



CRRN –Inpatient Rehabilitation Legislation

Presented By:

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Disclaimer: The information provided in this presentation is subject to revision based upon future updates and clarifications by ARN and other Leaders on the legislative history of IRFs. Please consult with available resources.

I have no financial relationships to disclose; no conflicts of interests to disclose; and will not promote any commercial products or services. Thank You.

1



Purpose of Presentation

- **The intent of this presentation is to review/discuss the evolution of inpatient rehabilitation in the U.S. which occurred through a series of Federal laws, Acts, and Medicare payment reforms, culminating in the IRF PPS established in 1997.**

Primary Presentation Resources:

***ARN. The Specialty Practice of Rehabilitation Nursing – 8th Edition.
Chapters 1 & 7 (2019)***

CMS: Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Regulatory and Legislative History (2026)

2

Rehab Nurses Involvement

- The processes of developing, implementing, and modifying government policies provide opportunities for rehabilitation nurses to share their expertise with local, State, and Federal government agencies, legislators, and others.
- Rehabilitation nurses' unique knowledge and understanding of the needs of people with disabilities position them to advocate for health policy changes.

3

Laws Governing Access To Health Care

- **National Defense Act of 1916:** Authorized Federal funding for rehabilitation of veterans (World War I soldiers) & overhauled U.S. military (expansion of Army & National Guard).
- **Smith-Hughes Act (1917); Smith-Sears Veterans Rehabilitation Act (1918); & Smith-Fess Act (1920):** Supported vocational and rehabilitation training by mandating vocational training opportunities for those with disabilities. Amendments in 1943, 1954, and 1965 addressed rehabilitation needs of wounded soldiers.

4

Laws Governing Access To Health Care

- **Social Security Act of 1935 (amended 1954 and 1975):**

- ✓ Established an income maintenance system for those unable to work and included provisions for medical and therapeutic service for children with disabilities.
- ✓ Established permanent vocational rehab programs.
- ✓ Established Social Security Disability Insurance (1954).
- ✓ Mandated vocational rehabilitation with use of Social Security Disability Insurance funds (1965).
- ✓ Made people with disabilities eligible for Medicare medical benefits (1972).

5

Laws Governing Access To Health Care

- **Vocational Rehabilitation Act (amended 1954 and 1965):**

- Expanded services for *mentally retarded/mentally ill* (1954),*
- Expanded the definition of term *handicapped* (1965).*
- Established Federal grants to states for development of statewide service delivery systems (1965).
- Established Federal funding for rehabilitation centers (1965).

* *Next slide addresses terms.*

6

Laws Governing Access To Health Care (continued)

- In 2010, the U.S. government enacted Rosa's law which removed all uses of the terms "*mental retardation*" and "*mentally retarded*" from government use, law & policies. "**Intellectual disability**" and "**individual with an intellectual disability**" is the preferred official and legal terms.
- The term "*mentally ill*" is generally considered outdated and potentially stigmatizing; person-first language like "**a person with a mental health condition**" is preferred.
- "*Handicapped*" historically referred to people with physical or mental conditions that make certain activities difficult, but **modern language considers it offensive** when describing individuals

7

Medicare – History

- Early proposals for national health insurance date back to Theodore Roosevelt's 1912 campaign. President Harry S. Truman called for a national health insurance program in 1945, 1947, and 1949, but Congress did not act.
- In 1961, President John F. Kennedy's task force recommended a national health insurance program for Americans over 65.
- By the early 1960s, more than half of Americans over 65 lacked hospital insurance, strengthening calls for reform.
- **Medicare was signed into law on July 30, 1965, by President Lyndon B. Johnson, with coverage beginning in 1966 and initially providing Part A (hospital insurance) & Part B (medical insurance) for Americans aged 65 & older.**

8

Medicare – History (continued)

- Medicare is a Federal Health Insurance Program under the authority of the U.S. DHHS. It began with the enactment of Title XVIII of the Social Security Act of 1965.
- Former President Truman received the first Medicare card.
- Medicare coverage took effect in **1966**, enrolling 19 million people in its first year.
- **Original Medicare/Traditional** included:
 - Part A:** Hospital insurance (no premium for those with sufficient payroll contributions).
 - Part B:** Optional medical insurance with a monthly premium (initially \$3).

