CHAPTER 13
SECTION 6.1D

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS DRG-BASED PAYMENT SYSTEM (APPLICABILITY OF THE DRG SYSTEM)

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I. ISSUE

What providers and services are to be reimbursed under the TRICARE/CHAMPUS DRG-based payment system?

II. POLICY

A. Areas affected. The TRICARE/CHAMPUS DRG-based payment system shall apply to hospital services in the fifty states, the District of Columbia, and Puerto Rico. The DRG-based payment system shall not be used with regard to services rendered outside the fifty states, the District of Columbia, or Puerto Rico.

1. State waivers. Any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs may be exempt from the TRICARE/CHAMPUS DRG-based payment system under the following circumstances:

a. The following requirements must be met in order for a state to be exempt.

(1) The state must be exempt from the Medicare PPS;

(2) The state must request, in writing to TMA, that it be exempt from the TRICARE/CHAMPUS DRG-based payment system; and

(3) Payments in the state must continue to be at a level to maintain savings comparable to those which would be achieved under the TRICARE/CHAMPUS DRG-based payment system. TMA will monitor reimbursement levels in any exempted state to ensure that payment levels there do not exceed those under the TRICARE/CHAMPUS DRG-based payment system. If they do exceed that level, TMA will work with the state to resolve the problem. However, if a satisfactory solution cannot be found, TMA will terminate the exemption after due notice has been given to the state.

b. The only states which have been exempted are Maryland and New Jersey. The exemption for New Jersey ended for discharges occurring on or after January 1, 1989.

B. Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to TRICARE/CHAMPUS beneficiaries by hospitals below are subject to the TRICARE/CHAMPUS DRG-based payment system.

C. Services exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the TRICARE/CHAMPUS DRG-based payment system, are exempt from the TRICARE/CHAMPUS DRG-based payment system and shall be reimbursed under the appropriate procedures.

1. Services provided by hospitals exempt from the DRG-based payment system as defined below.

2. All services which would otherwise be paid under one of the psychiatric DRGs which are numbers 424 - 432. This applies only to admissions occurring from October 1, 1987, through September 30, 1988. Effective for admissions occurring on or after October 1, 1988, this exemption is eliminated.

3. All services which would otherwise be paid under one of the substance abuse DRGs which are numbers 433 - 438. This applies only to admissions occurring from October 1, 1987, through September 30, 1988. Effective for admissions occurring on or after October 1, 1988, this exemption is eliminated.

4. All services related to solid organ acquisition, including the costs of the donor's inpatient stay for TRICARE/CHAMPUS covered transplants by TRICARE/CHAMPUS-authorized transplantation centers. If these services are included on a bill paid under the DRG-based payment system, the hospital is to be notified that the services must be billed separately.

5. All services related to heart, heart-lung, and liver transplantation through September 30, 1998. Effective October 1, 1998, heart and heart-lung transplants will be paid under DRG 103 and liver transplants will be paid under DRG 480. Acquisition costs related to these transplants will continue to be paid on a reasonable cost basis and are not included in the DRG.

6. All services related to a lung transplantation through September 30, 1994. Effective October 1, 1994, lung transplants will be paid under DRG 495. Acquisition costs related to the lung will continue to paid on a reasonable cost basis and are not included in the DRG.

7. All services related to TRICARE/CHAMPUS covered solid organ transplants for which there is no DRG assignment.

8. All services provided by hospital-based professionals (physicians, psychologists, etc.) which, under normal TRICARE/CHAMPUS requirements, would be billed by the hospital. This does not include any therapy services (physical, speech, etc.), since these are included in the DRG-based payment. For radiology and pathology services provided by hospital-based physicians, any related non-professional (i.e., technical) component of these services is included in the DRG-based payment and cannot be billed separately. The services of hospital-based professionals which are employed by, or under contract to, a hospital must

still be billed by the hospital and must be billed on a participating basis. They will be billed under revenue codes 90.1, 91.4-8, 96X, 97X, and 98X.

These services, as well as other services which can be billed separately, must be billed on a HCFA 1500 or UB-92 if adequate CPT coding information is submitted. ("Employed by, or under contract to, a hospital" means the professional is paid by the hospital. If the hospital-based professional merely has an agreement with the hospital to provide services with no requirement that the hospital reimburse the physician, the physician may bill TRICARE/CHAMPUS for his or her services.) Payment for services of all hospital-based professionals and other separately-billed services will be determined under the allowable charge methodology used for other professional services. If services of hospital-based professionals are included on the UB-92, the contractor need not distinguish them in any way in processing the claim. However, the EOB is to contain a message that the DRG-based payment does not include professional services. This message can appear on all DRG claims or only on those claims which include professional services.

