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renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in §413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in §405.521 of this chapter.

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers.

(5) The costs of qualified nonphysician anesthetists' services, as described in §412.113(c).

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:

(1) Outlier cases, as described in subpart F of this part.

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in §412.105 for inpatient operating costs and in §412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in §412.115.

(4) Bad debts of Medicare beneficiaries, as provided in §412.115(a).

(5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in §412.104.

(6) Serving a disproportionate share of low-income patients, as provided in §412.106 for inpatient operating costs and §412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this subchapter and the furnishing fee specified in §410.63 of this subchapter.

(9) Special additional payment for certain new technology as specified in §§412.87 and 412.88 of subpart F.

(g) *Payment adjustment for certain replaced devices.* CMS makes a payment adjustment for certain replaced devices, as provided under §412.89.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.2, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment

under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part;

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter;

(3) An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program; or

(4) A critical access hospital.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in §412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* (1) For a fiscal year prior to FY 2006, for purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent years for which data are available:

(i) The DRG must have a geometric mean length of stay of at least 3 days.

(ii) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(iii) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iii) of this section.

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5 years of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) For purposes of paragraph (c), a discharge is also considered to be a transfer if it meets the following conditions:

(i) The discharge is assigned to a DRG that contains only cases that were assigned to a DRG that qualified under this paragraph within the previous 2 years; and

(ii) The latter DRG was split or otherwise modified within the previous 2 fiscal years.

(3) For fiscal years beginning with FY 2006, for purposes of paragraph (c) of this section—

(i) The qualifying DRGs must meet the following criteria using data from the March 2005 update of the FY 2004 MedPAR file and Version 23.0 of the DRG Definitions Manual (FY 2006):

(A) The DRG has at least 2,050 total postacute care transfer cases;

(B) At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG;

(C) The DRG must have a geometric mean length of stay greater than 3 days;

(D) The DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or major cardiovascular condition that, it meets the criteria specified in paragraphs (d)(3)(i)(A) and (d)(3)(ii)(B) of this section.

(ii) If a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on

the version of the DRG Definitions Manual in use when the new or revised DRG first becomes effective, using the most recent complete year of MedPAR data:

(A) The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs;

(B) The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs;

(C) The DRG is paired with a DRG based on the presence or absence of a comorbidity or a complication or major cardiovascular condition that meets the criteria specified under paragraphs (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section; and

(D) In the case of MS-DRGs that share the same base MS-DRG, if one MS-DRG meets the criteria specified under paragraph (d)(3)(ii)(B) of this section, every MS-DRG that shares the same base MS-DRG is a qualifying DRG.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with §412.2(b).

(f) *Payment for transfers*—(1) *General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211 for fiscal years prior to FY 2006.* For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210, or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG for newborns that die or are transferred to another hospital.* If a transfer is classified into CMS DRG 385 (Neonates, Died or Transferred) prior to October 1, 2007, or into MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) on or after October 1, 2007, the transferring hospital is paid in accordance with §412.2(b).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

(5) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2005, and prior to October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section.

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days; and

(iv) If a DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the criteria specified in paragraphs (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

(6) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days.

(iv) If a DRG is part of an MS-DRG group that meets the criteria specified in paragraphs (f)(6)(i) through (f)(6)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

[63 FR 41003, July 31, 1998, as amended at 65 FR 47106, Aug. 1, 2000; 67 FR 50111, Aug. 1, 2002; 68 FR 45469, Aug. 1, 2003; 69 FR 49240, Aug. 11, 2004; 70 FR 47484, Aug. 12, 2005; 72 FR 47410, Aug. 22, 2007; 75 FR 50413, Aug. 16, 2010]

§ 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* CMS recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

[57 FR 39819, Sept. 1, 1992]

§ 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates*—(1) *For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the FEDERAL REGISTER on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the FEDERAL REGISTER on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) CMS proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a FEDERAL REGISTER document published for public comment not later than the April 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(2) Except as provided in paragraph (c) of this section, CMS publishes a FEDERAL REGISTER document setting