(b) *Assignment of discharges to LTC-DRGs.* (1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and the patient's discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC-DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC-DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC-DRG assignment is appropriate. If the intermediary decides that a different LTC-DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in §476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

§412.515 LTC–DRG weighting factors.

(a) For each LTC–DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

(b)(1) Beginning FY 2023, each LTC–DRG weight is subject to a maximum 10 percent reduction as compared to the weight for the same LTC–DRG for the prior fiscal year, except as provided in paragraph (b)(2) of this section.

(2) The limitation described in paragraph (b)(1) of this section does not apply to LTC–DRGs with less than 25 applicable LTCH cases in the data used to determine the relative weights for the fiscal year.

[87 FR 49405, Aug. 10, 2022]

§412.517 Revision of LTC-DRG group classifications and weighting factors.

(a) CMS adjusts the classifications and weighting factors annually to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of hospital resources.

(b) Beginning in FY 2008, the annual changes to the LTC–DRG classifications and recalibration of the weighting factors described in paragraph (a) of this section are made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.

(c) Beginning in FY 2016, the annual recalibration of the weighting factors described in paragraph (a) of this section is determined using long-term care hospital discharges described in §412.522(a)(2) (or that would have been described in such section had the application of the site neutral payment rate been in effect at the time of the discharge).

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 26991, May 11, 2007; 80 FR 49768, Aug. 17, 2015]

§412.521 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) Except as provided for in §412.526, the amount of payment under the prospective payment system is based on

either the long-term care hospital prospective payment system standard Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, or the site neutral payment rate established in accordance with § 412.522(c), or, if applicable during a transition period, the blend of the LTCH PPS standard Federal payment rate and the applicable site neutral payment rate described in § 412.522(c)(3).

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in §§ 412.2(c)(1) through (c)(4) of this part and § 412.540 and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§ 413.75 through 413.83, 413.85, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in § 413.89 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements, as specified in § 412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with § 476.78(c) of this chapter.

(c) *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 that is primary to Medicare pays in full or in part, payment is determined in accordance with the guidelines specified in § 412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in § 412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) 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.

(ii) 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.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthetists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior

to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 69 FR 49250, Aug. 11, 2004; 70 FR 47487, Aug. 12, 2005; 75 FR 50416, Aug. 16, 2010; 79 FR 50355, Aug. 22, 2014; 80 FR 49768, Aug. 17, 2015]

§412.522 Application of site neutral payment rate.

(a) *General.* For discharges in cost reporting periods beginning on or after October 1, 2015—

(1) Except as provided for in paragraph (b) of this section, all discharges are paid based on the site neutral payment rate as determined under the provisions of paragraph (c) of this section.

(2) Discharges that meet the criteria for exclusion from site neutral payment rate specified in paragraph (b) of this section are paid based on the standard Federal prospective payment rate established under §412.523.

(b) *Criteria for exclusion from the site neutral payment rate*—(1) *General criteria*—(i) *Basis and scope.* A discharge that meets the following criteria is excluded from the site neutral payment rate specified under this section.

(A) The discharge from the long-term care hospital does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation based on the LTC–DRG assignment of the discharge under §412.513; and

(B) The admission to the long-term care hospital was immediately preceded by a discharge from a subsection (d) hospital and meets either the intensive care unit criterion specified in paragraph (b)(1)(ii) of this section or the ventilator criterion specified in paragraph (b)(1)(iii) of this section. In order for an admission to a long-term care hospital to be considered immediately preceded for purposes of this section, the patient discharged from the subsection (d) hospital must be directly admitted to the long-term care hospital.

(ii) *Intensive care unit criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the subsection (d) hospital that immediately preceded the admission to the long-term care hospital includes at least 3 days in an intensive care unit (as defined in §413.53(d) of this chapter), as evidenced by at least one of the revenue center codes on the claim for the discharge that indicate such services were provided for the requisite number of days during the stay.

(iii) *Ventilator criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the long-term care hospital is assigned to a LTC–DRG based on the patient's receipt of ventilator services of at least 96 hours, as evidenced by the procedure code on the discharge bill indicating such services were provided during the stay.

(2) *Special criteria*—(i) *Definitions.* For purposes of this paragraph (b)(2) the following definitions are applicable:

Severe wound means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound with morbid obesity as identified by the applicable code on the claim from the long-term care hospital.

Wound means an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(ii) *Discharges for severe wounds.* A discharge that occurs on or after April 21, 2016 and before January 1, 2017 for a patient that was treated for a severe wound that meets the all of following criteria is excluded from the site neutral payment rate specified under this section:

(A) The severe wound meets the definition specified in paragraph (b)(2)(i) of this section.