9. Anesthesia services provided by nurse anesthetists. This may be separately billed only when the nurse anesthetist is the primary anesthetist for the case. The services must be billed separately by the hospital under the same procedures for hospital-based professionals above.

NOTE: As a general rule, TRICARE/CHAMPUS will only pay for one anesthesia claim per case. When an anesthesiologist is paid for anesthesia services, a nurse anesthetist is not authorized to bill for those same services. Services which support the anesthesiologist in the operating room fall within the DRG allowed amount and are considered to be already included in the facility fee, even if the support services are provided by a nurse anesthetist. Charging for such services is considered an inappropriate billing practice.

10. All outpatient services related to inpatient stays.

11. For admissions occurring before April 1, 1989, all services related to discharges involving newborns and infants who are less than 29 days old upon admission, except for discharges which are grouped into DRG 391 (normal newborn). If any other DRG is assigned to the claim, the claim is exempt from the TRICARE/CHAMPUS DRG-based payment system. For claims involving DRGs other than 391, it is the patient's age when initially admitted to a hospital which is the factor to consider in determining if the inpatient stay is subject to DRG-based payment. If the patient is less than 29 days old upon admission and is subsequently transferred to another hospital, the inpatient stay in both the transferring hospital and the receiving hospital will be exempt from DRG-based payment. When a transfer is involved and the claim is grouped into DRGs 385-390, the contractor can assume that the patient was less than 29 days old upon admission to the initial hospital. All other claims involving transfers should be paid under the DRG-based payment system, unless information on the face of the claim clearly indicates that the patient was less than 29 days old when initially admitted to the hospital.

12. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) bone marrow transplants which would otherwise be paid under DRG 481. This includes ICD-9-CM diagnosis code V42.4 and ICD-9 procedure codes 41.00, 41.01, 41.02, 41.03 and 41.91.

13. All services related to discharges involving children (beneficiary less than 18 years old upon admission) who have been determined to be HIV seropositive. This will be ICD-9-CM diagnosis codes 042 through 044 and 795.8.

14. All services related to discharges involving pediatric (beneficiary less than 18 years old upon admission) cystic fibrosis. This will be ICD-9-CM diagnosis code 277.0.

NOTE: The services described in 11 through 14 above were exempted from DRG-based reimbursement under P.L. 100-202, the 1988 Department of Defense Appropriations Act. For 12, 13, and 14, the exemption applies whether the stated condition is the principal or a secondary diagnosis. The law required this exemption to be retroactive to October 1, 1987, and fiscal intermediaries shall adjust previously processed claims in these categories whenever, but only if, the provider or the beneficiary requests an adjustment. This exemption was initially based on a single year appropriation, but 12, 13, and 14 shall continue to be exempt until notice from TMA.

15. For admissions occurring on or after October 1, 1997, an additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a TRICARE/CHAMPUS patient who is a hemophiliac. Payment will be made for blood clotting factor only if there is an ICD-9-CM diagnosis code for hemophilia included on the bill.

a. For admissions occurring on or after October 1, 1994, and prior to admissions occurring on or after October 1, 1997, the cost of the blood clotting factor for hemophilia inpatients is no longer eligible for separate reimbursement.

b. For admissions occurring on or after October 1, 1990, and before October 1, 1994, and for admissions occurring on or after October 1, 1997, the blood clotting factor for hemophilia inpatients must be billed separately on the inpatient claim, and an additional payment shall be made to the hospital for each unit of factor. The payment for factor is to be added to the DRG-based payment on the same claim--it is not to be paid on a separate claim nor is the claim to be split. (The payment for factor is to be shown on a separate line on the EOB and summary voucher.) Payment rates have been established as indicated below.

