

## § 412.500

## 42 CFR Ch. IV (10–1–06 Edition)

### § 412.500 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 123 of Public Law 106–113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act. This subpart also reflects the provisions of section 307 of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

### § 412.503 Definitions.

As used in this subpart—

*CMS* stands for the Centers for Medicare & Medicaid Services.

*Discharge.* A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

*Long-term care hospital prospective payment system rate year* means the 12-month period of July 1 through June 30.

*LTC-DRG* stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and

average resource use, for prospective payment purposes.

*Outlier payment* means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

*QIO* (formerly PRO or Peer Review Organization) stands for the Quality Improvement Organization.

### § 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) *Long-term care hospitals subject to the prospective payment system.* To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

### § 412.507 Limitation on charges to beneficiaries.

(a) *Prohibited charges.* Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered 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 system. If Medicare has paid the full LTC-DRG payment, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met. If Medicare pays less than the full LTC-DRG payment, that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(b) *Permitted charges.* (1) A long-term care hospital that receives a full LTC-DRG payment under this subpart for covered days in a hospital stay may charge the Medicare beneficiary only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter, and for items and services as specified under § 489.20(a) of this chapter.

(2) A long-term care hospital that receives less than the full LTC-DRG payment for a short-stay case, in accordance with § 412.529, may only charge the Medicare beneficiary for the applicable deductible and coinsurance under §§ 409.82, 409.83, and 409.87 of this subchapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay payment.

#### § 412.508 Medical review requirements.

(a) *Admission and quality review.* A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

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

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.523(d)(1) and 412.525(a).

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

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

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

(b) *Physician acknowledgement.* Payment under the long-term care hospital 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. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *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 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.

(2) *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.

(c) *Denial of payment as a result of admissions and quality review.* (1) 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 or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—