

## Centers for Medicare & Medicaid Services, HHS

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### Subpart A—General Provisions

#### § 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983, and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991.

(i) Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis.

(ii) Payment for other costs related to inpatient hospital services is made on a reasonable cost basis as follows:

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(A) Organ acquisition costs incurred by hospitals with approved organ transplant programs.

(B) The costs of qualified nonphysician anesthetist's services, as described in § 412.113(c).

(C) Direct costs of approved nursing and allied health educational programs.

(D) Costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant as described in § 412.113(e).

(iii) Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §§ 413.75 through 413.83 of this chapter.

(iv) Additional payments are made for outlier cases, bad debts, indirect medical education costs, for serving a disproportionate share of low-income patients, and for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators.

(v) Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 124 of Public Law 106–113 by establishing a per diem prospective payment system for the inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N of this part.

(3) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of § 412.604.

(4) This part implements the following regarding long-term care hospitals—

(i) Section 123 of Public Law 106–113, which provides for the establishment of a prospective payment system for the costs of inpatient hospital services fur-

nished to Medicare beneficiaries by long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act, for cost reporting periods beginning on or after October 1, 2002.

(ii) The provisions of section 307(b) of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to the long-term care hospital prospective payment system, including adjustments to diagnosis-related group (DRG) weights, area wage adjustments, geographic reclassification, outlier adjustments, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(iii) Section 114 of Public Law 110–173, which contains several provisions regarding long-term care hospitals, including the—

(A) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act.

(B) Revision of the standard Federal rate for RY 2008.

(5) This part implements section 1886(q) of the Act, which provides that, effective for discharges from an “applicable hospital” beginning on or after October 1, 2012, payments to those hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions, under the Hospital Readmissions Reduction Program. This reduction will be made through an adjustment to the hospital's base operating DRG payment amounts under the prospective payment system for inpatient operating costs.

(6) This part implements section 1886(o)(1)(B) of the Act, which directs the Secretary to begin to make value-based incentive payments under the Hospital Value-Based Purchasing Program to hospitals for discharges occurring on or after October 1, 2012, through an adjustment to the base operating

DRG payment amounts under the prospective payment system for inpatient operating costs.

(7) This part implements section 1866(k) of the Act, which directs hospitals described in section 1886(d)(1)(B)(v) of the Act to submit data on quality measures to the Secretary.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B of this part sets forth all of the following:

(i)(A) The classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section.

(B) Requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(ii) Requirements for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to

hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart N describes the prospective payment system specified in paragraph (a)(2) of this section for inpatient psychiatric facilities and sets forth the general methodology for paying the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities effective with cost reporting periods beginning on or after January 1, 2005.

(13) Subpart O of this part describes the prospective payment system specified in paragraph (a)(4) of this section for long-term care hospitals and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals, effective with cost reporting periods beginning on or after October 1, 2002.

(14) Subpart P describes the prospective payment system specified in paragraph (a)(3) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation

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units effective with cost reporting periods beginning on or after January 1, 2002.

[66 FR 41385, Aug. 7, 2001, as amended at 67 FR 56048, Aug. 30, 2002; 69 FR 66976, Nov. 15, 2004; 70 FR 47484, Aug. 12, 2005; 73 FR 24879, May 6, 2008; 77 FR 53673, Aug. 31, 2012; 85 FR 59020, Sept. 18, 2020; 86 FR 45518, Aug. 13, 2021; 86 FR 73510, Dec. 27, 2021; 87 FR 72286, Nov. 23, 2022]

### § 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:

(i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in § 411.400 of this chapter.

(ii) Guarantee of payment days, as authorized under § 409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hos-

pital has reason to believe is entitled to Medicare benefits at the time of admission.

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in § 412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(1) Operating costs for routine services (as described in § 413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;

(2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(3) Special care unit operating costs (intensive care type unit services, as described in § 413.53(b) of this chapter);

(4) Malpractice insurance costs related to services furnished to inpatients; and

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the condition specified in paragraph (c)(5)(i) of this section and at least one of the conditions specified in paragraphs (c)(5)(ii) through (c)(5)(iv).

(i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity.

An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in §413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in §405.521 of this chapter.

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) in-

curred by approved transplant programs.

(5) The costs of qualified nonphysician anesthetists' services, as described in §412.113(c).

(6) For cost reporting periods beginning on or after October 1, 2020, the costs of allogeneic hematopoietic stem cell acquisition, as described in §412.113(e), for the purpose of an 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.

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(9) Special additional payment for certain new technology as specified in §§ 412.87 and 412.88 of subpart F.

(10) A payment adjustment for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators as specified in § 412.113.

(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 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 med-

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ical 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. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under § 419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

(i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.

(ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.

