(3) For discharges occurring on or after July 1, 2008, a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) Long-term care hospitals subject to the prospective payment system. To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) General requirements. (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

§ 412.507 Limitation on charges to beneficiaries.

(a) Prohibited charges. Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system. If Medicare has paid the full LTC-DRG payment, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met. If Medicare pays less than the full LTC-DRG payment, that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(b) Permitted charges. (1) A long-term care hospital that receives a full LTC-DRG payment under this subpart for covered days in a hospital stay may charge the Medicare beneficiary only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter, and for items and services as specified under § 489.20(a) of this chapter.

(2) A long-term care hospital that receives less than the full LTC-DRG payment for a short-stay case, in accordance with § 412.529, may only charge the Medicare beneficiary for the applicable deductible and coinsurance under §§ 409.82, 409.83, and 409.87 of this subchapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay payment.

§ 412.508 Medical review requirements.

(a) Admission and quality review. A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(1) The medical necessity, reasonableness, and appropriateness of hospital admissions and discharges.

(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.