

(c) Related to the inpatient stay. A preadmission service is related if—

(1) It is diagnostic (including clinical diagnostic laboratory tests); or

(2) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(3) On or after June 25, 2010, it is non-diagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(d) Not one of the following—

(1) Ambulance services.

(2) Maintenance renal dialysis services.

[75 FR 50416, Aug. 16, 2010]

§412.541 Method of payment under the long-term care hospital prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments—*(1) *Criteria for receiving periodic interim payments.* (i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) As provided in §413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.* (i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under §§412.533(a)(5) and 412.533(c), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes

biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in §412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in §412.533(a), and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the long-term care hospital no longer meets the requirements of §413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed non-physician anesthetists or obtained

under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to $\frac{1}{26}$ of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a long-term care

hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 10988, Mar. 7, 2003; 71 FR 48141, Aug. 18, 2006]

§ 412.560 Requirements under the Long-Term Care Hospital Quality Reporting Program (LTCH QRP).

(a) *Participation in the LTCH QRP.* A long-term-care hospital must begin submitting data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, under the LTCH QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.

(b) *Data submission requirements and payment impact.* (1) Except as provided in paragraph (c) of this section, a long-term care hospital must submit to CMS data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1) and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act. Such data must be submitted in a form and manner, and at a time, specified by CMS.

(2) A long-term care hospital that does not submit data in accordance