

§ 412.50

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, 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 types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

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

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

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

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

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

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

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 60 FR 63188, Dec. 8, 1995; 65 FR 18537, Apr. 7, 2000]

§ 412.52 Reporting and recordkeeping requirements.

All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

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Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 DRG classification and weighting factors.

(a) *Diagnosis-related groups.* CMS establishes a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(b) *DRG weighting factors.* CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups, subject to a maximum ten percent reduction to the weighting factor for a DRG as compared to the weighting factor for the same DRG for the prior fiscal year.

(c) *Assignment of discharges to DRGs.* CMS establishes a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(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 discharge status.

(2) Each discharge is assigned to only one DRG (related, except as provided in paragraph (c)(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. CMS's DRG classification system provides a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of