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§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), (d), and (e) of this section, all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in §412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2005, covered inpatient hospital services furnished to Medicare beneficiaries by an inpatient psychiatric facility that meets the conditions of §412.404 are paid under the prospective payment system described in subpart N of this part.

(c)(1) Effective for cost reporting periods beginning on or after January 1,
§ 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 specified in §412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in §412.23. For purposes of this subpart, the term "hospital" includes a critical access hospital (CAH).

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section, and §412.20(b), (c), and (d), 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 as specified 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 paragraphs (e)(1)(vi) and (f) of this section, a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the

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prospective payment systems specified in §412.1(a)(1):

(1) Except as specified in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997—

(i) 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.

(ii) 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 by a third entity that controls both hospitals.

(iii) 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 by-laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) Chief executive officer. The hospital has a single chief executive officer through whom all administration 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.

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

(A) The hospital performs the basic functions specified in §§482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 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.

(B) 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 obtains 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)(1)(v)(B), however, the costs of preadmission services are those specified under §413.40(c)(2) rather than those specified under §412.2(c)(5).

(C) 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.

(vi) Effective October 1, 2008, if a State hospital that is occupying space in the same building or on the same campus as another State hospital cannot meet the criterion under paragraph (e)(1)(i) of this section solely because
its governing body is under the control of the State hospital with which it shares a building or a campus, or is under the control of a third entity that also controls the State hospital with which it shares a building or a campus, the State hospital can nevertheless qualify for exclusion if it meets the other applicable criteria in this section and—

(A) Both State hospitals occupy space in the same building or on the same campus and have been continuously owned and operated by the State since October 1, 1995;
(B) Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and
(C) Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the inpatient prospective payment system through September 30, 2008.

(2) Effective for long-term care hospitals-within-hospitals for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the governance and control requirements at paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(3) Notification of co-located status. 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, or in one or more entire buildings located on the same campus as buildings used by another hospital that changes the terms and conditions under which it operates after September 30, 2003, continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that 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 may increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time without affecting the provisions of paragraph (f)(1) or (f)(2) of this section.

(i) If a hospital to which the provisions of paragraph (f)(1) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 1995.

(ii) If a hospital to which the provisions of paragraph (f)(2) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 2003, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital.
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does not exceed the number of beds at the hospital on September 30, 2003.

(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)(5) 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 paragraphs (h)(3), (h)(4), (h)(5), (h)(7) and (h)(8) 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 acute care hospital inpatient 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 the 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) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) Except as provided in paragraph (h)(2)(iii)(A)(2) of this section, for cost reporting periods beginning on or after October 1, 2009, the governing body of the hospital of which the satellite facility is a part is not under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located.

(2) If a hospital and its satellite facility were excluded from the inpatient prospective payment system under the provisions of this section for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does not have to meet the requirements of paragraph (h)(2)(iii)(A)(2) of this section, with respect to that satellite facility, in order to retain its IPPS-excluded status.

(3) A hospital described in paragraph (h)(2)(iii)(A)(2) of this section that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, must meet the criteria in this section, including the provisions of paragraph (h)(2)(iii)(A)(2) of this section with respect to the additional satellite facility, in order to be excluded from the inpatient prospective payment system.

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

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

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

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

(F) 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.
(G) 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 paragraphs (h)(4) and (h)(5) 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 the 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)(ii).

(4) For cost reporting periods beginning before October 1, 2006, 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

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

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section—

(i) Any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage or decrease the number of beds considered to be part of the satellite facility at any time without affecting the provisions of paragraph (h)(3) of this section; and

(ii) If the satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the satellite facility does 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]

EDITORIAL NOTE: For Federal Register citations affecting §412.22, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.
(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 or unit must meet the requirements specified in §412.29 of this subpart to be excluded from the prospective payment systems specified in §412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in §412.1(a)(3) of this subpart and in subpart P of this part.

(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) of this subpart 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 25 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 (c)(1)(iv) of this section.

(3) Calculation of average length of stay. (i) Subject to the provisions of paragraphs (e)(3)(ii) through (v) 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 (v) 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 seeks exclusion from the inpatient prospective payment system as a long-term care hospital and a change of ownership (as described in § 489.18 of this chapter) occurs within the period of at least 5 months of the 6-month period preceding its petition for long-term care hospital status, the hospital may be excluded from the inpatient prospective payment system as a long-term care hospital for the next cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the cost reporting period for which the hospital is seeking exclusion from the inpatient prospective payment system as a long-term care hospital (including time before the change of ownership), the hospital has met the required average length of stay, has continuously operated as a hospital, and has continuously participated as a hospital in Medicare.