(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; 85 FR 86300, Dec. 29, 2020; 86 FR 63992, Nov. 16, 2021]

#### §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 the geometric mean length of stay for the DRG during the most recent 5 years of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) For purposes of paragraph (c), a discharge is also considered to be a transfer if it meets the following conditions:

(i) The discharge is assigned to a DRG that contains only cases that were assigned to a DRG that qualified under this paragraph within the previous 2 years; and

(ii) The latter DRG was split or otherwise modified within the previous 2 fiscal years.

(3) For fiscal years beginning with FY 2006, for purposes of paragraph (c) of this section—

(i) The qualifying DRGs must meet the following criteria using data from

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the March 2005 update of the FY 2004 MedPAR file and Version 23.0 of the DRG Definitions Manual (FY 2006):

(A) The DRG has at least 2,050 total postacute care transfer cases;

(B) At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG;

(C) The DRG must have a geometric mean length of stay greater than 3 days;

(D) The DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or major cardiovascular condition that, it meets the criteria specified in paragraphs (d)(3)(i)(A) and (d)(3)(ii)(B) of this section.

(ii) If a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first becomes effective, using the most recent complete year of MedPAR data:

(A) The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs;

(B) The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs;

(C) The DRG is paired with a DRG based on the presence or absence of a comorbidity or a complication or major cardiovascular condition that meets the criteria specified under paragraphs (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section; and

(D) In the case of MS-DRGs that share the same base MS-DRG, if one MS-DRG meets the criteria specified under paragraph (d)(3)(ii)(B) of this section, every MS-DRG that shares the same base MS-DRG is a qualifying DRG.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with § 412.2(b).

(f) *Payment for transfers—(1) General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital

that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211 for fiscal years prior to FY 2006.* For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210, or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG for newborns that die or are transferred to another hospital.* If a transfer is classified into CMS DRG 385 (Neonates, Died or Transferred) prior to October 1, 2007, or into MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) on or after October 1, 2007, the transferring hospital is paid in accordance with § 412.2(b).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

(5) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2005, and prior to October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c)

of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section.

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days; and

(iv) If a DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the criteria specified in paragraphs (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

(6) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days.

(iv) If a DRG is part of an MS-DRG group that meets the criteria specified in paragraphs (f)(6)(i) through (f)(6)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

[63 FR 41003, July 31, 1998, as amended at 65 FR 47106, Aug. 1, 2000; 67 FR 50111, Aug. 1, 2002; 68 FR 45469, Aug. 1, 2003; 69 FR 49240, Aug. 11, 2004; 70 FR 47484, Aug. 12, 2005; 72 FR 47410, Aug. 22, 2007; 75 FR 50413, Aug. 16, 2010; 83 FR 41700, Aug. 17, 2018]

#### § 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* CMS recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

[57 FR 39819, Sept. 1, 1992]

#### § 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates—* (1) *For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30,

1984) were determined in accordance with documents published in the FEDERAL REGISTER on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the FEDERAL REGISTER on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) CMS proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a FEDERAL REGISTER document published for public comment not later than the April 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(2) Except as provided in paragraph (c) of this section, CMS publishes a FEDERAL REGISTER document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the August 1 before the Federal fiscal year in which the rates would apply.

(c) *Publication schedule for FY 2007.* For FY 2007, not later than August 1, 2006, CMS publishes a FEDERAL REGISTER document setting forth a description of the methodology and data used in computing the inpatient prospective payment rates for that year.

[57 FR 39820, Sept. 1, 1992, as amended at 62 FR 46025, Aug. 29, 1997; 71 FR 48136, Aug. 18, 2006]

**§ 412.10 Changes in the DRG classification system.**

(a) *General rule.* CMS issues changes in the DRG classification system in a FEDERAL REGISTER notice at least annually. Except as specified in paragraphs (c) and (d) of this section, the DRG changes are effective prospectively with discharges occurring on or after the same date the payment rates are effective.

(b) *Basis for changes in the DRG classification system.* All changes in the DRG classification system are made using the principles established for the DRG system. This means that cases are classified so each DRG is—

(1) Clinically coherent; and

(2) Embraces an acceptable range of resource consumption.

(c) *Interim coverage changes—(1) Criteria.* CMS makes interim changes to the DRG classification system during the Federal fiscal year to incorporate items and services newly covered under Medicare.

(2) *Implementation and effective date.* CMS issues interim coverage changes through its administrative issuance system and makes the change effective as soon as is administratively feasible.

(3) *Publication for comment.* CMS publishes any change made under paragraph (c)(1) of this section in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(d) *Interim changes to correct omissions and inequities—(1) Criteria.* CMS makes interim changes to the DRG classification system to correct a serious omission or inequity in the system only if failure to make the changes would have—

(i) A potentially substantial adverse impact on the health and safety of beneficiaries; or

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* CMS publishes these changes in the FEDERAL REGISTER in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPAC.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPAC upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPAC before implementation.

[50 FR 35688, Sept. 3, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 57 FR 39820, Sept. 1, 1992]