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.

§ 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 the 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 cost 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 under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year’s experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to \( \frac{1}{26} \) of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) Special interim payment for unusually long lengths of stay—(1) First interim payment. A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) Additional interim payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were
§ 412.600 Basis and scope of subpart.

(a) Basis. This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as “inpatient rehabilitation facilities”).

(b) Scope. This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

CMS stands for the Centers for Medicare & Medicaid Services.

Comorbidity means a specific patient condition that is secondary to the patient’s principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Discharge. A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized patient assessment software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within...