(v) For periods beginning on or after October 1, 2011, a hospital that is excluded from the inpatient prospective payment system as a long-term care hospital that plans to undergo a change of ownership (as described in § 489.18 of this chapter) must notify its fiscal intermediary or MAC within 30 days of the effective date of such change of ownership. The hospital will continue to be excluded from the inpatient prospective payment system as a long-term care hospital for the cost reporting period following the change of ownership only if, for the period of at least 5 months of the 6 months immediately preceding the change of ownership, the hospital meets the required average length of stay (calculated in accordance with paragraph (e)(3)(i) of this section).

(4) Rules applicable to new long-term care hospitals—(1) 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.

(5) Freestanding long-term care hospital. For purposes of this paragraph, a freestanding long-term care hospital
means a hospital that meets the requirements of paragraph (e)(1) and (2) of this section and all of the following:
(i) Does not occupy space in a building also used by another hospital.
(ii) Does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital.
(iii) Is not part of a hospital that provides inpatient services in a building also used by another hospital.

(6) Moratorium on the establishment of new long-term care hospitals and long-term care hospital satellite facilities—(i) General rule. Except as specified in paragraph (e)(6)(ii) of this paragraph, for the period beginning December 29, 2007 and ending December 28, 2012, a moratorium applies to the establishment and classification of a long-term care hospital or long-term care hospital satellite facility as described in §412.23(e).
(ii) Exception. The moratorium specified in paragraph (e)(6)(i) of this section is not applicable to the establishment and classification of a long-term care hospital that meets the requirements in paragraph (e) of this section or a long-term care hospital satellite facility that meets the requirements in §412.22(h), if the long-term care hospital met one of the following criteria on or before December 29, 2007:
(A) Began its qualifying period for payment in accordance with paragraph (e) of this section.
(B)(1) Has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease or demolition for a long-term care hospital; and
(2) Has expended, before December 29, 2007, at least 10 percent (or, if less, $2.5 million) of the estimated cost of the project specified in paragraph (ii)(B)(1) of this paragraph.
(C) Had obtained an approved certificate of need from the State, when required by State law.

(7) Moratorium on increasing the number of beds in existing long-term care hospitals and existing long-term care hospital satellite facilities. (i) For purposes of this paragraph, an existing long-term care hospital or long-term care hospital satellite facility means a long-term care hospital that meets the requirements of paragraph (e) of this section or long-term care hospital satellite facility that meets the requirements of §412.22(h) of this part and received payment under the provisions of subpart O of this part on or before December 29, 2007.
(ii) Effective for the period beginning December 29, 2007 and ending December 28, 2012—
(A) Except as specified in paragraph (e)(7)(ii)(B) and (C) of this section, the number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section must not be increased beyond the number of Medicare-certified beds on December 29, 2007.
(B) Except as specified in paragraph (e)(7)(ii)(B) of this section, the moratorium specified in paragraph (e)(7)(ii)(A) of this section is not applicable to—
(1) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that meets both of the following requirements:
(i) Is located in a State where there is only one other long-term care hospital that meets the criteria specified in §412.23(e) of this subpart.
(ii) Requests an increase in the number of Medicare-certified beds after the closure or decrease in the number of Medicare-certified beds of another long-term care hospital in the State; or
(2) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that obtained a certificate of need for an increase in beds and that meets both of the following requirements:
(i) Is in a State for which such certificate of need is required, and
(ii) Such certificate was issued on or after April 1, 2005, and before December 29, 2007.
(C) The exceptions specified in paragraph (e)(7)(ii)(B) of this section do not affect the limitation on increasing beds under §412.22(f) and §412.22(h)(3) of subpart.

(8) Application of LTCH moratorium on the increase in beds at section 114(d)(1)(B) of Public Law 110–173 to LTCHs and
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LTCH satellite facilities established or classified as such under section 114(d)(2) of Public Law 110–173. Effective for the period beginning October 1, 2011, and ending December 28, 2012, for long-term care hospitals and long-term care hospital satellite facilities established under paragraph (e)(6)(ii) of this section for the period beginning December 29, 2007, and ending September 30, 2011, the moratorium under paragraph (e)(7) of this section applies and the number of Medicare-certified beds must not be increased beyond the number of beds that were certified by Medicare at the long-term care hospital or the long-term care hospital satellite facility as of October 1, 2011.

