

(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 collocation 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.

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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.

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this

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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 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) 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 (vi) 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 (vi) 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, as specified in § 424.516(e) of this subchapter. The hospital will continue to be excluded from the inpatient prospective payment sys-

tem 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).

(vi) For cost reporting periods beginning on or after October 1, 2015, the Medicare inpatient days and discharges that are paid at the site neutral payment rate specified at § 412.522(c)(1) or paid under a Medicare Advantage plan (Medicare Part C) will not be included in the calculation of the Medicare inpatient average length of stay specified under paragraph (e)(2)(i) of this section. The provisions of this paragraph (e)(3)(vi) only apply to a hospital that is classified as of December 10, 2013, as a long-term care hospital (as defined in this section) for purposes of determining whether the requirements of paragraph (e)(2)(i) or (e)(2)(ii) of this section are met.

(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

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(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 paragraphs (e)(6)(ii) and (e)(6)(iii) of this section for the period beginning December 29, 2007 and ending December 28, 2012, and the period beginning April 1, 2014 and ending September 30, 2017, a moratorium applies to the establishment and classification of a long-term care hospital as described in paragraphs (e) and (e)(1) through (e)(5) of this section or a long-term care hospital satellite facility as described in §412.22(h).

(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 of paragraphs (e) introductory

text and (e)(1) through (e)(5) of this section, or a long-term care hospital satellite facility that meets the requirements of §412.22(h), if the long-term care hospital or long-term care satellite facility meets one or more of the following criteria on or before December 27, 2007, or prior to April 1, 2014, as applicable:

(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)(i) Has expended prior to December 29, 2007, at least 10 percent (or, if less, \$2.5 million) of the estimated cost of the project specified in paragraph (e)(6)(ii)(B)(1) of this section; or

(ii) Has expended, before April 1, 2014, at least 10 percent (or, if less, \$2.5 million) of the estimated cost of the project specified in paragraph (e)(6)(ii)(B)(1) of this section.

(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 a long-term care hospital satellite facility that meets the requirements of §412.22(h) that received payment under the provisions of subpart O of this part prior to the dates noted in the following moratorium clauses.

(ii) December 29, 2007, through December 28, 2007—

(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)(C) 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.

(iii) April 1, 2014 through September 30, 2017—The number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility must not be increased beyond the number of Medicare-certified beds prior to April 1, 2014.

(8) *Application of LTCH moratorium on the increase in beds at section 114(d)(1)(B) of Public Law 110-173 to LTCHs and 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 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

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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 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;

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(ii) Is not excluded in its entirety from the prospective payment systems; and

(iii) Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are not excluded from the inpatient prospective payment system, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater. Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an inpatient psychiatric facility unit, the hospital must have enough beds that are not excluded from the inpatient prospective payment system 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