

§ 412.10

42 CFR Ch. IV (10–1–24 Edition)

§ 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 clas-

sification 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]

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), (d), and (e) of this section, all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2005, covered inpatient hospital services furnished to Medicare beneficiaries by an inpatient psychiatric facility that meets the conditions of § 412.404 are paid under the prospective payment system described in subpart N of this part.

(c)(1) Effective for cost reporting periods beginning on or after January 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(2) CMS will not pay for services under subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not