

(6) Any evidence that supports the inpatient psychiatric facility's reconsideration request, such as emails and other documents.

(c) An inpatient psychiatric facility that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

[77 FR 53678, Aug. 31, 2012, as amended at 86 FR 42678, Aug. 4, 2021]

Subpart O—Prospective Payment System for Long-Term Care Hospitals

SOURCE: 67 FR 56049, Aug. 30, 2002, unless otherwise noted.

§ 412.500 Basis and scope of subpart.

(a) *Basis.* This subpart implements the following:

(1) Section 123 of Public Law 106-113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act.

(2) Section 307 of Public Law 106-554, which states that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(3) Section 114 of Public Law 110-173, which contains several provisions regarding long-term care hospitals, including the—

(i) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106-113 and section 307(b) of Public Law 106-554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act; and

(ii) Revision of the standard Federal rate for RY 2008.

(4) Section 4302(a) of Public Law 111-5, which amended sections 114(c) and

(d) of Public Law 110-173 relating to several moratoria on the establishment of new long-term care hospitals and satellite facilities and on the increase in the number of beds in existing long-term care hospitals and satellite facilities under the long-term care hospital prospective payment system.

(5) Sections 3106(a) and 10312(a) of Public Law 111-148, which extended certain payment rules and moratoria under the long-term care hospital prospective payment system by further amending sections 114(c) and (d) of Public Law 110-173.

(6) Section 1206 of Public Law 113-67, which further extended certain payment rules and moratoria under the long-term care hospital prospective payment system by amending sections 114(c) and (d) of Public Law 110-173, and which:

(i) Added a new section 1886(m)(6) to the Act to establish a site neutral payment amount for long-term care hospital discharges that fail to meet the applicable criteria in cost reporting periods beginning on or after October 1, 2015; and

(ii) Requires the Secretary's review of the payment rates and regulations governing long-term care hospitals established under section 1886(d)(1)(B)(iv)(II) of the Act and application of payment adjustments based on that review.

(7) Section 411 of Public Law 114-10 which revises the annual update to the LTCH PPS standard Federal payment rate in FY 2018.

(8) Public Law 114-255 which at—

(i) Section 15004 amended the moratorium on increasing beds in existing LTCHs and LTCH satellite facilities and amended high cost outlier payment requirements;

(ii) Section 15006 amended moratoria on certain payment policies;

(iii) Section 15007 amended the average length of stay requirements;

(iv) Section 15009 temporally excepted certain spinal cord specialty hospitals from the site neutral payment rate; and

(v) Section 15010 temporally excepted certain wound care discharges from certain LTCHs from the site neutral payment rate.

(9) Section 51005(a) of Public Law 115–123 which extended the blended payment rate for the site neutral payment rate cases to apply to discharges occurring in cost reporting periods beginning in FYs 2018 and 2019.

(10) Section 51005(b) of Public Law which reduces the IPPS comparable amount for the site neutral payment rate cases by 4.6 percent for FYs 2018 through 2026.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

[67 FR 56049, Aug. 30, 2002, as amended at 73 FR 24879, May 6, 2008; 79 FR 50355, Aug. 22, 2014; 82 FR 38512, Aug. 14, 2017; 83 FR 41704, Aug. 17, 2018]

§ 412.503 Definitions.

As used in this subpart—

CMS stands for the Centers for Medicare & Medicaid Services.

Discharge. A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of “long-term care hospital prospective payment system rate year” and “long-term care hospital prospective payment system fiscal year” specified in this section.

Long-term care hospital prospective payment system rate year means—

(1) From July 1, 2003 and ending on or before June 30, 2008, the 12-month period of July 1 through June 30.

(2) From July 1, 2008 and ending on September 30, 2009, the 15-month period of July 1, 2008 through September 30, 2009.

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

LTC-DRG stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes. Effective October 1, 2007, long-term care hospital patient discharges occurring on or after October 1, 2007, are classified by a severity-adjusted patient classification system, the MS-LTC-DRGs. Any reference to the term “LTC-DRG” shall be considered a reference to the term “MS-LTC-DRG” when applying the provisions of this subpart for policy descriptions and payment calculations for discharges from a long-term care hospital occurring on or after October 1, 2007.

MSA means a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

MSA-dominant area means an MSA in which an MSA-dominant hospital is located.

MSA-dominant hospital means a hospital that has discharged more than 25 percent of the total subsection (d) hospital Medicare discharges in the MSA (not including discharges paid by a Medicare Advantage plan) in which the hospital is located.

MS-LTC-DRG stands for the severity-adjusted diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes for discharges from a long-term care hospital occurring on or after October 1, 2007.

Outlier payment means an additional payment beyond the long-term care hospital standard Federal payment rate or the site neutral payment rate (including, when applicable, the blended payment rate), as applicable, for cases with unusually high costs.