not exceed the number of beds at the satellite facility on September 30, 1999.

(6) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number, those hospital(s) with which it is co-located.

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any long-term care hospital that is subject to the long-term care hospital prospective payment system under Subpart O of this subpart, effective for cost reporting periods occurring on or after October 1, 2002, and that elects to be paid based on 100 percent of the Federal prospective payment rate as specified in §412.533(c), beginning with the first cost reporting period following that election, or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, or to a new long-term care hospital, as defined in §412.23(e)(4).

(8) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

[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; 66 FR 41386, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 67 FR 56048, Aug. 30, 2002; 68 FR 10988, Mar. 7, 2003; 68 FR 34162, June 6, 2003; 68 FR 45469, Aug. 1, 2003; 69 FR 49240, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 69 FR 66976, Nov. 15, 2004; 70 FR 24222, May 6, 2005; 71 FR 48136, Aug. 18, 2006; 72 FR 26991, May 11, 2007]

§412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in §412.1(a)(1):

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

(1) Meet the following requirements to be excluded from the prospective payment system as specified in §412.1(a)(1) and to be paid under the prospective payment system as specified in §412.1(a)(2) and in subpart N of this part;

(2) 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

(3) 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 to be excluded from the prospective payment systems specified in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3) and in Subpart P of this part:

(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 classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, a hospital must show that during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), it served an inpatient population that meets the criteria under paragraph (b)(2)(i) or (b)(2)(ii) of this section.

(i) For cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, the hospital has served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent, and for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph

(b)(2)(iii) of this section. A patient with a comorbidity, as defined at §412.602, may be included in the inpatient population that counts toward the required applicable percentage if—

(A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;

(B) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2)(iii) of this section; and

(C) The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

(ii) For cost reporting periods beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified in paragraph (b)(2)(iii) of this section. A patient with a comorbidity as described in paragraph (b)(2)(i) of this section is not included in the inpatient population that counts toward the required 75 percent.

(iii) *List of conditions.* (A) Stroke.

(B) Spinal cord injury.

(C) Congenital deformity.

(D) Amputation.

(E) Major multiple trauma.

(F) Fracture of femur (hip fracture).

(G) Brain injury.

(H) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(I) Burns.

(J) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(K) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(L) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

(M) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

(*1*) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

(*2*) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

(3) The patient is age 85 or older at the time of admission to the IRF.

(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 classification under this paragraph 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 that 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 occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in §412.1(a)(1) or is paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in accordance with the provisions in §412.130.

(c) [Reserved]

(d) *Children's hospitals.* A children's hospital must—

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

(2) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, when applicable, the additional requirement of §412.22(e), to be excluded from the prospective payment system specified in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(4) and in Subpart O of this part.

(1) *Provider agreements.* The hospital must have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(2) *Average length of stay.* (i) The hospital must have an average Medicare inpatient length of stay of greater than 25 days (which includes all covered and noncovered days of stay of Medicare patients) as calculated under paragraph (e)(3) of this section; or

(ii) For cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the prospective payment system under this section in 1986 meets the length of stay

criterion if it has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrates that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(3) *Calculation of average length of stay.* (i) Subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient length of stay specified under paragraph (e)(2)(i) of this section is calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average inpatient length of stay specified under paragraph (e)(2)(ii) of this section is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period.

(ii) Effective for cost reporting periods beginning on or after July 1, 2004, in calculating the hospital's average length of stay, if the days of a stay of an inpatient involves days of care furnished during two or more separate consecutive cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future consecutive cost reporting period, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged. However, if after application of this provision, a hospital fails to meet the average length of stay specified under paragraphs (e)(2)(i) and (ii) of this section, Medicare will determine the hospital's average inpatient length of stay for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2005, by dividing the applicable total days for Medicare inpatients under paragraph (e)(2)(i) of this section or the total days for all inpatients under paragraph (e)(2)(ii) of this section, during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period.

(iii) If a change in a hospital's average length of stay specified under paragraph (e)(2)(i) or paragraph (e)(2)(ii) of this section is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iv) If a hospital has undergone a change of ownership (as described in §489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(4) *Rules applicable to new long-term care hospitals*—(i) *Definition.* For purposes of payment under the long-term care hospital prospective payment system under subpart O of this part, a new long-term care hospital is a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

(ii) *Satellite facilities and remote locations of hospitals seeking to become new long-term care hospitals.* Except as specified in paragraph (e)(4)(iii) of this section, a satellite facility (as defined in §412.22(h)) or a remote location of a hospital (as defined in §413.65(a)(2) of this chapter) that voluntarily reorganizes as a separate Medicare participating hospital, with or without a concurrent change in ownership, and that seeks to qualify as a new long-term care hospital for Medicare payment purposes must demonstrate through

documentation that it meets the average length of stay requirement as specified under paragraphs (e)(2)(i) or (e)(2)(ii) of this section based on discharges that occur on or after the effective date of its participation under Medicare as a separate hospital.

(iii) *Provider-based facility or organization identified as a satellite facility and remote location of a hospital prior to July 1, 2003.* Satellite facilities and remote locations of hospitals that became subject to the provider-based status rules under §413.65 as of July 1, 2003, that become separately participating hospitals, and that seek to qualify as long-term care hospitals for Medicare payment purposes may submit to the fiscal intermediary discharge data gathered during 5 months of the immediate 6 months preceding the facility's separation from the main hospital for calculation of the average length of stay specified under paragraph (e)(2)(i) or paragraph (e)(2)(ii) of this section.

(f) *Cancer hospitals*—(1) *General rule.* Except as provided in paragraph (f)(2) of this section, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after October 1, 1989. A hospital classified after December 19, 1989, is excluded beginning with its first cost reporting period beginning after the date of its classification.

(i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.

(ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a State operating a demonstration project under section 1814(b) of the Act, the classification is made on or before December 31, 1991.

(iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).

(iv) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.)

(2) *Alternative.* A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria set forth in paragraph (f)(1) of this section is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after January 1, 1991, if it meets the criterion set forth in paragraph (f)(1)(i) of this section and the hospital is—

(i) Licensed for fewer than 50 acute care beds as of August 5, 1997;

(ii) Is located in a State that as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act; and

(iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(g) *Hospitals outside the 50 States, the District of Columbia, or Puerto Rico.* A hospital is excluded from the prospective payment systems if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(h) *Hospitals reimbursed under special arrangements.* A hospital must be excluded from prospective payment for inpatient hospital services if it is reimbursed under special arrangement as provided in §412.22(c).

(i) *Changes in classification of hospitals.* For purposes of exclusions from the prospective payment system, the classification of a hospital is effective for the hospital's entire cost reporting

period. Any changes in the classification of a hospital are made only at the start of a cost reporting period.

[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; 66 FR 39933, Aug. 1, 2001; 66 FR 41386, Aug. 7, 2001; 67 FR 56048, Aug. 30, 2002; 68 FR 45469, Aug. 1, 2003; 69 FR 25720, May 7, 2004; 69 FR 25775, May 7, 2004; 69 FR 66976, Nov. 15, 2004; 71 FR 48408, Aug. 18, 2006]

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in § 412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in § 412.1(a)(3), 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 CMS 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