

(h) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(i) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that re-

solved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[65 FR 47106, Aug. 1, 2000, as amended at 66 FR 32192, June 13, 2001; 70 FR 47485, Aug. 12, 2005]

**§ 412.78 Recovery of excess transition period payment amounts resulting from unlawful claims.**

If a hospital's base-year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base-period costs are adjusted to remove the effect of the excess costs, and CMS recovers both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39822, Sept. 1, 1992. Redesignated at 65 FR 47106, Aug. 1, 2000]

**Subpart F—Payment for Outlier Cases and Special Treatment Payment for New Technology**

**PAYMENT FOR OUTLIER CASES**

**§ 412.80 Outlier cases: General provisions.**

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in

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paragraph (b) of this section concerning transferring hospitals, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the following conditions is met:

(i) The beneficiary's length-of-stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length-of-stay for the applicable DRG by the lesser of the following:

(A) A fixed number of days, as specified by CMS; or

(B) A fixed number of standard deviations, as specified by CMS.

(ii) The beneficiary's length-of-stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in § 412.84(h), exceed the DRG payment for the case, payments for indirect costs of graduate medical education (§ 412.105), and payments for serving disproportionate share of low-income patients (§ 412.106), plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments and beyond

additional payments for new medical services or technology specified in §§ 412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§ 412.105), payments for serving a disproportionate share of low-income patients (§ 412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(b) *Outlier cases in transferring hospitals.* CMS provides cost outlier payments to a transferring hospital for cases paid in accordance with § 412.4(f), if the hospital's charges for covered services furnished to the beneficiary, adjusted to costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS, divided by the geometric mean length of stay for the DRG, and multiplied by an applicable factor determined as follows:

(1) For transfer cases paid in accordance with § 412.4(f)(1), the applicable factor is equal to the length of stay plus 1 day.

(2) For transfer cases paid in accordance with § 412.4(f)(2), the applicable factor is equal to 0.5 plus the product of the length of stay plus 1 day multiplied by 0.5.

(c) *Publication and revision of outlier criteria.* CMS will issue threshold criteria for determining outlier payment in the annual notice of the prospective payment rates published in accordance with § 412.8(b).

[62 FR 46028, Aug. 29, 1997, as amended at 63 FR 41003, July 31, 1998; 66 FR 46924, Sept. 7, 2001; 67 FR 50111, Aug. 1, 2002]

### **§ 412.82 Payment for extended length-of-stay cases (day outliers).**

(a) For discharges occurring before October 1, 1997, if the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary