

requirements in § 412.23(b)(2), CMS adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130 of this part.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43420, Aug. 30, 1991; 57 FR 39821, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45847, Sept. 1, 1995; 62 FR 46027, Aug. 29, 1997; 68 FR 45699, Aug. 1, 2003; 69 FR 25776, May 7, 2004]

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.40 General requirements.

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.

(b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—

(1) Withhold Medicare payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

(2) Terminate the hospital's provider agreement.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992]

§ 412.42 Limitations on charges to beneficiaries.

(a) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

(b) *Permitted charges—Stay covered.* A hospital receiving payment under the prospective payment systems for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the following:

(1) The applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter.

(2) Noncovered items and services, furnished at any time during a covered

stay, unless they are excluded from coverage only on the basis of the following:

(i) The exclusion of custodial care under § 405.310(g) of this chapter (see paragraph (c) of this section for when charges may be made for custodial care).

(ii) The exclusion of medically unnecessary items and services under § 405.310(k) of this chapter (see paragraphs (c) and (d) of this section for when charges may be made for medically unnecessary items and services).

(iii) The exclusion under § 405.310(m) of this chapter of nonphysician services furnished to hospital inpatients by other than the hospital or a provider or supplier under arrangements made by the hospital.

(iv) The exclusion of items and services furnished when the patient is not entitled to Medicare Part A benefits under subpart A of part 406 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished when the patient is not entitled to benefits).

(v) The exclusion of items and services furnished after Medicare Part A benefits are exhausted under § 409.61 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished after benefits are exhausted).

(c) *Custodial care and medically unnecessary inpatient hospital care.* A hospital may charge a beneficiary for services excluded from coverage on the basis of § 411.15(g) of this chapter (custodial care) or § 411.15(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

(1) The hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care. (The phrase "inpatient hospital care" includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF-level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care

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because either a SNF-level bed has become available or the patient no longer requires SNF-level care.)

(2) The attending physician agrees with the hospital's determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the QIO. Concurrence by the QIO in the hospital's determination will serve in lieu of the physician's agreement.

(3) The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or person acting on his or her behalf) in writing that—

(1) In the hospital's opinion, and with the attending physician's concurrence or that of the QIO, the beneficiary no longer requires inpatient hospital care;

(ii) Customary charges will be made for continued hospital care beyond the second day following the date of the notice;

(iii) The QIO will make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital after he or she is liable for charges;

(iv) The determination of the QIO made after the beneficiary received the purportedly noncovered services will be appealable by the hospital, the attending physician, or the beneficiary under the appeals procedures that apply to QIO determinations affecting Medicare Part A payment; and

(v) The charges for continued care will be invalid and refunded if collected by the hospital, to the extent that a finding is made that the beneficiary required continued care beyond the point indicated by the hospital.

(4) If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, se-

cures concurrence, and notifies the beneficiary, as required in paragraphs (c)(1), (c)(2), and (c)(3) of this section.

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under § 405.310(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

(1) In the hospital's opinion, which has been agreed to by the intermediary, the services to be furnished are not considered reasonable and necessary under Medicare.

(2) Customary charges will be made if he or she receives the services.

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the QIO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.

(5) The charges for the services will be invalid and, to the extent collected, will be refunded by the hospital if the services are found to be covered by Medicare.

(e) *Services furnished on days when the individual is not entitled to Medicare Part A benefits or has exhausted the available benefits.* The hospital may charge the beneficiary its customary charges for noncovered items and services furnished on outlier days (as described in Subpart F of this part) for which payment is denied because the beneficiary is not entitled to Medicare Part A or his or her Medicare Part A benefits are exhausted. (1) If payment is considered

for outlier days, the entire stay is reviewed and days up to the number of days in excess of the outlier threshold may be denied on the basis of non-entitlement to Part A or exhaustion of benefits. (2) In applying this rule, the latest days will be denied first.

(f) *Differential for private room or other luxury services.* The hospital may charge the beneficiary the customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or the request of the person acting on his or her behalf).

(g) *Review.* (1) The QIO or intermediary may review any cases in which the hospital advises the beneficiary (or the person acting on his or her behalf) of the noncoverage of the services in accordance with paragraph (c)(3) or (d) of this section.

(2) The hospital must identify such cases to the QIO or intermediary in accordance with CMS instructions.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 54 FR 41747, Oct. 11, 1989; 57 FR 39821, Sept. 1, 1992]

§ 412.44 Medical review requirements: Admissions and quality review.

Beginning on November 15, 1984, a hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(a) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges.

(b) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter.

(c) The validity of the hospital's diagnostic and procedural information.

(d) The completeness, adequacy, and quality of the services furnished in the hospital.

(e) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

[50 FR 15326, Apr. 17, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 50 FR 41886, Oct. 16, 1985]

§ 412.46 Medical review requirements: Physician acknowledgement.

(a) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

(b) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(c) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

[60 FR 45847, Sept. 1, 1995]

§ 412.48 Denial of payment as a result of admissions and quality review.

(a) If CMS determines, on the basis of information supplied by a QIO that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may as appropriate—