9

Medicare – History (continued)

- **1972:** Coverage extended to people under 65 with long-term disabilities, Social Security Disability Insurance recipients, and those with End-Stage Renal Disease (ESRD).
- **1980s:** Standardization of Medigap supplemental plans and Hospice benefits added to Medicare.
- **1990s:** Creation of cost-assistance programs (Extra Help, Medicare Savings Programs) and launched Medicare Part C (Medicare Advantage).
- **2010:** Affordable Care Act expanded preventive services, improved care coordination, and closed the Part D “donut hole” (coverage gap) - officially closed January 01, 2025 (temporary coverage phase where patients had to pay a much higher share of their prescription drug costs out of pocket).

10



Medicare – Currently

- **2020s:** Medicare enrollment expanded during COVID-19.
- Medicare spending reached **\$1.03 trillion in 2023**, about 21% of national health expenditures.
- **As of 2025**, Medicare covers **about 69 million Americans**, roughly 20% of the U.S. population.
- Coverage now includes **Parts A**–hospital care, **B**–medical services, **C**–Advantage Plan, and **D**–prescription drugs.
- Eligibility extended to younger individuals with disabilities or specific medical conditions (ESRD & Lou Gehrig’s Disease).
- Medicare’s evolution reflects ongoing efforts to expand access, improve quality, and adapt to the healthcare needs of an aging population.

11



Medicaid – Foundation

- Began with the enactment of Title XIX of the Social Security Act of 1965.
- Health insurance program for certain individuals and families with low income and resources. Provides medical assistance to people and families receiving cash assistance (i.e. welfare)*.
- Expanded in 2014 to cover healthcare and long-term care services for specific categories; people younger than 65 years with an income of up to 133% of the Federal poverty level (The Henry J. Kaiser Family Foundation).
- Managed by each State through State agency with oversight from CMS. Financed by Federal-State partnership in which the Federal government matches State Medicaid spending.

12

Medicaid – Foundation (continued)

- Covers a wide range of healthcare and long-term care services; mental health care; and services/support for people with disabilities. Comprehensive services for children covered.
- Covered services vary by State; some States require enrollment in a managed care plan.
- Assist low-income Medicare beneficiaries, referred to as “dual eligibility.”
- Largest funding source for coverage of long-term care.
- People qualify if they meet the financial criteria; belong to one of the groups that are “categorically” eligible for the program; and are an American citizen

13

Medicaid - Foundation

- To be eligible for Federal funds, States are required to provide coverage for “mandatory” groups as follows:
 - Families with limited incomes with children who meet certain eligibility requirements in the State’s Aid to Families with Dependent Children.
 - Most older adults and people with disabilities who receive Supplemental Security Income.
 - Children younger than 6 years.
 - Pregnant women whose family income is at or below 133% of Federal poverty level.
 - Children ages 6-18 years living below 100% of Federal poverty level.

14

Private Health Insurance

- Employers and other organizations can purchase private health insurance on behalf of a group of individuals/employees.
- ❖ Purchasing groups often negotiate coverage, so benefits vary by group.
- ❖ Group members/employees contribute to the insurance premium.
- ❖ Alternately, an individual can purchase private health insurance through a State Marketplace.

15

Other Health Insurance Plans

- **Indemnity Plans:** Provides comprehensive coverage for medical and hospital services and employers usually negotiate coverage. Employer or employee/subscriber pays a premium, deductible, copayments and amounts over the usual/customary rate to receive services from physicians, hospitals or qualified providers of choice and are medically necessity.
- **Managed Care Plans:** Provides set of medical or hospital care services for fixed, predetermined premium. MCO can restrict subscriber's choice of providers and control access and subscriber is usually assigned a primary care physician who acts as gatekeeper and is under contract with MCO. This plan can include precertification of elective admissions and case management of catastrophic cases.