For admissions occurring October 1, 1990, through September 30, 1991:

Factor VIII - $.64 per unit
Factor IX - $.26 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.00 per unit

For admissions occurring October 1, 1991, through September 30, 1992:

Factor VIII - $.72 per unit
Factor IX - $.26 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.11 per unit

For admissions occurring October 1, 1992, through September 30, 1993:

Factor VIII - $.76 per unit
Factor IX - $.30 per unit
Other Hemophilia Clotting Factors - $1.02 per unit

For admissions occurring October 1, 1993, through September 30, 1994:

Factor VIII - $.76 per unit
Factor IX - $.33 per unit
Other Hemophilia Clotting Factors - $1.02 per unit

For admissions occurring on or after October 1, 1997, through September 30, 1998:

Factor VIII (antihemophilic factor-human) - $.76 per unit
Factor VIII (antihemophilic factor-recombinant) - $1.00 per unit
Factor IX (complex) - $.32 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors) - $1.10 per unit

For admissions occurring on or after June 11, 1998, through September 30, 1998, the following payment rates shall be used for purified Factor IX products:

Factor IX (antihemophilic factor-nonrecombinant)	$0.93 per unit
Factor IX (antihemophilic factor-recombinant)	1.00 per unit

Contractors are not required to review their systems for claims already processed, but shall reprocess claims for this period if brought to their attention by the provider.

For admissions occurring on or after October 1, 1998, through September 30, 1999:

Factor VIII (antihemophilic factor-human)	$0.78 per unit
Factor VIII (antihemophilic factor-recombinant)	1.00 per unit
Factor IX (complex)	0.38 per unit
Other Hemophilia clotting factors (e.g., anti-inhibitors)	1.10 per unit
Factor IX (antihemophilic factor, nonrecombinant)	0.93 per unit
Factor IX (antihemophilic factor, recombinant)	1.00 per unit

For admissions occurring on or after October 1, 1990 and before October 1, 1994, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor. These are the same codes used under the Medicare Prospective Payment System. However, these codes are not to be used for reporting payments for clotting factor in TRICARE/CHAMPUS payment records.

Factor VIII - J7190
Factor IX - J7194

All other factors - Q0048

For admissions occurring on or after October 1, 1997, through September 30, 1998, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor-recombinant) - J7192
Factor IX (complex) - J7194
All other factors - J7196

For admissions occurring on or after June 11, 1998, through September 30, 1998, hospitals will use the following new HCPCS billing codes for purified Factor IX products:

Factor IX (antihemophilic factor-nonrecombinant) - Q0160
Factor IX (antihemophilic factor-recombinant) - Q0161

Contractors are not required to review their systems for claims already processed, but shall reprocess claims for this period if brought to their attention by the provider.

For admissions occurring on or after October 1, 1998, through September 30, 1999, hospitals will use the following special procedure codes (and revenue code 636) to bill for blood clotting factor:

Factor VIII (antihemophilic factor-human) - J7190
Factor VIII (antihemophilic factor-recombinant) - J7192
Factor IX (complex) - J7194
Other Hemophilia clotting factors (e.g., anti-inhibitors) - J7196
Factor IX (antihemophilic factor, nonrecombinant) - Q0160
Factor IX (antihemophilic factor, recombinant) - Q0161

Each unit billed on the hospital claim represents 100 payment units. For example, if the hospital indicates that 25 units of Factor VIII were provided, this would represent 2,500 actual units of factor, and the payment would be $1,600 (paid at $.64/unit - Factor VIII).

NOTE: Since the costs of blood clotting factor are reimbursed separately for admissions occurring on or after October 1, 1990, and before October 1, 1994, and for admissions occurring on or after October 1, 1997, for these claims all charges associated with the factor are to be subtracted from the total charges in determining applicability of a cost outlier. However, the charges for the blood clotting factor are to be included when calculating the cost-share based on billed charges.

D. Hospitals subject to the TRICARE/CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are authorized to provide services to TRICARE/CHAMPUS beneficiaries are subject to the DRG-based payment system except for those hospitals and hospital units below.

E. Substance Use Disorder Rehabilitation Facilities. With admissions on or after July 1, 1995, substance use disorder rehabilitation facilities, are subject to the DRG-based system.

F. Hospitals and hospital units exempt from the TRICARE/CHAMPUS DRG-based payment system. The following types of hospitals and hospital units are exempt. The contractor will be responsible for determining if a hospital or unit is exempt from the TRICARE/CHAMPUS DRG-based payment system. When the exemption status of a hospital or unit changes, the effective date of the status is to be the date the status was granted by Medicare, or, if the hospital or unit is not Medicare-certified, the date of the determination by the contractor. In cases where the exemption status of a hospital or unit has changed, the exemption status on the date of discharge for inpatient stays prior to the change is to be used. For those claims for which the inpatient stay spans the date the exemption status changed, if the claim includes any days for which the hospital or unit was exempt, the entire stay is to be considered exempt. Designation by Medicare as one of these types of hospitals or units will result in automatic exemption under TRICARE/CHAMPUS, and a hospital which has been denied this status by Medicare cannot be exempt under TRICARE/CHAMPUS. Except for sole community hospitals and cancer hospitals, Medicare participating hospitals which have not applied for exempt or special status under Medicare may still be determined to be exempt under TRICARE/CHAMPUS. Nevertheless, it is strongly encouraged that hospitals first seek exempt or special status under Medicare. Exempt hospitals will be reimbursed under the procedures in Chapter 13, Section 6.2, Section 6.3, and Section 6.5.

G. Subject to the criteria set forth in paragraph II.G.1. below, a hospital within a hospital is excluded from the TRICARE/CHAMPUS DRG-based payment system if it meets the criteria for one or more of the excluded classifications described in paragraph II.G.2., II.G.3., II.G.7., II.G.10., or II.G.11. below.

1. Hospitals within hospitals. A hospital within a hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system. In order for a hospital within a hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, the following criteria must be met:

a. Except as provided in paragraph II.G.1.b., below, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the TRICARE/CHAMPUS DRG-based payment system:

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

(2) Separate chief medical officer. The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under

contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

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

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

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

(a) The hospital performs the basic functions specified in Secs. 482.21 through 428.27, 482.30, and 482.42 of Title 42 CFR (Medicare Prospective Payment System) through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or 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 the same campus, or 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 length-of-stay in paragraph II.G.7., below or for hospitals other than long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in Sec. 412.2(c) of Title 42 CFR. For purposes of this paragraph, however, the costs of preadmission services are those specified under Sec. 413.40(c)(2) of Title 42 CFR, rather than those specified under Sec 412.2(c)(5).

(c) For the same period of at least 6 months used to determine compliance with the criterion regarding the length-of-stay in paragraph II.G.7., below or for hospitals other than 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 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.

b. Application for certain hospitals. If a hospital has been excluded from the TRICARE/CHAMPUS DRG-based payment system on or before September 30, 1995, the criteria in paragraph II.G.1.a., above, do not apply to the hospital.

c. 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.

2. Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, it must be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons (see Chapter 13, Section 6.5 and OPM Part Two, Chapter 4, Section II.C. for specific criteria).

3. Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, it must meet the criteria in this section under Policy. In addition, it must:

a. Have treated, during the past twelve (12) months, an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(1) Stroke.

(2) Spinal cord injury.

(3) Congenital deformity.

(4) Amputation.

(5) Major multiple trauma.

(6) Fracture of femur (hip fracture).

(7) Brain injury.

(8) Polyarthritis, including rheumatoid arthritis.

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

(10) Burns.

b. Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment;

c. Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, social services or psychological services, and orthotic and prosthetic services;

d. Have a director of rehabilitation who:

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

(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 two-years of training or experience in the medical-management of inpatients requiring rehabilitation services.

e. 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; and,

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

g. A hospital that seeks exclusion as a rehabilitation hospital for the first full 12-month period that occurs after it becomes a TRICARE/CHAMPUS participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements above instead of showing that it has treated such a population during the past twelve (12) months.

4. Alcohol/drug hospitals.

a. During FY 1988. An alcohol/drug hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system for admissions occurring during FY 1988. In order for an alcohol/drug hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system during FY 1988, it must have met the criteria in the OPM Part Two, Chapter 2, Section III. In addition, it must:

(1) Treat only patients whose admission to the hospital is required for diagnosis or treatment of alcohol or drug dependence, or both.

(2) Provide treatment using a multidisciplinary team consisting of at least:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A certified alcohol/drug counselor, and

(d) To the extent deemed necessary by the program director, other qualified health professionals (for example, clinical psychologists or social workers).

(3) Ensure that each inpatient is admitted on the authority of, and his or her care is under the direction of, a doctor of medicine or osteopathy who is a member of the hospital's medical staff.

(4) Have a program director to whom the governing body of the hospital has delegated responsibility for maintaining proper standards and assuring quality medical care. The director must be a doctor of medicine or osteopathy who has one year of post-medical school education, or equivalent clinical experience, in the alcohol/drug field, including at least six months of education or experience in an alcohol/drug treatment inpatient program.

(5) Have a full-time director of nursing services who is a registered nurse with 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 with equivalent experience in alcohol/drug treatment.

(6) Have a written treatment plan for each inpatient that is established, reviewed, and revised as needed by the multidisciplinary team. The plan must include a medical assessment and a social/psychological assessment, a record of progress during the course of treatment, and a plan of treatment upon discharge.

(7) Involve inpatients in individual, group, and family educational or therapy programs and other medical or psychological approaches designed to treat the psychological and physical aspects of alcohol/drug dependence and to motivate them to use suitable community support and facilities for long-range rehabilitation.

(8) Coordinate its program with appropriate alcohol/drug abuse programs of other organizations operating in the vicinity such as community mental health centers and Veterans Administration hospitals, voluntary programs such as halfway houses and recovery homes and the Salvation Army, and self-help groups such as Alcoholics Anonymous, Al-Anon and Alateen.

b. After FY 1988. Alcohol/drug hospitals are no longer exempt from the TRICARE/CHAMPUS DRG-based payment system for admissions occurring on or after October 1, 1988. For the period October 1, 1988, through June 30, 1995, there is one exception for alcohol/drug hospitals which are not Medicare-participating and which decline to sign a participation agreement with TMA. In such cases, if there is no alternative source of care (whether an alcohol/drug hospital or a general acute-care hospital capable of providing the necessary care) within a 50-mile radius, the alcohol/drug hospital is to be considered a sole community provider. Any alcohol/drug hospital which believes it meets these criteria and wishes this special designation should notify TMA, which will make the determination and notify the hospital and the contractor.

5. Psychiatric, rehabilitation and alcohol/drug units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system. In order for a psychiatric unit which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, it must meet the requirements below. In order for a rehabilitation unit which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system, it must meet the requirements below. Alcohol/drug units which are exempt from the Medicare prospective payment system are also exempt from the TRICARE/CHAMPUS DRG-based payment system for admissions occurring during FY 1988. Beginning with admissions occurring on or after October 1, 1988, alcohol/drug units are no longer exempt. In order for a alcohol/drug unit to be exempt from the TRICARE/CHAMPUS DRG-based payment system during FY 1988, it must have met the requirements below.

a. A distinct part unit must:

(1) Have written admission criteria that are applied uniformly to all patients;

(2) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available;

(3) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit;

(4) Meet applicable State licensure laws;

(5) Have utilization review standards applicable for the type of care offered in the unit;

(6) Have beds physically separate from (i.e., not commingled with) the hospital's other beds;

(7) Be serviced by the same contractor as the hospital;

(8) Be treated as a separate cost center for cost funding and apportionment purposes;

(9) Use an accounting system that properly allocates costs;

(10) Maintain adequate statistical data to support the basis of allocation; and

(11) Use the same fiscal period and the same method of apportionment as the hospital.

b. A psychiatric unit (distinct part) must:

(1) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital

setting, of a psychiatric principal diagnosis that is listed in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.

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

(3) 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:

(a) 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. The identification data must include the inpatient's legal status. 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. The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved or both. The social services 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. When indicated, a complete neurological examination must be recorded at the time of the admitting physical examination.

(b) Psychiatric evaluation. Each inpatient must receive a psychiatric evaluation that must: be completed within 60 hours of admission; include a medical history; contain a record of mental status; note the onset of illness and the circumstances leading to admission; describe attitudes and behavior; estimate intellectual functioning, memory functioning, and orientation; and include an inventory of the inpatient's assets in descriptive, not interpretative fashion.

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

(d) Recording progress. Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient. They may also be recorded by a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities.

(e) 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.

(4) Meet special staff requirements in the unit. 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:

(a) Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to: evaluate inpatients; formulate written individualized, comprehensive treatment plans; provide active treatment measures; and engage in discharge planning.

(b) 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. 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. The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

(c) Nursing services. The unit must have a qualified director of psychiatric 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. 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. The staffing pattern must ensure the availability (on-duty) 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.

(d) 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.

(e) 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.

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

c. A rehabilitation unit (distinct part) must:

(1) Have treated, during the past twelve (12) months, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(a) Stroke.

(b) Spinal cord injury.

(c) Congenital deformity.

(d) Amputation.

(e) Major multiple trauma.

(f) Fracture of femur (hip fracture).

(g) Brain injury.

(h) Polyarthritis, including rheumatoid arthritis.

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

(j) Burns

(2) 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 program or assessment;

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

(4) 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; and

(5) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical

record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment; and

(6) Have a director of rehabilitation who:

(a) Provides services to the unit and to its inpatients for at least 20 hours per week;

(b) Is a doctor of medicine or osteopathy;

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

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

(7) A unit that seeks exclusion as a rehabilitation unit for the first full 12-month period that occurs after it becomes a TRICARE/CHAMPUS participating unit may provide a written certification that the inpatient population it intends to serve meets the requirements above instead of showing that it has treated such a population during the past twelve (12) months.

d. Exclusion of new rehabilitation units and expansion of units already excluded.

(1) Bed capacity in units. A decrease in bed capacity must remain in effect for at least a full 12-month cost reporting period before an equal or less number of beds can be added to the hospital's licensure and certification and considered "new" under paragraph II.G.5.d.(2) below, thus, when a hospital seeks to establish a new unit under the criteria under paragraph II.G.5.d.(2) below or to enlarge an existing unit under the criteria under paragraph II.G.5.d.(4) below, the regional HCFA office will review its records on the facility to determine whether any beds have been delicensed and decertified during the 12-month cost reporting period before the period for which the hospital seeks to add the beds. To the extent bed capacity was removed from the hospital's licensure and certification during that period, that amount of bed capacity may not be considered "new" under paragraph II.G.5.d.(2) below.

(2) New units.

(a) A hospital unit is considered a new unit if the hospital--

1 Has not previously sought exclusion for any rehabilitation unit; and

2 Has obtained approval, under State licensure and Medicare certification, for any increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

(b) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to service meets the requirements of paragraph II.G.3.a. instead of showing that the unit has treated such a population during the hospital's most recent cost reporting period.

(c) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital. The written certification described in paragraph II.G.5.d.(2)(b) above, also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(d) The written certification described in paragraph II.G.5.d.(2)(b) above, is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care. If the hospital has not previously participated in the Medicare program as a hospital, the written certification also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(e) A hospital that has undergone a change of ownership or leasing as defined in Section 489.18 of Title 42 CFR, is not considered to have participated previously in the Medicare program.

(3) Converted units. A hospital unit is considered a converted unit if it does not qualify as a new unit under paragraph II.G.5.d.(2)(a) of this section. A converted unit must have treated, for the hospital's most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitation services for the treatment of one or more conditions listed under paragraph II.G.3.a.

(4) Expansion of excluded rehabilitation units.

(a) New bed capacity. The beds that a hospital seeks to add to its excluded rehabilitation unit are considered new beds only if--

1 The hospital's State-licensed and Medicare-certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its excluded rehabilitation unit, or at any time after the start of the preceding cost reporting period; and

2 The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit.

(b) Conversion of existing bed capacity.

1 Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph II.G.5.d.(4)(a) above.

2 A hospital may increase the size of its excluded rehabilitation unit through conversion of existing bed capacity only if its shows that, for all of the hospital's most recent cost reporting period of at least 12 months, the beds have been used to treat an inpatient population meeting the requirements in paragraph II.G.3.a.

(5) Retroactive adjustments for certain units. For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new rehabilitation unit excluded from the prospective payment systems for a cost reporting period under paragraph II.G.5.d.(2) above or expands an existing rehabilitation unit under paragraph II.G.5.d.(4) above, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period does not meet the requirements in paragraph II.G.3.a., TRICARE/CHAMPUS will make a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the TRICARE/CHAMPUS DRG-based payment system.

e. An Alcohol/drug unit (distinct part) will be exempt from the TRICARE/CHAMPUS DRG-based payment system if it:

(1) Treats only patients whose admission to the unit is required for diagnosis or treatment of alcohol or drug dependence, or both.

(2) Provides treatment using a multidisciplinary team consisting of at least:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A certified alcohol/drug counselor, and

(d) To the extent deemed necessary by the unit director, other qualified health professionals (for example, clinical psychologists or social workers).

(3) Ensures that each inpatient is admitted on the authority of, and his or her care is under the direction of, a doctor of medicine or osteopathy who is a member of the unit's medical staff.

(4) Has a director to whom the governing body of the hospital has delegated responsibility for maintaining proper standards and assuring quality medical care. The director must be a doctor of medicine or osteopathy who has one year of post-medical school education, or equivalent clinical experience, in the alcohol/drug field, including at least six months of education or experience in an alcohol/drug treatment inpatient unit.

