§ 412.30

(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;
(2) Is a doctor of medicine or osteopathy;
(3) Is licensed under State law to practice medicine or surgery; and
(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient’s medical record to note the patient’s status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(j) Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in §412.130.

[76 FR 47891, Aug. 5, 2011]

§ 412.40

General requirements.

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.

(b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—

(1) Withhold Medicare payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

(2) Terminate the hospital’s provider agreement.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992]
(iv) The exclusion of items and services furnished when the patient is not entitled to Medicare Part A benefits under subpart A of part 406 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished when the patient is not entitled to benefits).

(v) The exclusion of items and services furnished after Medicare Part A benefits are exhausted under §409.61 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished after benefits are exhausted).

(c) Custodial care and medically unnecessary inpatient hospital care. A hospital may charge a beneficiary for services excluded from coverage on the basis of §411.15(g) of this chapter (custodial care) or §411.15(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

1. The hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care. (The phrase “inpatient hospital care” includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF-level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care because either a SNF-level bed has become available or the patient no longer requires SNF-level care.)

2. The attending physician agrees with the hospital’s determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the QIO as described in §405.1208 of this chapter. Concurrency by the QIO in the hospital’s determination will serve in lieu of the physician’s agreement.

3. The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or his or her representative) of his or her discharge rights in writing consistent with §405.1205 and notifies the beneficiary, in accordance with §405.1206 of this chapter (if applicable) that in the hospital’s opinion, and with the attending physician’s concurrence or that of the QIO, the beneficiary no longer requires inpatient hospital care.

4. If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary, as required in paragraphs (c)(1), (c)(2), and (c)(3) of this section.

(d) Medically unnecessary diagnostic and therapeutic services. A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under §411.15(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

1. In the hospital’s opinion, which has been agreed to by the intermediary, the services to be furnished are not considered reasonable and necessary under Medicare.

2. Customary charges will be made if he or she receives the services.

3. If the beneficiary receives the services, a formal determination on the validity of the hospital’s finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the QIO.

4. The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.
(5) The charges for the services will be invalid and, to the extent collected, will be refunded by the hospital if the services are found to be covered by Medicare.

(e) Services furnished on days when the individual is not entitled to Medicare Part A benefits or has exhausted the available benefits. The hospital may charge the beneficiary its customary charges for noncovered items and services furnished on outlier days (as described in Subpart F of this part) for which payment is denied because the beneficiary is not entitled to Medicare Part A or his or her Medicare Part A benefits are exhausted. (1) If payment is considered for outlier days, the entire stay is reviewed and days up to the number of days in excess of the outlier threshold may be denied on the basis of non-entitlement to Part A or exhaustion of benefits. (2) In applying this rule, the latest days will be denied first.

(f) Differential for private room or other luxury services. The hospital may charge the beneficiary the customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or the request of the person acting on his or her behalf).

(g) Review. (1) The QIO or intermediary may review any cases in which the hospital advises the beneficiary (or the person acting on his or her behalf) of the noncoverage of the services in accordance with paragraph (c)(3) or (d) of this section.

(2) The hospital must identify such cases to the QIO or intermediary in accordance with CMS instructions.


§ 412.46 Medical review requirements: Physician acknowledgement.

(a) Basis. Because payment under the 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, physicians must complete an acknowledgement statement to this effect.

(b) 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, 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.

(c) 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.

VerDate Mar<15>2010 11:34 Oct 28, 2011 Jkt 223182 PO 00000 Frm 00552 Fmt 8010 Sfmt 8010 Q:\42\42V2.TXT ofr150 PsN: PC150

§ 412.44 Medical review requirements: Admissions and quality review.

Beginning on November 15, 1984, a hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

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