16

Other Health Insurance Plans (continued)

- **Health Maintenance Organization/HMO:** This is an organized healthcare system that is responsible for both financing and delivery of a broad range of healthcare services to enrollee. HMOs must ensure that their members have access to covered healthcare services and are responsible for the quality and appropriateness of these services.
- **Preferred Provider Organization/PPO:** This plan gives members flexibility in choosing healthcare providers. It features a **network of preferred providers**, offering the highest coverage when using in-network doctors, hospitals, or facilities. Non-PPO providers are allowed, but out-of-pocket costs will generally be higher. PPOs do not require a primary care physician (PCP) referral to see a specialist, making it more convenient for direct access to care

17

Other Health Insurance Plans (continued)

- **Point of Service:** These plans offer enrollees some indemnity-type coverage but typically have high deductibles and coinsurance to encourage use of HMO-type services.
- **Consumer-Driven Healthcare:** This program involves employers providing employees with a personal care account of fixed amount in form of voucher, refundable tax credit, higher wages, or some other transfer of funds. Employees choose services/providers & manage own healthcare spending.
- **Auto Liability:** This plan covers medical care needed as a result of MVA and are often limited (dollars available).

18

Other Health Insurance Plans (continued)

- **TRICARE – Department of Defense’s Health Insurance:** Insurance program provides civilian health benefits for military service members, retirees and dependents, including some members of the Reserves. Veterans of any age, except those dishonorably discharged, can apply for this medical benefits. To receive benefits from the VA Medical Benefits Package, the person must be a veteran, enrolled in VA Health System and receive health care at VA facilities. Program managed by TRICARE Management Activity (authority of U.S. Assistant Secretary of Defense for Health Affairs).

19

Other Health Insurance Plans (continued)

- **Indian Health Service (IHS):** Administered by Department of HHS; provides hospital care, dental and health benefits, substance abuse counseling, public health nursing and other services. IHS services administered through 12 area offices and 161 IHS and tribally managed service units. Eligibility is limited to members of the 564 Federally recognized Indian tribes and descendants.

20

Table 7-1. Funding Sources for Healthcare and Rehabilitation Programs

Program	Medicare (Federal)	Medicaid (State)	Workers' Compensation	Private Health Insurance
Eligibility requirements	Must be >65 years, have end-stage renal disease, or have been disabled for 2 years	For people with low income	Workers injured in the course of employment	Policyholders
Benefits	Part A—Hospital Part B—Supplemental medical insurance Part C—Medicare Advantage plans Part D—Prescription drug coverage	Hospital costs and visits to a physician	Medical care for a work-related injury Income support during periods of disability	Hospital costs and outpatient treatment, as specified in policy Physician visits, as specified in policy May or may not cover rehabilitation care

From The Specialty Practice of Rehabilitation Nursing: A Core Curriculum (3rd ed., p. 227), by A. E. McCourt (Ed.), 1993, Skokie, IL: Association of Rehabilitation Nurses. Copyright 1993 Association of Rehabilitation Nurses.

21

Laws Governing Access To Health Care

• Workers' Compensation (1910 – 1973):

- Government sponsored and employee-financed systems for compensating employees who incur an injury or illness in connection with their employment.
- Provided income and medical benefits for injured workers;
- Established primary goal of returning worker to pre-injury level of employment;
- Obtained private-sector services with focus on:
 - Medical case management;
 - Consultation about job restructuring;
 - Survey of labor market.

Development of “Life Care Plan.”

22

Laws Governing Equal Access

- Rehabilitation Act of 1973 (amended 1974 & 1976):

- ❖ Addressed equal access for people with disabilities by increasing services for those with disabilities including:

Affirmative Action: Developing/designing policies and procedures to eliminate unlawful discrimination, remedy the effects of past discrimination, and promote equal opportunity in education and employment.

Architectural Barriers: Removing physical obstacles that prevent people with disabilities from entering, moving through, or using a building. These physical features limit access to goods, services, and public spaces

23

Laws Governing Equal Access

(continued)

- Rehabilitation Act of 1973 (amended 1974 & 1976):

Discrimination in Employment: Requiring employer to treat qualified job applicants or employees favorably (i.e. individual/applicant/employee with physical or mental disability, a history of a disability, or perceived as having a disability).

