

a risk-basis HMO by common ownership or control (see §417.250(c) of this chapter).

(3) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of §413.40 or part 412 of this chapter. The intermediary will grant the exception without request from the provider.

(g) *Appeals.* A request by a provider for a hearing on the determination of an intermediary concerning the therapy costs determined to be allowable based on the provisions of this section, including a determination with respect to an exception under paragraph (f) of this section, is made to the intermediary only after submission of its cost report and receipt of the notice of amount of program reimbursement reflecting such determination, in accordance with the provisions of subpart R of part 405 of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 63 FR 5139, Jan. 30, 1998]

**§413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.**

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals having a swing-bed approval. Payments to these hospitals for posthospital SNF care furnished in general routine inpatient beds are based on the reasonable cost of posthospital SNF care in accordance with paragraph (c) of this section. Swing-bed hospitals approved after March 31, 1988 with more than 49 beds must meet additional payment requirements as set forth in paragraph (d) of this section.

(b) *Definitions.* For purposes of this section—

*Availability date* means with respect to a posthospital SNF care patient in a swing-bed hospital, the later of—

(i) Any date on which a bed is available for the patient in a Medicare-participating SNF located within the hospital's geographic region;

(ii) The date that a hospital learns that a bed is available in a Medicare-participating SNF; or

(iii) If the notice is prospective, the date that a bed will become available in a Medicare-participating SNF.

*Geographic region* means an area that includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area that includes all the SNFs within 50 miles (as defined in §412.92(c)(1) of this chapter) of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within a hospital's geographic region or the SNF is inaccessible to hospital patients, the HCFA Regional Office makes a determination.

*Swing-bed hospital* means a hospital or CAH participating in Medicare that has an approval from HCFA to provide posthospital SNF care as defined in §409.20 of this chapter, and meets the requirements specified in §482.66 or §485.645 of this chapter, respectively.

(c) *Principle.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

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(2) The reasonable cost of ancillary services furnished as posthospital SNF care is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with §413.55(a)(1).

(d) *Additional requirements*—(1) *General rule.* Prior to Medicare payment being made to a swing-bed hospital with more than 49 beds (but fewer than 100) the following payment requirements must be met:

(i) If there is an available SNF bed in the geographic region, a posthospital SNF care patient must be transferred within 5 days (excluding weekends and holidays) of the availability date, unless the patient’s physician certifies within the 5-day period that transfer is not medically appropriate.

(ii) The number of patient days for posthospital SNF care in a cost reporting period does not exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the period. In those States that do not license their hospital beds, the hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON), excluding bassinets. If during the cost reporting period, there is an increase or decrease in the number of “licensed” beds, the number of “licensed” beds for each part of the period is to be multiplied by the number of days for which that number of “licensed” beds was available. After totalling the results, compute 15 percent of the total available “licensed” bed days to determine the payment limitation.

(2) *Payment restrictions.* (i) The hospital must not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient’s physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate.

(ii) The hospital must not seek payment for posthospital SNF care in a cost reporting period to the extent that they exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the period. In those States that do not

license hospital beds, the hospital must use the average number of hospital beds reported on its most recent CON, excluding bassinets.

(3) *Payment exception.* Payment will continue to be made during the cost reporting period in which the 15 percent limit specified in paragraph (d)(1)(ii) of this section is reached for those patients who are receiving posthospital SNF care at the time the hospital reaches the limit.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 37274, Sept. 7, 1989; 56 FR 54545, Oct. 22, 1991; 58 FR 30671, May 26, 1993; 61 FR 51616, Oct. 3, 1996; 62 FR 46037, Aug. 29, 1997]

**§413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.**

(a) *Basis and scope.* This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with HCFA to be paid in accordance with §416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) *Definitions.* For purposes of this section—

*Facility services* are those items and services, as specified in §416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in §416.65 of this chapter.

*Standard overhead amount* means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) *Payment principle.* The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under §416.65 of this chapter) is equal to the lesser of—

(1) The hospital’s reasonable cost or customary charges, as determined in