

weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in §412.116.

(iv) As provided in §413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of

this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of §413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments—(1) General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not

receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

Subpart A—Introduction and General Rules

Sec.

- 413.1 Introduction.
- 413.5 Cost reimbursement: General.
- 413.9 Cost related to patient care.
- 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.
- 413.17 Cost to related organizations.

Subpart B—Accounting Records and Reports

- 413.20 Financial data and reports.
- 413.24 Adequate cost data and cost finding.

Subpart C—Limits on Cost Reimbursement

- 413.30 Limitations on payable costs.
- 413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.
- 413.40 Ceiling on the rate of increase in hospital inpatient costs.

Subpart D—Apportionment

- 413.50 Apportionment of allowable costs.
- 413.53 Determination of cost of services to beneficiaries.
- 413.56 [Reserved]

Subpart E—Payments to Providers

- 413.60 Payments to providers: General.
- 413.64 Payments to providers: Specific rules.
- 413.65 Requirements for a determination that a facility or an organization has provider-based status.
- 413.70 Payment for services of a CAH.
- 413.74 Payment to a foreign hospital.

Subpart F—Specific Categories of Costs

- 413.75 Direct GME payments: General requirements.
- 413.76 Direct GME payments: Calculation of payments for GME costs.
- 413.77 Direct GME payments: Determination of per resident amounts.
- 413.78 Direct GME payments: Determination of the total number of FTE residents.
- 413.79 Direct GME payments: Determination of the weighted number of FTE residents.
- 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.
- 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.
- 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.
- 413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.
- 413.85 Cost of approved nursing and allied health education activities.
- 413.87 Payments for Medicare+Choice nursing and allied health education programs.
- 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.
- 413.89 Bad debts, charity, and courtesy allowances.
- 413.90 Research costs.
- 413.92 Costs of surety bonds.
- 413.94 Value of services of nonpaid workers.
- 413.98 Purchase discounts and allowances, and refunds of expenses.
- 413.100 Special treatment of certain accrued costs.
- 413.102 Compensation of owners.
- 413.106 Reasonable cost of physical and other therapy services furnished under arrangements.
- 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.