

less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility 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 inpatient rehabilitation facility no longer meets the requirements of §413.64(h) of this chapter.

(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 costs of an approved education program and other 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 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

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AUTHORITY: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

SOURCE: 51 FR 34793, Sept. 30, 1986, unless otherwise noted.

Subpart A—Introduction and General Rules

§ 413.1 Introduction.

(a) *Basis, scope, and applicability—(1) Statutory basis—(i) Basic provisions.* (A) Section 1815 of the Act requires that the Secretary make interim payments to providers and periodically determine the amount that should be paid under

Part A of Medicare to each provider for the services it furnishes.

(B) Section 1814(b) of the Act (for Part A) and section 1833(a) (for Part B) provide for payment on the basis of the lesser of a provider's reasonable costs or customary charges.

(C) Section 1861(v) of the Act defines “reasonable cost”.

(ii) *Additional provisions.* (A) Section 1138(b) of the Act specifies the conditions for Medicare payment for organ procurement costs.

(B) Section 1814(j) of the Act provides for exceptions to the “lower of costs or charges” provisions.

(C) Sections 1815(a) and 1833(e) of the Act provide the Secretary with authority to request information from providers to determine the amount of Medicare payment due providers.

(D) Section 1833(a)(4) and (i)(3) of the Act provide for payment of a blended amount for certain surgical services furnished in a hospital's outpatient department.

(E) Section 1833(n) of the Act provides for payment of a blended amount for outpatient hospital diagnostic procedures such as radiology.

(F) Section 1834(c)(1)(C) of the Act establishes the method for determining Medicare payment for screening mammograms performed by hospitals.

(G) Section 1834(g) of the Act provides that payment for critical access hospital (CAH) outpatient services is the reasonable costs of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter.

(H) Section 1881 of the Act authorizes payment for services furnished to ESRD patients.

(I) Section 1883 of the Act provides for payment for post-hospital SNF care furnished by a rural hospital that has swing-bed approval.

(J) Sections 1886(a) and (b) of the Act impose a ceiling on the rate of increase in hospital inpatient costs.

(K) Section 1886(h) of the Act provides for payment to a hospital for the services of interns and residents in approved teaching programs on the basis of a “per resident” amount.

(2) *Scope.* This part sets forth regulations governing Medicare payment for services furnished to beneficiaries by—

- (i) Hospitals and critical access hospitals (CAHs);
- (ii) Skilled nursing facilities (SNFs);
- (iii) Home health agencies (HHAs);
- (iv) Comprehensive outpatient rehabilitation facilities (CORFs);
- (v) End-stage renal disease (ESRD) facilities;
- (vi) Providers of outpatient physical therapy and speech pathology services (OPTs); and
- (vii) Organ procurement agencies (OPAs) and histocompatibility laboratories.

(3) *Applicability.* The payment principles and related policies set forth in this part are binding on CMS and its fiscal intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section.

(b) *Reasonable cost reimbursement.* Except as provided under paragraphs (c) through (h) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services, if lower. Regulations implementing section 1861(v) are found generally in this part beginning at §413.5.

(c) *Outpatient maintenance dialysis and related services.* Section 1881 of the Act authorizes special rules for the coverage of and payment for services furnished to ESRD patients. Sections 413.170 and 413.174 implement various provisions of section 1881. In particular, §413.170 establishes a prospective payment method for outpatient maintenance dialysis services that applies both to hospital-based and independent ESRD facilities, and under which Medicare pays for both home and inpatient dialysis services furnished on or after August 1, 1983.

(d) *Payment for inpatient hospital services.* (1) For cost reporting periods beginning before October 1, 1983, the amount paid for inpatient hospital

services is determined on a reasonable cost basis.

(2) Payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of hospital inpatient services for cost reporting periods beginning on or after October 1, 1983, and for the capital-related costs of inpatient services for cost reporting periods beginning on or after October 1, 1991, are determined prospectively on a per discharge basis under part 412 of this chapter except as follows:

(i) Payment for capital-related costs for cost reporting periods beginning before October 1, 1991, medical education costs, kidney acquisition costs, and the costs of certain anesthesia services, is described in §412.113 of this chapter.

(ii) Payment to children's and psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that are excluded from the prospective payment systems under subpart B of Part 412 of this subchapter and hospitals outside the 50 states and the District of Columbia is on a reasonable cost basis, subject to the provisions of §413.40.

(iii) Payment to hospitals subject to a State reimbursement control system is described in paragraph (e) of this section.

(iv) For cost reporting periods beginning before January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is made on a reasonable cost basis, subject to the provisions of §413.40.

(v) For cost reporting periods beginning on or after January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of §412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

(vi) For cost reporting periods beginning before October 1, 2002, payment to long-term care hospitals that are excluded under subpart B of Part 412 of this subchapter from the prospective payment systems is on a reasonable

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cost basis, subject to the provisions of §413.40.

(vii) For cost reporting periods beginning on or after October 1, 2002, payment to the long-term hospitals that meet the condition for payment of §§412.505 through 412.511 of this subchapter is based on prospectively determined rates under subpart O of Part 412 of this subchapter.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this part, if the State system is approved by CMS. Regulations implementing this alternative reimbursement authority are set forth in subpart C of part 403 of this chapter.

(f) *Services of qualified nonphysician anesthetists.* For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, costs incurred for the services of qualified nonphysician anesthetists are not paid on a reasonable cost basis unless the provisions of §412.113(c)(2) of this chapter apply. These services are paid under the special rules set forth in §405.553 of this chapter.

(g) *Payment for services furnished in SNFs.* (1) Except as specified in paragraph (g)(2)(ii) of this section, the amount paid for services furnished in cost reporting periods beginning before July 1, 1998, is determined on a reasonable cost basis or, where applicable, in accordance with the prospectively determined payment rates for low-volume SNFs established under section 1888(d) of the Act, as set forth in subpart I of this part.

(2) The amount paid for services (other than those described in §411.15(p)(2) of this chapter)—

(i) That are furnished in cost reporting periods beginning on or after July 1, 1998, to a resident who is in a covered Part A stay, is determined in accordance with the prospectively determined payment rates for SNFs established under section 1888(e) of the Act, as set forth in subpart J of this part.

(ii) That are furnished on or after July 1, 1998, to a resident who is not in a covered Part A stay, is determined in

accordance with any applicable Part B fee schedule or, for a particular item or service to which no fee schedule applies, by using the existing payment methodology utilized under Part B for such item or service.

(h) *Payment for services furnished by HHAs.* The amount paid for home health services as defined in section 1861(m) of the Act (except durable medical equipment and the covered osteoporosis drug as provided for in that section) that are furnished beginning on or after October 1, 2000 to an eligible beneficiary under a home health plan of care is determined according to the prospectively determined payment rates for HHAs set forth in part 484, subpart E of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 57 FR 39829, Sept. 1, 1992; 58 FR 30670, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 60 FR 33136, June 27, 1995; 60 FR 37594, July 21, 1995; 60 FR 50441, Sept. 29, 1995; 62 FR 31, Jan. 2, 1997; 62 FR 46032, 46037, Aug. 29, 1997; 63 FR 26309, May 12, 1998; 65 FR 18537, Apr. 7, 2000; 65 FR 40535, June 30, 2000; 65 FR 41211, July 3, 2000; 65 FR 46796, July 31, 2000; 66 FR 41394, Aug. 7, 2001; 67 FR 44077, July 1, 2002; 67 FR 56055, Aug. 30, 2002]

§413.5 Cost reimbursement: General.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services furnished Medicare beneficiaries are subject to the provisions of §§413.13 and 413.30.