Accessibility of Electronic Information Technology: Developer designs digital tools, websites, and electronic documents so people with disabilities can use them equally and independently.

24

Laws Governing Equal Access

(continued)

Public Education for all Students with Disability:

Mandates that State and local governments, including all public K-12 and charter schools, from discriminating based on a disability. It requires physical access, equal program access, and reasonable modifications

In summary: U.S. public education for students with disabilities is grounded in civil rights laws that guarantee equal access, individualized support, and inclusion (Disabilities Education Act/IDEA and Section 504 of the Rehabilitation Act of 1973 as primary legal protection).

25

Laws Governing Access To Health Care

(continued)

- **Rehabilitation Act of 1973 (amended 1974 & 1976):**

- ❖ Included with this legislation was the *right of students* to receive services such as:

- Speech Therapy;
- Audiology;
- Physical Therapy;
- Occupational Therapy;
- Psychological Counseling; and,
- Medical Counseling and Care.

26

Laws Governing Access To Health Care (continued)

- Rehabilitation Act of 1973 (amended 1974 & 1976):

- ❖ Established funding for research.
- ❖ Emphasized program evaluation.
- ❖ Included a comprehensive needs study.
- ❖ **Established Federal funding for independent living.**

27

Laws Governing Access To Health Care (continued)

- Rehabilitation, Comprehensive Services and Development Disabilities Amendments of 1978:

- ❑ Provided Federal funding for:
 - Counseling
 - Physical rehabilitation**
 - Case Management
 - Therapeutic treatment
 - Equipment needs

28

Laws Governing Equal Access

(continued)

- Rehabilitation, Comprehensive Services and Development Disabilities Amendments of 1978:

- ❑ Established Federal grants to States for:
 - Independent living centers;
 - Services for the blind;
 - Promoting employment capabilities;
 - Promoting independent community living.

29

Laws Governing Equal Access

(continued)

- Americans with Disabilities Act (ADA) of 1990:

- Established civil right for individuals with disabilities.
- ADA ensures:
 - Equal employment opportunities;
 - State and local government services;
 - Public and private transportation;
 - Public accommodations;
 - Access to telephone services.

30

Signing of ADA by President George Bush – July 26, 1990



31

ADA (continued)

- The ADA is a civil rights law that prohibits public and private discrimination against people with disabilities. The intent of the law is to ensure that people with disabilities have the same rights and opportunities as everyone else. The “Titles” associated with the ADA include:
- **Title I (Employment):** Prohibits discrimination against qualified people with disabilities in any area of employment including reasonable accommodations. It applies to employers with 15 or more employees. People with disabilities have access to the same employment opportunities and benefits as people without disabilities.

32

ADA (continued)

- **Title II (Public Services):** Provides civil rights for qualified people; addresses public services at the State and local level and prohibits discrimination on the basis of disability by “public entities”(State and local government agencies). It requires that public entities make their programs, services including public transportation and other activities accessible to people with disabilities and outlines requirement for making reasonable modification to policies, practices, and procedures where necessary to avoid discrimination (i.e. architectural barriers, effective communication with people with hearing, vision and speech disabilities; etc.).

33

ADA (continued)

- **Title III (Public Accommodations):** Affects almost all private businesses, services, agencies, public accommodations (hotels, restaurants, retail merchants, doctor’s offices, golf courses, schools, day care, etc.). Also, requires the removal of architectural and communication barriers when it is readily feasible to do so. New construction is to be accessible, including alterations for existing buildings.
- **Title IV (Telecommunications):** Reformed the national telephone system and internet companies to include people with hearing and speech impairments. Providers of telephone service must provide “relay” service. Relay operators enable people using telecommunications devices for the deaf to talk to others using regular phones. This includes “closed caption.” ³⁴

ADA (continued)

