

§ 412.374

for inpatient hospital capital-related costs.

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) *FY 1998 through FY 2004.* Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) *FY 2005 and FYs thereafter.* For discharges occurring on or after October 1, 2004, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 25 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 75 percent of the Federal rate, as determined under § 412.308.

(c) Effective for fiscal year 1998, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997, is reduced by 15.68 percent.

(d) For discharges occurring on or after October 1, 1997 through September 30, 2002, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997 is further reduced by 2.1 percent.

[62 FR 46032, Aug. 29, 1997, as amended at 69 FR 49250, Aug. 11, 2004]

Subpart N—Prospective Payment System for Inpatient Hospital Services of Inpatient Psychiatric Facilities

SOURCE: 69 FR 66977, Nov. 15, 2004, unless otherwise noted.

§ 412.400 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 124 of Public Law 106-113, which provides for the implementation of a

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per diem-based prospective payment system for inpatient hospital services of inpatient psychiatric facilities.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for the inpatient hospital services of inpatient psychiatric facilities, including the methodology used for the development of the Federal per diem rate, payment adjustments, implementation issues, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2005, payment for the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined payment amount applied on a per diem basis.

§ 412.402 Definitions.

As used in this subpart—

Comorbidity means all specific patient conditions that are secondary to the patient's primary diagnosis and that coexist at the time of admission, develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

Federal per diem base rate means the payment based on the average routine operating, ancillary, and capital-related cost of 1 day of hospital inpatient services in an inpatient psychiatric facility.

Federal per diem payment amount means the Federal per diem base rate with all applicable adjustments.

Fixed dollar loss threshold amount means a dollar amount which, when added to the Federal payment amount for a case, the estimated costs of a case must exceed in order for the case to qualify for an outlier payment.

Inpatient psychiatric facilities means hospitals that meet the requirements as specified in § 412.22, § 412.23(a), § 482.60, § 482.61, and § 482.62, and units that meet the requirements as specified in § 412.22, § 412.25, and § 412.27.

Interrupted stay means a Medicare inpatient is discharged from an inpatient psychiatric facility and is admitted to

any inpatient psychiatric facility within 3 consecutive calendar days following discharge. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of the third day.

New graduate medical education program means a medical education program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after November 15, 2004.

Outlier payment means an additional payment beyond the Federal per diem payment amount for cases with unusually high costs.

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility also referred to as primary diagnosis. Principal diagnosis is also referred to as primary diagnosis.

Qualifying emergency department means an emergency department that is staffed and equipped to furnish a comprehensive array of emergency services and meeting the definitions of a dedicated emergency department as specified in § 489.24(b) of this chapter and the definition of “provider-based status” as specified in § 413.65 of this chapter.

Rural area means for cost reporting periods beginning January 1, 2005, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2006, an area as defined in § 412.62(f)(1)(iii). For discharges occurring on or after July 1, 2006, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

Urban area means for cost reporting periods beginning on or after January 1, 2005, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2006, an area as defined in § 412.62(f)(1)(ii). For discharges occurring on or after July 1, 2006, urban area means an area as defined in § 412.64(b)(1)(ii)(A) and § 412.64(b)(1)(ii)(B).

[69 FR 66977, Nov. 15, 2004; 70 FR 19728, Apr. 1, 2005, as amended at 71 FR 27086, May 9, 2006]

§ 412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished in to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient psychiatric facility fails to comply fully with these conditions, CMS may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient psychiatric facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient psychiatric facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment system as specified in § 412.1(a)(1).

(b) *Inpatient psychiatric facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in § 412.22. In order to be excluded from the hospital inpatient prospective payment system as specified in § 412.1(a)(1), a psychiatric hospital must meet the criteria set forth in § 412.23(a), § 482.60, § 482.61, and § 482.62 and psychiatric units must meet the criteria set forth in § 412.25 and § 412.27.

(c) *Limitations on charges to beneficiaries—*(1) *Prohibited charges.* Except as permitted in paragraph (c)(2) of this section, an inpatient psychiatric facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility’s cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient psychiatric facility receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and