intends to serve will require intensive rehabilitation services for treatment of one or more of the conditions specified in §412.29(b)(2).			
A3603	**§412.29(c)(1) New IRFs**. An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of 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 report period.	If an IRF hospital has been closed for 5 years (more than 60 calendar months), it can open its doors as a new rehabilitation hospital. Verify either through the SA or RO that the IRF hospital has been closed for the 5 years before approving the IRF hospital as new.	**NOTE:** An IRF hospital or IRF unit is considered new if it has not been paid under the 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.			

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A3604	**§412.29(c)(2) New IRFs 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 report period. A full 12-month cost report period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.	If the rehabilitation hospital added beds, 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. The surveyor will verify that the hospital didn't have more than one increase in beds during a single cost reporting period. Surveyors must verify that if the rehabilitation hospital decreased beds, it didn't thereafter add beds unless a full 12-month cost reporting period had elapsed.	If new IRF beds were added during the previous 12 months, the IRF hospital representative will verify that: The IRF hospital received State approval (certification of need or State licensure) prior to any bed increase, if prior approval is required by the State; The IRF hospital received written approval from the applicable CMS Location before the new beds were added; and, The IRF hospital didn't have more than one increase in beds during a single cost reporting period. If the IRF hospital removed or decertified beds, the IRF hospital representative will verify that: The IRF hospital didn't thereafter add any additional beds until after a full 12-month cost reporting period had elapsed.			

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A3605	**§412.29(c)(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 system specified in § 412.1(a)(3) before and after the change of ownership or leasing, if the new owner(s) of the IRF accept assignment of the previous owner's Medicare provider agreement, and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owner's Medicare provider agreement, the IRF is considered to be voluntarily terminated, and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412(a)(1).	• 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.	• The IRF hospital representative will verify whether the IRF hospital is currently undergoing a change of ownership. • If so, the IRF hospital representative will verify whether the new owner(s) of the IRF hospital have accepted assignment of the existing Medicare provider agreement.			

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A3606	**§412.29(c)(4) Mergers.** If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s)of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412,1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. 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 with the existing 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) would not be eligible for reimbursement until the new owner(s) reapplied 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 IRF hospital representative will verify whether the IRF hospital has merged with another hospital. • If so, the IRF hospital representative will verify whether new hospital owner(s) accepted assignment of the IRF hospital's existing Medicare provider agreement.			

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A3607	**§412.29(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 has a preadmission screening procedure in place. • A review of the clinical records should indicate whether the IRF is using the screening procedure.	The IRF unit representative will verify that: • The IRF hospital has 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; and, • The IRF hospital is using the preadmission screening procedure on all patients admitted to the rehab unit.			
A3608	**§412.29(e)** Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by	• As part of the clinical record review, look for documentation supporting the physician and non-physician practitioner visits. • Review the hospital's procedures or other alternative documents or records to verify the hospital has a procedure detailing close medical supervision for patients.	The IRF hospital representative will verify that: • The IRF hospital has a procedure which requires close medical supervision of the patients; and • This procedure includes the rehabilitation physician making at least 3 face-to-face visits per week by a licensed physician with specialized training and			

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A3608 (cont.)	at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process except that during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week, as defined in § 412.622, of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.		experience in inpatient rehabilitation, for the purpose of assessing 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; and Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.			

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A3609	**§412.29(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 services), 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 IRF hospital representative will verify that: • The IRF hospital's patients receive rehabilitation nursing care, physical therapy, occupational therapy, and, if needed, speech-language pathology services, social services, psychological services (including neuropsychological services) and orthotic and prosthetic services; and • All IRF unit professional staff that provide the above-stated services have current licenses and certifications, as applicable.			
A3610	**§412.29 (g)** Have a director of rehabilitation who-	Verifies the rehab hospital has a director of rehabilitation by reviewing personnel logs or rosters and organization charts.	The IRF hospital representative will verify that the IRF hospital has a Director of Rehabilitation.			

