

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* HCFA publishes these changes in the FEDERAL REGISTER in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPAC.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPAC upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPAC before implementation.

[50 FR 35688, Sept. 3, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 57 FR 39820, Sept. 1, 1992]

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraph (b) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid for under the prospective payment systems.

(b) Inpatient hospital services will not be paid for under the prospective payment systems under any of the following circumstances:

(1) The services are furnished by a hospital (or hospital unit) explicitly excluded from the prospective payment systems under §§ 412.23, 412.25, 412.27, and 412.29.

(2) The services are emergency services furnished by a nonparticipating hospital in accordance with § 424.103 of this chapter.

(3) The services are paid for by an HMO or competitive medical plan

(CMP) that elects not to have HCFA make payments directly to a hospital for inpatient hospital services furnished to the HMO's or CMP's Medicare enrollees, as provided in § 417.240(d) and § 417.586 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 39820, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994]

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section, all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this chapter.

(c) *Special payment provisions.* The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment system:

(1) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(2) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(3) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(4) *Chief executive officer.* The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(5) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(i) The hospital performs the basic functions specified in §§482.21 through 482.27, 482.30, and 482.42 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(ii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in §412.23(d)(2) or the length-of-stay criterion in §412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in §412.2(c). For purposes of this paragraph (e)(5)(ii), however, the costs of preadmission services are those specified under §413.40(c)(2) rather than those specified under §412.2(c)(5).

(iii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in §412.23(d)(2) or the length-of-stay criterion in §412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital.

(g) *Definition of control.* For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(B) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(C) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(D) It is treated as a separate cost center of the hospital of which it is a part.

(E) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(F) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under § 412.23(e)(2).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

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(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39820, Sept. 1, 1994; 62 FR 46026, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41540, July 30, 1999]

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section may not be reimbursed under the prospective payment systems.

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(2) Meet the conditions of participation for hospitals and special conditions of participation for psychiatric hospitals set forth in part 482 of this chapter.

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements:

(1) Have a provider agreement under part 489 of this chapter to participate as a hospital.

(2) Except in the case of a newly participating hospital seeking exclusion for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

- (i) Stroke.
- (ii) Spinal cord injury.
- (iii) Congenital deformity.
- (iv) Amputation.
- (v) Major multiple trauma.
- (vi) Fracture of femur (hip fracture).
- (vii) Brain injury.
- (viii) Polyarthrits, including rheumatoid arthritis.
- (ix) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
- (x) Burns.

(3) Have in effect a preadmission screening procedure under which each

prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment.

(4) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services.

(5) Have a director of rehabilitation who—

(i) Provides services to the hospital and its inpatients on a full-time basis;

(ii) Is a doctor of medicine or osteopathy;

(iii) Is licensed under State law to practice medicine or surgery; and

(iv) Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(6) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(7) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment.

(8) A hospital that seeks exclusion as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated such a population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months