

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.

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.

§ 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.

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§ 412.521 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, long-term care hospitals receive a predeter-

mined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, and, if applicable during a transition period, on a blend of the Federal payment rate and the cost-based reimbursement rate described in § 412.533.

(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 anesthesiologists 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