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at the off-campus location, the policies set forth in this paragraph (h) and in §412.536 do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007 and before July 1, 2012, and for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013.

(6) For long-term care hospitals and satellite facilities with cost reporting periods beginning on or after July 1, 2012 and before October 1, 2012.

(i) Payments to long-term care hospitals and satellite facilities described in paragraphs (h)(4) and (h)(5) of this section are determined using the methodology specified in paragraph (c)(1) of this section for discharges occurring prior to October 1, 2012 during the hospital's or satellite facility's cost reporting period beginning on or after July 1, 2012 and before October 1, 2012. Such policies will not be applied to discharges occurring on or after October 1, 2012 and before the beginning of the hospital's or satellite facility's next cost reporting period.

(ii) In determining whether the percentage of discharges during a long-term care hospital's or satellite facility's cost reporting period beginning on or after July 1, 2012 and before October 1, 2012 exceeds the 25-percent threshold, those discharges occurring on or after October 1, 2012 and before the beginning of the hospital's or satellite facility's next cost reporting period will not be counted towards that threshold.

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

[69 FR 49251, Aug. 11, 2004, as amended at 69 FR 78529, Dec. 30, 2004; 71 FR 27900, May 12, 2006; 72 FR 26992, May 11, 2007; 73 FR 26839, May 9, 2008; 73 FR 29709, May 22, 2008; 74 FR 43998, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53679, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012]

§412.535 Publication of the Federal prospective payment rates.

Except as specified in paragraph (b), CMS publishes information pertaining to the long-term care hospital prospec-

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tive payment system effective for each annual update in the FEDERAL REGISTER.

(a) For the period beginning on or after July 1, 2003 and ending on June 30, 2008, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of each long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(b) For the period beginning on July 1, 2008 and ending on September 30, 2009, information of the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of the long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(c) For the period beginning on or after October 1, 2009, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before August 1 prior to the start of the Federal fiscal year which begins October 1, unless for good cause it is published after August 1, but before September 1.

(d) Information on the LTC-DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.

[68 FR 34163, June 6, 2003, as amended at 73 FR 26839, May 9, 2008]

§412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital.

(a) *Scope.* (1) Except as specified in paragraph (a)(2) of this section, for cost reporting periods beginning on or after July 1, 2007, the policies set forth in this section apply to discharges from the following:

(i) Long-term care hospitals as described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(e).

(ii) Long-term care hospitals as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(f).

(iii) Long-term care hospital satellite facilities as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(h).

(iv) Long-term care hospitals as described in § 412.23(e)(5).

(2) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2012, and for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013, the policies set forth in this section are not applicable to discharges from:

(i) A long-term care hospital described in § 412.23(e)(5) of this part; or

(ii) A long-term care hospital described in § 412.23(e)(2)(i) of this part and that meet the criteria specified in § 412.22(f) of this part; or

(iii) A long-term care hospital or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location.

(3) For certain long-term care hospitals with cost reporting periods beginning on or after July 1, 2012 and before October 1, 2012—

(i) Payments to long-term care hospitals described in paragraph (a)(1)(iv) of this section are determined using the methodology specified in either paragraph (b)(1) or paragraph (b)(2) of this section, for discharges occurring prior to October 1, 2012 during the hospital's cost reporting period beginning on or after July 1, 2012 and before October 1, 2012. Such policies will not be applied to the discharges occurring on or after October 1, 2012 and before the beginning of the hospital's next cost reporting period.

(ii) In determining whether the percentage of long-term care hospital discharges during a long-term care hospital's cost reporting period beginning on or after July 1, 2012 and before October 1, 2012 exceeds the 25 percent threshold, those discharges occurring on or after October 1, 2012, and before the beginning of the hospital's next

cost reporting period, will not be counted towards that threshold.

(iii) In determining the percentage of Medicare discharges admitted to the long-term care hospital from any referring hospital not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital under paragraphs (b)(1) and (b)(2) of this section, patients on whose behalf a Medicare high cost outlier payment was made to the referring hospital are not counted toward the 25 percent threshold from that referring hospital.

(b) For cost reporting periods beginning on or after July 1, 2007, payments for discharges of Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite facility will be made under either paragraph (b)(1) or paragraph (b)(2) of this section.

(1) Except as provided in paragraphs (c), (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or a long-term care hospital satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the long-term care hospital or the satellite facility from any individual hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payments for the Medicare discharges admitted from that hospital are made under the rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (c) and (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the long-term care hospital or satellite facility from any individual hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who cause the long-term care hospital or satellite facility to exceed

the 25 percent threshold for discharged patients who have been admitted from that referring hospital is the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that would be determined under the rules at subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(3) In determining the percentage of Medicare discharges admitted to the long-term care hospital or long-term care hospital satellite facility from any referring hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, under paragraphs (b)(1) and (b)(2) of this section, patients on whose behalf a Medicare high cost outlier payment was made to the referring hospital are not counted towards the 25 percent threshold from that referring hospital.

(c) *Special treatment of rural hospitals.*

(1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is located in a rural area as defined in §412.503 that has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or long-term care hospital satellite facility from a hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for Medicare discharges is determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that is otherwise payable under subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's Medicare discharges admitted

from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(2) In determining the percentage of Medicare discharges admitted from the referring hospital under paragraph (c)(1) of this section, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward the 50 percent threshold.

(d) *Special treatment of urban single or MSA dominant hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that admits Medicare patients from the only other hospital in the MSA or from a referring MSA dominant hospital as defined in paragraph (d)(4) of this section, that are not co-located with the long-term care hospital or with the satellite of a long-term care hospital for any cost reporting period beginning on or after July 1, 2007, in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (d)(2) of this section were admitted to the hospital from the single or MSA-dominant referring hospital, payment for the Medicare discharges who are admitted from the referring hospital and who cause the long-term care hospital or long-term care hospital satellite facility to exceed the applicable threshold for Medicare discharges who have been admitted from the referring hospital is the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that otherwise would be determined under subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(2) For purposes of paragraph (d)(1) of this section, the percentage threshold is equal to the percentage of total Medicare discharges in the Metropolitan Statistical Area (MSA) in which

the hospital is located that are from the referring hospital, but in no case is less than 25 percent or more than 50 percent.

(3) In determining the percentage of patients admitted from the referring hospital under paragraph (d)(1) of this section, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the applicable threshold.

(4) For purposes of this paragraph, an “MSA-dominant hospital” is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(e) *Calculation of adjusted payment—*
 (1) *Calculation of adjusted long-term care hospital prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be paid under the hospital inpatient prospective payment system at subpart A, §412.1(a). The amount is based on the sum of the applicable hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the long-term care hospital discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications defined at §412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for nonreclassified hospitals. For long-term care hospitals located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

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

(3) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment 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

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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]

§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.

(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 nondiagnostic 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