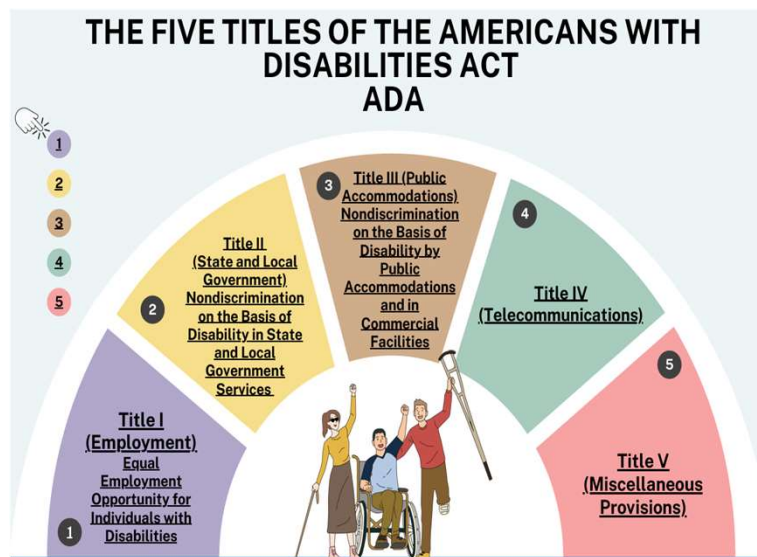
- **Title V (Miscellaneous Provisions):** Established an access board to issue guidelines to ensure that facilities and vehicles are accessible to persons with disabilities. Additional provisions include anti-retaliation protections, State immunity, guidelines for enforcement, construction for ADA, etc.

Resources:

ARN. The Specialty Practice of Rehabilitation Nursing – 8th Edition. Chapters 1 & 7 (2019)

ADA.gov: “Americans with Disabilities Act of 1990, As Amended” (website accessed 08/2026)

35



36

Assistive Technology Act of 1998

- This Act (as amended), supports the State's efforts to provide direct aid to people with disabilities to ensure that they have access to needed assistive technology devices and services.
- Assistive Technology refers to any item, piece of equipment, or product system (whether acquired commercially, off the shelf, modified, or customized), that is used to increase, maintain, or improve the functional capabilities of people with disabilities.
- Insurance programs do not pay for assistive-devices if they are not considered medically necessary.

37

Patient Protection & Affordable Care Act (2010)/ACA– Known as Obamacare

- This Act focuses on increasing the availability of health insurance by expanding Medicaid eligibility and introducing State Insurance Markets.
- The Act initially mandated that individuals buy insurance and that insurers cover a list of essential health benefits (later repealed).
- Insurers in these markets accept all applicants and charge the same rates, regardless of preexisting conditions or sex.
- By 2016, estimated that 20-24 million people were covered. As of 2024, **approximately 45 million individuals** were enrolled in some form of ACA-related health insurance.

38



Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- The intent of this Act was to standardize post-acute care data to improve Medicare beneficiary outcomes through shared decision making, care coordination & enhanced D/C planning.
- This Act requires the submission of standardize data:
 - LTCH: Long-Term Care Hospital/CARE Data Set (13 pages)*
 - SNF: Minimum Data Set/MDS (49 plus pages)*
 - HHA: Outcome/Assessment Information Set/OASIS (36 pages)*
 - IRF: Inpatient Rehabilitation Facility Patient Assessment Instrument (30 pages)***

* Admission Assessments

39



Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- The areas of standardized assessment are functional status; cognitive function and mental status; special services; treatments and interventions; medical conditions and comorbidities; impairments, etc.
- This Act requires the implementation of quality and resource use measures. Quality measure include skin integrity and changes; functional status; cognitive function; changes in function and cognitive function; medications; incidence of major falls; transfer of health information, etc.
- The resource measure may include estimated Medicare spending per beneficiary, D/C to community, preventable hospital readmissions rate, etc.

40

IRF PPS and Payment Reform

(1997 – Present)

Balance Budget Act of 1997: Created the IRF-PPS, replacing the prior cost-based payment system for inpatient rehabilitation hospitals and units. This reform mandated the IRF PPS to promote efficiency and quality in inpatient rehabilitation.

