Centers for Medicare & Medicaid Services, HHS
§ 412.507

MS-LTC-DRG stands for the severity-adjusted 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 for discharges from a long-term care hospital occurring on or after October 1, 2007.

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.

Rural area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in § 412.62(f)(1)(iii);
(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an area as defined in § 412.64(b)(1)(i)(C); and
(3) For discharges occurring on or after July 1, 2008, any area outside an urban area.

Urban area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in § 412.62(f)(1)(ii);
(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an urban area means an area as defined in § 412.64(b)(1)(ii)(A) and (B); and
(3) For discharges occurring on or after July 1, 2008, a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

§ 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 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 §§ 412.529(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 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.

(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—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to