

inpatient hospital services if it is reimbursed under special arrangement as provided in § 412.22(c).

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 51 FR 22041, June 17, 1986; 51 FR 31496, Sept. 3, 1986; 52 FR 33057, Sept. 1, 1987; 55 FR 36068, Sept. 4, 1990; 55 FR 46887, Nov. 7, 1990; 56 FR 43240, Aug. 30, 1991; 57 FR 39820, Sept. 1, 1992; 59 FR 45396, Sept. 1, 1994; 60 FR 45846, Sept. 1, 1995; 62 FR 46026, Aug. 29, 1997]

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment system, a psychiatric or rehabilitation unit must meet the following requirements.

- (1) Be part of an institution that—
 - (i) Has in effect an agreement under part 489 of this chapter to participate as a hospital;
 - (ii) Is not excluded in its entirety from the prospective payment systems; and
 - (iii) Has enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by § 413.24(c) of this chapter.
- (2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.
- (3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.
- (4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.
- (5) Meet applicable State licensure laws.
- (6) Have utilization review standards applicable for the type of care offered in the unit.
- (7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.
- (8) Be serviced by the same fiscal intermediary as the hospital.
- (9) Be treated as a separate cost center for cost finding and apportionment purposes.
- (10) Use an accounting system that properly allocates costs.
- (11) Maintain adequate statistical data to support the basis of allocation.

(12) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) through (b)(3) of this section.

(1) *Increase in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies its fiscal intermediary and the HCFA Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(3) *Exception to changes in square footage and bed size.* The number of beds in an excluded unit may be decreased, and the square footage considered to be part of the unit may be either increased or decreased, at any time, if these changes are made necessary by relocation of a unit—

- (i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or
- (ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

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(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(d) *Number of excluded units.* Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems.

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(4) of this section, a satellite facility is a part of a hospital unit 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 (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems for any period:

(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and

Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For a rehabilitation unit, the requirements under § 412.23(b)(2); or

(B) For a psychiatric unit, the requirements under § 412.27(a).

(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 unit of which it is a part.

(D) It is treated as a separate cost center of the hospital unit 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 specified in paragraph (e)(4) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

(4) In applying the provisions of paragraph (h)(3) of this section, any unit structured as a satellite facility as of

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 at any time, if these changes are made necessary by relocation of the facility—

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

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

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39820, Sept. 1, 1992; 58 FR 46337, Sept. 1, 1993; 59 FR 45400, Sept. 1, 1994; 64 FR 41540, July 30, 1999]

§ 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment systems, a psychiatric unit must meet the following requirements:

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.

(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy.

(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:

(1) *Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.

(i) The identification data must include the inpatient's legal status.

(ii) A provisional or admitting diagnosis must be made on every inpatient

at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.

(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(2) *Psychiatric evaluation.* Each inpatient must receive a psychiatric evaluation that must—

(i) Be completed within 60 hours of admission;

(ii) Include a medical history;

(iii) Contain a record of mental status;

(iv) Note the onset of illness and the circumstances leading to admission;

(v) Describe attitudes and behavior;

(vi) Estimate intellectual functioning, memory functioning, and orientation; and

(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.

(3) *Treatment plan.*

(i) Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and

(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.

(4) *Recording progress.* Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others