FY 2002 IRF PPS Final Rule: Authorized under **section 1886(j) of the Social Security Act.** Implemented per-discharge payment rates based on clinical case-mix groups (CMGs), comorbidities, and patient characteristics. This covers operating and capital costs for covered rehabilitation services,

41

IRF PPS and Payment Reform

(continued)

- For FY 2002, CMS used **100 case-mix groups (CMGs)** defined/organized across 21 Rehabilitation Impairment Categories/RICs based on primary reason for admission, functional motor/cognitive scores, age and comorbidity tiers.
- For FY 2020, CMS started using **95 Clinical CMGs** defined by RICs. 5 additional CMGs existed outside the standard 95 to account for unique scenarios (short stays or patient deaths).
- For FY 2027, the 95 Clinical CMGs continue as well as the 5 additional CMGs and four comorbidity tiers.
- NOTE: In 2002, there were three (3) Tiers: Highest Severity– Moderate - Low. In 2007, each of the CMGs were split into four payment tiers based on presence & severity of patient's comorbidities: Tiers A – B – C - D.

42

IRF PPS and Payment Reform (continued)

- To qualify for payment under Medicare's Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), a facility & admitted patients must meet strict clinical, coverage, and documentation criteria outlined as follows:
- **Comprehensive Preadmission Screening (PAS):** Completed prior to admission (or updated within 48 hours) detailing the medical necessity, prior function, expected measurable improvement, etc. (closely monitored by external reviewers).
- **Intensity of Therapy:** Patients must generally be able to tolerate and reasonably benefit from an intensive rehabilitation program, traditionally requiring at least 3 hours of therapy per day or an equivalent intensive, coordinated schedule.

43

IRF PPS and Payment Reform (continued)

- **36-Hour Initiation Rule:** All required therapy treatments and evaluations ordered for an IRF patient must start within 36 hours from midnight on the day of admission (PT, OT, SLP).
- **Physician Supervision:** Patient requires active, ongoing care from rehab physician, including face-to-face visits at least 3 days per week throughout the stay (qualified non-physician practitioner may conduct 1 of 3 visits starting in week two).
- **Individualized Plan of Care (POC):** Synthesized and approved by the rehabilitation physician within 4 days of admission with input from interdisciplinary team.

44

IRF PPS and Payment Reform (continued)

- **Interdisciplinary Team (IDT):** Initial IDT meeting must occur on or before the 4th day from midnight on date of admission, with subsequent meetings conducted weekly.
- **IRF Patient Assessment Instrument (IRF-PAI):** Completed and submitted accurately to classify the patient into the correct case-mix group for proper reimbursement under the [Inpatient Rehabilitation Facility PPS - CMS](#) guidelines.
- **60% Rule:** At least 60% of the facility's total inpatient population must require active and intensive treatment for one or more of 13 specific qualifying conditions (such as stroke, SCI, major multiple trauma, orthopedic disorder, etc.)

45

Review Choice Demonstration (RCD)

- Beginning August 21, 2023, CMS implemented the Review Choice Demonstration (RCD) for IRF services, covered by Traditional Medicare, in Alabama with follow up expansions: Pennsylvania (6/17/2024); Texas (3/02/2026) and California (May 01, 2026). CMS will be expanding the RCD to all IRFs that bill MAC Jurisdiction J, regardless of the State in which they are physically located, effective January 1, 2027.
- According to CMS, the purpose of RCD is to improve compliance and reduce appeals for IRF Providers.
- IRF Providers were required to make their review choice selection of either 100% pre-claim review or 100% post-payment review. Dates were provided for the “selection period start date as well as the end date.”

