

(iii) A hospital that did not qualify for reasonable cost payment for non-physician anesthesiologist services furnished in calendar year 1989 can qualify for reasonable cost payment in subsequent calendar years, if it meets the criteria in §412.113(c)(2)(i) (A), (B) and (D) above, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Organ acquisition.* Payment for organ acquisition costs incurred by hospitals with approved transplantation centers is made on a reasonable cost basis. The term "Organs" is defined in §486.302 of this chapter.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected in the Finding Aids section of this volume.

#### §412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.80 of this chapter for bad debts attributable to deductible and co-insurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac.

(c) *PRO photocopy and mailing costs.* An additional payment is made to a hospital in accordance with §466.78 of this chapter for the costs of

photocopying and mailing medical records requested by a PRO.

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#### §412.116 Method of payment.

(a) *General rule.* Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded psychiatric or a rehabilitation unit of a hospital are made as described in §413.64 (a), (c), (d), and (e) of this chapter.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The

hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in §412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in §413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These 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.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as deter-

mined under §412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1, 1991, the intermediary computes a hospital's estimated average prospective payment amount for capital-related costs by multiplying its prospective payment rate as determined under §412.340 or §412.344(a), as applicable, and under §412.308 for cost reporting periods beginning on or after October 1, 2001 but without adjustment by a DRG weighting factor, by the hospital's case-mix index. The intermediary may take into account estimated additional payments per discharge under §412.348. If the hospital is paid under §412.344(a)(1), the intermediary includes an estimated payment for old capital costs per discharge.

(C) If a hospital has payment experience under the prospective payment system for operating costs, and, for cost reporting periods beginning on or after October 1, 1991, for inpatient capital-related costs, the intermediary computes a hospital's estimated average prospective payment amount for operating costs and capital-related costs based on that payment experience, adjusted for projected changes, and subtracts from this amount estimated deductibles and coinsurance.

(4) *Termination of periodic interim payments—(i) Request by the hospital.* A hospital receiving periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates periodic interim payments if—

(A) A hospital no longer meets the requirements of §413.64(h);

(B) A hospital is receiving payment under the criterion in paragraph (b)(1)(i) of this section and the intermediary meets the prompt payment requirements of section 1816(c)(2) of the Act for three consecutive calendar months; or

(C) A hospital that is receiving payment under the criterion set forth in paragraph (b)(1)(iii) of this section no longer meets the criterion.

(iii) *Limitation on reelection.* If a hospital that is receiving periodic interim payments under the criterion set forth in paragraph (b)(1)(ii) or (b)(1)(iii) of this section is removed from that method of payment at its own request, it may reelect to receive periodic interim payments only under the criterion set forth in paragraph (b)(1)(i) of this section. However, if the hospital is removed from that method of payment by its intermediary because it no longer meets the requirements of §413.64(h) of this chapter, that hospital may subsequently reelect to receive periodic interim payments if it qualifies under the provisions of paragraph (b)(1)(ii) or (b)(1)(iii) of this section, subject to the requirements in §413.64(h) of this chapter.

(c) *Special interim payments for certain costs.* For capital-related costs for cost-reporting periods beginning before October 1, 1991 and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§413.130 and 413.85 of this chapter, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items for cost-reporting periods beginning before October 1, 1991 and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Medicare Part A and for kidney acquisition costs in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made two weeks after the end of a biweekly period of services, as described in §413.64(h)(5) of this chapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(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 after a Medicare beneficiary has been in the hospital at least 60 days. 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 the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph (d).

(e) *Outlier payments.* Payments for outlier cases (described in subpart F of this part) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

(f) *Accelerated payments—(1) General rule.* Upon request, an accelerated payment may be made to a hospital that is not receiving periodic interim payments under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the hospital.

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

(2) *Approval of payment.* A hospital's request for an accelerated payment must be approved by the intermediary and HCFA.

(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 hospital bills are processed or by direct payment by the hospital.

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