

Centers for Medicare & Medicaid Services, HHS

§ 412.513

(a) Classification methodology. CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) Assignment of discharges to LTC-DRGs. (1) The classification of a particular discharge is based, as appropriate, on the patient’s age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient’s admission to the hospital), secondary diagnoses, procedures performed, and the patient’s discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient’s principal diagnosis), regardless of the number of conditions treated or services furnished during the patient’s stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient’s principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in § 409.3 of this subchapter).

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§ 412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

§ 412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of § 412.521(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians’ services that meet the requirements of § 415.102(a) of this subchapter.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualifying psychologist services, as defined in section 1861(i) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(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 a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department’s Office of Inspector General for handling in accordance with § 1001.201 of this title.


§ 412.513 Patient classification system.

(a) Classification methodology. CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) Assignment of discharges to LTC-DRGs. (1) The classification of a particular discharge is based, as appropriate, on the patient’s age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient’s admission to the hospital), secondary diagnoses, procedures performed, and the patient’s discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient’s principal diagnosis), regardless of the number of conditions treated or services furnished during the patient’s stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient’s principal diagnosis, the bill is returned to the hospital for validation and revalidation. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the
§ 412.515 LTC-DRG weighting factors.

For each LTC-DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

§ 412.517 Revision of LTC-DRG group classifications and weighting factors.

(a) CMS adjusts the classifications and weighting factors annually to reflect changes in—
   (1) Treatment patterns;
   (2) Technology;
   (3) Number of discharges; and
   (4) Other factors affecting the relative use of hospital resources.

(b) Beginning in FY 2008, the annual changes to the LTC-DRG classifications and recalibration of the weighting factors described in paragraph (a) of this section are made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.


§ 412.521 Basis of payment.

(a) Method of payment. (1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate established in accordance with §412.523, including adjustments described in §412.525, and, if applicable during a transition period, on a blend of the Federal payment rate and the cost-based reimbursement rate described in §412.533.

(b) Payment in full. (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in §§412.2(c)(1) through (c)(4) of this part and §412.540 and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:
   (i) The costs of approved medical education programs described in §§413.75 through 413.83, 413.85, and 413.87 of this subchapter.
   (ii) Bad debts of Medicare beneficiaries, as provided in §413.89 of this subchapter.
   (iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.
   (iv) Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements, as specified in §412.113(c)(2).
   (v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with §476.78(c) of this chapter.

(c) Payment by workers’ compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare. If workers’ compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in