

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§412.523(d)(1) and 412.525(a).

(3) The validity of the hospital's diagnostic and procedural information.

(4) The completeness, adequacy, and quality of the services furnished in the hospital.

(5) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Physician acknowledgement.* Payment under the long-term care hospital prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

NOTICE TO PHYSICIANS: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(2) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(c) *Denial of payment as a result of admissions and quality review.* (1) If CMS determines, on the basis of information supplied by a QIO, that a hospital has

misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived in accordance with §§411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General for handling in accordance with §1001.201 of this title.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

§412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of §412.521(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

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(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in §410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in §409.3 of this subchapter).

§412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

[71 FR 48140, Aug. 18, 2006]

§412.513 Patient classification system.

(a) *Classification methodology.* CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(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.

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.