(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 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]

EDITORIAL NOTE: For Federal Register citations affecting §412.23, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§412.25 Excluded hospital units: Common requirements.

(a) Basis for exclusion. In order to be excluded from the prospective payment
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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. Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(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 CMS 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)(5) 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 paragraphs (e)(3) and (e)(6) of this section, 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 acute care hospital inpatient 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 §412.29 of this subpart; or

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

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

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

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

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

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

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

(F) 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.

(G) 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 paragraphs (e)(4) and (e)(5) 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 at the satellite facility on September 30, 1999.

(4) In applying the provisions of paragraph (e)(3) of this section, any unit 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 considered to be part of the satellite facility at any time, if these changes are made by the relocation of a 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.
(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section—

(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of this section, without affecting the provisions of paragraph (e)(3) of this section; and

(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

(6) The provisions of paragraph (e)(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.

(f) Changes in classification of hospital units. For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit’s entire cost reporting period. Any changes in the classification of a hospital unit is made only at the start of a cost reporting period.

(g) CAH units not meeting applicable requirements. If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of §485.647 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of §485.647.


§ 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment system as specified in §412.1(a)(1), and paid under the prospective payment system as specified in §412.1(a)(2), 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 Fourth Edition, Text Revision 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, and therapeutic activities.

(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 therapeut ic 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 significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient’s progress in accordance with the original or revised treatment plan.

(5) Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient’s hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient’s condition on discharge.

(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:

(1) Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to—

(i) Evaluate inpatients;

(ii) Formulate written, individualized, comprehensive treatment plans;

(iii) Provide active treatment measures; and

(iv) Engage in discharge planning.

(2) Director of inpatient psychiatric services: Medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.
nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient’s active treatment program and to maintain progress notes on each inpatient.

(i) The director of psychiatric nursing services must be a registered nurse who has a master’s degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient’s active treatment program.

(4) Psychological services. The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.

(5) Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

(6) Therapeutic activities. The unit must provide a therapeutic activities program.

(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient’s active treatment program.

§412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:

(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.

(b) Except in the case of a “new” IRF or “new” IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:

(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section. A patient with a comorbidity, as defined at §412.602 of this part, may be included in the inpatient population that counts toward the required applicable percentage if—

(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;
(ii) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2) of this section; and
(iii) The comorbidity has caused significant decline in functional ability in the individual 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.

(2) List of 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) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson’s disease.
(ix) Burns.
(x) 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 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.)
(xii) Severe or advanced osteoarthritis (osteoarthritis 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.
(xiii) 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:
(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
(C) The patient is age 85 or older at the time of admission to the IRF.

(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2) of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF’s first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.
(1) New IRFs. An IRF hospital or IRF unit is considered new if it has not
been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.

(3) Change of ownership or leasing. An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in §489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital’s provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.

(d) 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. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient’s admission to the IRF.

(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process.

(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

(g) Have a director of rehabilitation who—
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(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;
(2) Is a doctor of medicine or osteopathy;
(3) Is licensed under State law to practice medicine or surgery; and
(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(h) 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.

(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient’s medical record to note the patient’s status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(j) Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in §412.130.

[76 FR 47891, Aug. 5, 2011]

§ 412.42 [Reserved]

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.40 General requirements.

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.

(b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—

(1) Withhold Medicare payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

(2) Terminate the hospital’s provider agreement.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992]

§ 412.42 Limitations on charges to beneficiaries.

(a) Prohibited charges. A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital’s costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

(b) Permitted charges—Stay covered. A hospital receiving payment under the prospective payment systems for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the following:

(1) The applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this chapter.

(2) Noncovered items and services, furnished at any time during a covered stay, unless they are excluded from coverage only on the basis of the following:

(i) The exclusion of custodial care under §405.310(g) of this chapter (see paragraph (c) of this section for when charges may be made for custodial care).

(ii) The exclusion of medically unnecessary items and services under §405.310(k) of this chapter (see paragraphs (c) and (d) of this section for when charges may be made for medically unnecessary items and services).

(iii) The exclusion under §405.310(m) of this chapter of nonphysician services furnished to hospital inpatients by other than the hospital or a provider or supplier under arrangements made by the hospital.