46



Review Choice Demonstration (RCD) (continued)

- **Choice 1 – Pre-Claim Review (PCR):** Medicare reviews claims before payment; services can start before review, but claim must be approved before payment.
- **Choice 2 – Post-Payment Review:** IRF provides services and submits claims normally; Medicare reviews after payment, requesting additional documentation if needed.
- Most IRFs selected “Pre-Claim Review.”
- With the “start up” for RCD, CMS provided resources for the IRF Providers including the [“IRF RCD Medical Review Checklist”](#) and an [“IRF RCD Patient Fact Sheet.”](#)

47



Review Choice Demonstration (RCD) (continued)

- In an effort to provide transparency to the IRF Provider community, CMS provided additional resources/documents including [“IRF RCD Helpful Hints”](#); [“IRF RCD Fiscal Year \(FY\) 2024 Quarterly Updates”](#); “Statistics on the IRF RCD by CMS”; as well as “Cycle Reports” covering involved States.
- The Medicare Administrator Contractors/MACs were tasked with reviewing IRF documentation submitted by IRF Provider to determine whether beneficiaries meet the RCD coverage requirements per “CMS’ Medicare Benefit Policy Manual.”
- MACs included Alabama - Palmetto GBA; Pennsylvania & Texas -Novitas Solutions; and California - Noridian. Each MAC have additional documentation requirements for RCD.

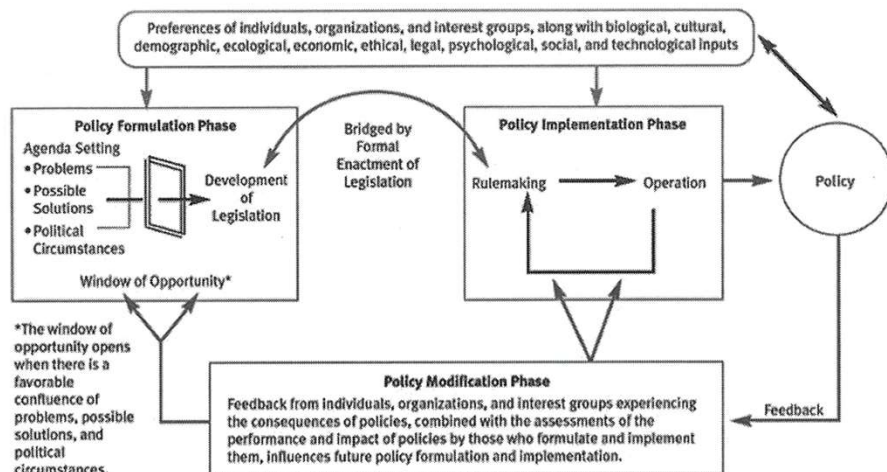
48

Health Policy-Development/Modification

- **Nurses interested in influencing healthcare policy** should have a basic understanding of the phases/stages of policymaking:
 - Policy Development (agenda setting)
 - Development of Legislation (proposals/bills drafted by members of Congress or **interest groups/individual citizens**).
- Note: Only members of Congress can officially sponsor bill
- Congress Assignment/Committee Review (hearings held)
 - Approval by both chambers of Congress required.
 - President's signature or veto OR
 - Veto overridden by two-thirds vote in both houses of Congress.
- See next slide for outline of public policymaking process.

49

Figure 7-2. A Model of the Public Policymaking Process in the United States



From Health Policymaking in the United States (p. 54), 2009, by B. B. Longest, Jr. Copyright 2009 by Health Administration Press. Reprinted with permission.

50



Health Policy-Development/Modification

- Once law is passed, implementation rests with the executive branch. Cabinet departments (HHS & agencies such as CMS and CDC) responsible for the implementation.
- Oversight responsibilities includes the Government Accountability Office, Congressional Budget Office, Congressional Research Office, and Office of Technology & Assessment.
- “Notice of Proposed Rulemaking” and “Final Rule” is published in the Federal Register.
- Once policy implemented, there may be modifications which must begin with the agenda-setting stage.

51



Resources - Summary

- **ARN:** “The Specialty Practice of Rehabilitation Nursing: A Core Curriculum, 8th edition (2019)”
- **ARN Website:** Rehabnurse.org.
- **CMS Website** - CMS.gov.
- **Medicare Website** – Medicare.gov
- **Additional Medicare Resource** - <https://www.medicarefaq.com/>

52



Thank you for participating in this CRRN Review Course. We appreciate all that you do for our Rehab Teams and Rehab Patients.

53

If you have any questions, you are welcome to contact me:

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Thank You.

54