

§ 412.120

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a biweekly period of services, as described in § 413.64(h)(5) of this subchapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(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 after a Medicare beneficiary has been in the hospital at least 60 days. 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 (d).

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a hospital that is not receiving periodic interim payments 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 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 hospital's request for an accelerated payment must be approved by the intermediary and 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 hospital bills are processed or by direct payment by the hospital.

[53 FR 1627, Jan. 21, 1988, as amended at 53 FR 38532, Sept. 30, 1988; 54 FR 36495, Sept. 1, 1989; 56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992; 59 FR 36712, July 19, 1994; 59 FR 45400, Sept. 1, 1994; 66 FR 41387, Aug. 7, 2001; 67 FR 56049, Aug. 30, 2002; 68 FR 45470, Aug. 1, 2003; 69 FR 66977, Nov. 15, 2004; 71 FR 48140, Aug. 18, 2006; 86 FR 73512, Dec. 27, 2021]

§ 412.120 Reductions to total payments.

(a) *Deductible and coinsurance.* Subject to paragraph (a)(2) of this section, the total Medicare payments otherwise payable to a hospital are reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§ 409.82, 409.83, and 409.87 of this chapter.

(b) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment is determined in accordance with the following guidelines:

(1) If workers' compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321 of this chapter.

(2) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325 of this chapter.

(3) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329 of this chapter.

(4) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and their spouses age 65–69, in accordance with the applicable provisions of

§§405.340 through 405.344 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 55 FR 36071, Sept. 4, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39825, Sept. 1, 1992]

§412.125 Effect of change of ownership on payments under the prospective payment systems.

When a hospital's ownership changes, as described in §489.18 of this chapter, the following rules apply:

(a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in §412.112, and payments for hemophilia clotting factor costs under §412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(2) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(b) Other payments under §412.113 and payments for bad debts as described in §412.115(a), are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43449, Aug. 30, 1991]

§412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* The intermediary makes the payment adjustment described in paragraph (b) of this section for the following hospitals:

(1) A hospital that was excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(3), as a new rehabilitation

hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under §412.29(c) regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of §412.29(b).

(2) A hospital that has a unit excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(3), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under §412.29(c) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of §412.29(b).

(3) A hospital that added new beds to its existing rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under §412.29(c) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of §412.29(b).

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the