§ 412.428 Payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

(c) Treatment of new inpatient psychiatric facilities. New inpatient psychiatric facilities, are facilities that under present or previous ownership or both have their first cost reporting period as an IPF beginning on or after January 1, 2005. New IPFs are paid based on 100 percent of the Federal per diem payment amount.


§ 412.428 Publication of Updates to the inpatient psychiatric facility prospective payment system.

CMS will publish annually in the Federal Register information pertaining to updates to the inpatient psychiatric facility prospective payment system. This information includes:

(a) A description of the methodology and data used to calculate the updated Federal per diem base payment amount.

(b)(1) For discharges occurring on or after January 1, 2005 but before July 1, 2006, the rate of increase factor, described in §412.424(a)(2)(iii), for the Federal portion of the inpatient psychiatric facility’s payment is based on the excluded hospital with capital market basket under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(2) For discharges occurring on or after July 1, 2006, the rate of increase factor for the Federal portion of the inpatient psychiatric facility’s payment is based on the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket.

(3) For discharges occurring on or after January 1, 2005 but before October 1, 2005, the rate of increase factor for the reasonable cost portion of the inpatient psychiatric facility’s payment is based on the 1997-based excluded hospital market basket.

(c) The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.

(d) Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.

(e) Describe the ICD–9–CM coding changes and DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system regulations.

(f) Update the electroconvulsive therapy adjustment by a factor specified by CMS.

(g) Update the national urban and rural cost to charge ratio median and ceilings. CMS will apply the national cost to charge ratio to—

(1) New inpatient psychiatric facilities that have not submitted their first Medicare cost report.

(2) Inpatient psychiatric facilities whose operating or capital cost to charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean.

(3) Other inpatient psychiatric facilities for which the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital cost to charge ratio or both.

(h) Update the cost of living adjustment factor if appropriate.

[69 FR 66977, Nov. 15, 2004, as amended at 71 FR 27087, May 9, 2006]

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

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

(b) Periodic interim payments (PIP). (1) Criteria for receiving PIP.

(1) An inpatient psychiatric facility receiving payment under this subpart may receive PIP for Part A services
under the PIP method subject to the provisions of §413.64(h) of this chapter.

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

(iii) A hospital that is receiving periodic interim payments also receives payment under this subpart for applicable services furnished by its excluded psychiatric unit.

(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 resulting in an overpayment to the provider.

(2) Frequency of payment. For facilities approved for PIP, the intermediary estimates the annual inpatient psychiatric facility's Federal per diem 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 psychiatric 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 the biweekly period of service as specified 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 psychiatric 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. Outlier payments are made based on the submission of a discharge bill and represents final payment subject to the cost report settlement specified in §412.84(i) and §412.84(m) of this part.

(e) Accelerated payments—(1) General rule. Upon request, an accelerated payment may be made to an inpatient psychiatric facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient psychiatric facility is experiencing financial difficulties because of the following:

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

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

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

(3) Amount of accelerated payment. The amount of the accelerated payment is
§ 412.500

computed as a percent of the net payment for unbilled or unpaid covered services.

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

[69 FR 66977, Nov. 15, 2004, as amended at 76 FR 26465, May 6, 2011]

Subpart O—Prospective Payment System for Long-Term Care Hospitals

Source: 67 FR 56049, Aug. 30, 2002, unless otherwise noted.

§ 412.503 Definitions.

As used in this subpart—

CMS stands for the Centers for Medicare & Medicaid Services.

Discharge. A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of “long-term care hospital prospective payment system rate year” and “long-term care hospital prospective payment system fiscal year” specified in this section.

Long-term care hospital prospective payment system rate year means—

(1) From July 1, 2003 and ending on or before June 30, 2006, the 12-month period of July 1 through June 30.

(2) From July 1, 2008 and ending on September 30, 2009, the 15-month period of July 1, 2008 through September 30, 2009.

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

LTC–DRG stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective