

in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Organ acquisition.* Payment for organ acquisition costs incurred by hospitals with approved transplantation centers is made on a reasonable cost basis. The term “Organs” is defined in §486.302 of this chapter.

(e) *Allogeneic hematopoietic stem cell acquisition.* For cost reporting periods beginning on or after October 1, 2020, in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual, payment to such hospital for hematopoietic stem cell acquisition costs is made on a reasonable cost basis.

(1) An allogeneic hematopoietic stem cell transplant is the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.

(2) Allogeneic hematopoietic stem cell acquisition costs recognized under this paragraph (e) are costs of acquiring hematopoietic stem cells from a donor. These costs are as follows:

(i) Registry fees from a national donor registry described in 42 U.S.C.

274k, if applicable, for stem cells from an unrelated donor.

(ii) Tissue typing of donor and recipient.

(iii) Donor evaluation.

(iv) Physician pre-admission/pre-procedure donor evaluation services.

(v) Costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services), and transportation costs of stem cells if the recipient hospital incurred or paid such costs.

(vi) Post-operative/post-procedure evaluation of donor.

(vii) Preparation and processing of stem cells derived from bone marrow, peripheral blood stem cells, or cord blood (but not including embryonic stem cells).

(3) A subsection (d) hospital that furnishes inpatient allogeneic hematopoietic stem cell transplants is required to hold all allogeneic hematopoietic stem cell acquisition charges and bill them to Medicare using the appropriate revenue code, when the transplant occurs.

(4) A subsection (d) hospital must maintain an itemized statement that identifies, for all costs defined in paragraph (e)(2) of this section, the services furnished in collecting hematopoietic stem cells including all invoices or statements for purchased services for all donors and their service charges. Records must be for the person receiving the services (donor or recipient; for all donor sources, the hospital must identify the prospective recipient), and the recipient’s Medicare beneficiary identification number.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.89 of this chapter for bad debts attributable to deductible and co-insurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac. 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 chapter and the furnishing fee specified in §410.63 of this subchapter.

(c) *QIO reimbursement for cost of sending requested patient records to the QIO.* An additional payment is made to a hospital in accordance with §476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

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§412.116 Method of payment.

(a) *General rules.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2005, payments for inpatient hospital services furnished by an inpatient psychiatric facility that meets the conditions of §412.404 are made as described in §412.432.

(4) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the

conditions of §412.604 are made as described in §412.632.

(5) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§412.505 through 412.511 are made as described in §412.521.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.