

## § 412.3

allogeneic hematopoietic stem cell transplant.

(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

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Finding Aids section of the printed volume and at [www.govinfo.gov](http://www.govinfo.gov).

### § 412.3 Admissions.

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. In addition, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622.

(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.

(c) The physician order must be furnished at or before the time of the inpatient admission.

(d)(1) Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately

treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.

(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under §419.22(n) of this chapter is generally appropriate for payment under Medicare Part A, regardless of the expected duration of care.

(3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015; 83 FR 41700, Aug. 17, 2018]

#### §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.

(4) For discharges occurring on or after October 1, 2018, to hospice care provided by a hospice program.

(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