

(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 surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC-DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC-DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC-DRG assignment is appropriate. If the intermediary decides that a different LTC-DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in §476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

§412.515 LTC-DRG weighting factors.

(a) 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.

(b)(1) Beginning FY 2023, each LTC-DRG weight is subject to a maximum 10 percent reduction as compared to the weight for the same LTC-DRG for the prior fiscal year, except as provided in paragraph (b)(2) of this section.

(2) The limitation described in paragraph (b)(1) of this section does not apply to LTC-DRGs with less than 25 applicable LTCH cases in the data used to determine the relative weights for the fiscal year.

[87 FR 49405, Aug. 10, 2022]

§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.

(c) Beginning in FY 2016, the annual recalibration of the weighting factors described in paragraph (a) of this section is determined using long-term care hospital discharges described in §412.522(a)(2) (or that would have been described in such section had the application of the site neutral payment rate been in effect at the time of the discharge).

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 26991, May 11, 2007; 80 FR 49768, Aug. 17, 2015]

§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) Except as provided for in §412.526, the amount of payment under the prospective payment system is based on