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A3611	**§412.29 (g)(1)** Provides services to the IRF hospital and its inpatients on a full-time basis.	The hospital will: • Verify the full-time hours through review of personnel time cards/logs, etc. • Define the term "full-time" as it applies to all of its employees. • The full-time hours may be any combination of patient services and administration. • A director of rehabilitation hours cannot be substituted by a Physician Assistant.	The IRF hospital representative will verify that the IRF hospital director provides service to the IRF hospital and its patients on a full-time basis.			
A3612	**§412.29(g)(2)** Is a doctor of medicine or osteopathy;	Review the physician's license to verify the physician is an MD or DO.	The IRF hospital representative will verify that the Director of Rehabilitation is a physician with current, valid licensure as an MD or DO.			
A3613	**§412.29(g)(3)** Is licensed under State law to practice medicine or surgery;	Surveyor will verify the physician has a current license issued by the State, as appropriate.	The IRF hospital representative will verify that the Director of Rehabilitation holds current, unexpired licensure as a physician in the State in which the IRF hospital is located.			

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A3614	**§412.29(g)**(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 IRF hospital representative will verify that the director of the IRF hospital has at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services (after completing 1 year of residency).			
A3615	**§412.29(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 IRF hospital representative will verify that the IRF hospital has an established plan of treatment for each inpatient that is prepared, reviewed and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.			

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A3616	**§412.29(h)(i)** Use a coordinated interdisciplinary 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 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 requirement.	The IRF hospital representative will verify whether the IRF hospital has an interdisciplinary team that meets once weekly to review patient progress and that documentation of this is put in each patient's medical record.			
A3617	**§412.29(h)(j)** Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in§ 412.1(a)(1) and paid under the prospective payment system specified in § 412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in § 412.130.	If the new IRF's inpatient population doesn't meet the 60% rule, the IRF will lose its IPPS exclusionary status. The RO will send notification to the facility prior to the beginning of the next cost report period that the facility has lost its IPPS excluded status and will revert to acute care hospital status.				

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ATTESTATION STATEMENT

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal and state laws.

I hereby certify that the responses in this form are true and correct to the best of my knowledge, information and belief.

Printed Name of IRF Hospital Representative:	**Title of IRF Hospital Representative:**
Signature of IRF Hospital Representative:	**Date Signed:**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0986 (Expires XX/XX/20XX)**. This is a **mandatory** (required to obtain payment from Medicare) information collection. The time required to complete this information collection is estimated to average **4 hours** 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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REHABILITATION HOSPITAL CRITERIA WORK SHEET (CMS-437B)

INSTRUCTIONS

1. The CMS-437B form is to be used by Inpatient Rehabilitation Facility (IRF) **hospitals** to attest to meeting the criteria set forth at 42 CFR, Subchapter B, Part 412, sections 412.25 and 412.29 to be excluded from the Medicare Hospital Inpatient Prospective Payment System (IPPS).

2. All criteria of sections 412.23 and 412.29 must be met by the IRF hospital in order to qualify for exclusion from Medicare's Hospital Inpatient Prospective Payment System (Hospital IPPS) or from the payment system used to pay Critical Access Hospitals (CAHs).

3. The hospital representative is expected to answer all questions accurately.

4. A **"Yes"** response indicates that the IRF **hospital** has complied with the applicable regulations. A **"No"** response indicates that the IRF **hospital** has not complied with the regulation. An **"N/A"** response indicates that the regulation section does not apply to that IRF **hospital.**

5. The IRF hospital representative completing this form should have all answers verified by the director of rehabilitation, medical director, medical records office, or any applicable facility management staff to ensure the accuracy of all responses.

6. The IRF hospital must submit the completed and verified CMS-437B form to the CMS Location via the State Survey Agency for their State.

7. The information and attestations contained in a CMS-437B form submitted by an IRF hospital may be verified by the State Survey Agency, CMS Location, or MAC, as applicable.