§ 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.


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 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.
Centers for Medicare & Medicaid Services, HHS § 412.82

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 (plus 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.

§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 will make an additional payment, on a per diem basis, to the discharging hospital for those days. A special request or submission by the hospital is not necessary to initiate this payment. However, a hospital may request payment for day outliers before the medical review required in paragraph (b) of this section.

(b) The QIO must review and approve to the extent required by CMS—

(1) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay; and

(2) The validity of the diagnostic and procedural coding; and

(3) The granting of grace days.

(c) Except as provided in §412.86, the per diem payment made under paragraph (a) of this section is derived by taking a percentage of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under subpart D of this part, by the arithmetic mean length of stay for that DRG. CMS issues the applicable percentage of the...