

system wage index value for non-reclassified hospitals, applicable large urban location and cost of living adjustment factors for long-term care hospitals for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the applicable fixed loss amount established for the hospital inpatient prospective payment system.

(f) *Transition period for long-term care hospitals and satellites paid under this section.* In the case of a long-term care hospital or satellite of a long-term care hospital that is paid under the provisions of this section, the thresholds applied under paragraphs (b), (c) and (d) of this section will not be less than the percentages specified below:

(1) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite of a long-term care hospital from that referring hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(2) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted from that referring hospital during the long-term care hospital's or

satellite's RY 2005 cost reporting period.

(3) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital to the long-term care hospital during the cost reporting period.

(4) In determining the percentage of Medicare discharges admitted from the referring hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward this threshold.

[72 FR 26993, May 11, 2007, as amended at 73 FR 26840, May 9, 2008; 73 FR 29711, May 22, 2008; 74 FR 44000, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53680, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012; 79 FR 50357, Aug. 22, 2014]

§ 412.538 [Reserved]

§ 412.540 Method of payment for preadmission services under the long-term care hospital prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(a) Otherwise payable under Medicare Part B;

(b) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the long-term care hospital, or to an entity wholly owned or wholly operated by the long-term care hospital; and

(1) An entity is wholly owned by the long-term care hospital if the long-term care hospital is the sole owner of the entity.

(2) An entity is wholly operated by a long-term care hospital if the long-term care hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the long-term care hospital also has policymaking authority over the entity.

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(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