(5) Has a full-time director of nursing services who is a registered nurse with 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 with equivalent experience in alcohol/drug treatment.

(6) Has a written treatment plan for each inpatient that is established, reviewed, and revised as needed by the multidisciplinary team. The plan must include a

medical assessment and a social/ psychological assessment, a record of progress during the course of treatment, and a plan of treatment upon discharge.

(7) Involves inpatients in individual, group, and family educational or therapy programs and other medical or psychological approaches designed to treat the psychological and physical aspects of alcohol/drug dependence and to motivate them to use suitable community support and facilities for long-range rehabilitation.

(8) Coordinates its program with appropriate alcohol/drug abuse programs of other organizations operating in the vicinity such as community mental health centers and Veterans Administration hospitals, voluntary programs such as halfway houses and recovery homes and the Salvation Army, and with self-help groups such as Alcoholics Anonymous, Al-Anon and Alateen.

f. Units which are exempt from the TRICARE/CHAMPUS DRG-based payment system because they are exempt from the Medicare prospective payment system cannot change with regard to the number of beds or square footage at any time during the Medicare cost reporting period. Any change in the number of beds or square footage considered to be part of an excluded unit may be made only at the start of a Medicare cost reporting period.

6. Children's hospitals. A children's hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system for admissions occurring before April 1, 1989. In order for a children's hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system for admissions occurring before April 1, 1989, it must meet the criteria in 32 CFR 199.6(b)(3). In addition, it must have been engaged in furnishing services to inpatients who were predominantly individuals under the age of 18. (See Chapter 13, Section 6.1H for payment procedures for admissions to children's hospitals on or after April 1, 1989.) Children's hospitals which do not participate in Medicare will be required to complete a participation agreement (as described below). If the children's hospital fails to complete the agreement, it will not be an authorized TRICARE/CHAMPUS provider for admissions occurring on or after April 1, 1989.

7. Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the TRICARE/CHAMPUS DRG-based payment system. In order for a long-term hospital to be exempt from the TRICARE/CHAMPUS DRG-based payment system, it must meet the requirements of paragraph II.G.7.a. or paragraph II.G.7.b. below, and where applicable the additional requirements outlined in paragraph II.G.1., above.

a. The hospital must have an average length of inpatient stay greater than 25 days as calculated under paragraph II.G.7.c. below.

b. For cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the Medicare prospective payment system in 1986 must have an average inpatient length-of-stay of greater than 20 days, as calculated under paragraph II.G.7.c. below, and must demonstrate 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 II.G.10.a.(3), below.

c. The average inpatient length of stay is calculated--

(1) By dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period;

(2) If a change in the hospital's average length-of-stay is indicated, by the same method for the immediately preceding 6-month period; or

(3) If a hospital has undergone a change of ownership as described in Sec. 489.18 of Title 42 CFR, at the start of a cost reporting period or at any time within the preceding 6 months, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length-of-stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

8. Sole community hospitals.

a. General. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the TRICARE/CHAMPUS DRG-based payment system. Except for certain special cases involving alcohol/drug hospitals, only hospitals which have received this designation under Medicare can be exempt as sole community hospitals under the TRICARE/CHAMPUS DRG-based payment system.

NOTE: Sole community hospitals are recognized only under the DRG-Based Payment System and the Inpatient Mental Health Per Diem Payment System. They are not recognized under any other payment mechanisms.

b. Identification of sole community hospitals. The contractor is responsible for identifying sole community hospitals within its jurisdiction. To assist in this, TMA will provide each contractor with a list of sole community hospitals when provided by HCFA, generally twice a year.

9. Christian Science sanitariums. All Christian Science sanitariums (as defined in 32 CFR 199.2 and OPM Part Two, Chapter 2, Section II.) are exempt from the TRICARE/CHAMPUS DRG-based payment system.

10. Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the TRICARE/CHAMPUS DRG-based payment system. It is the hospital's responsibility to notify the contractor of this designation. In order for a cancer hospital which does not participate in Medicare to be exempt from the TRICARE/CHAMPUS DRG-based payment system it must meet the following criteria:

a. Except as provided in paragraph II.G.10.b., below, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the TRICARE/CHAMPUS DRG-based payment system.

(1) 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;

(2) 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); and

(3) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (For 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.)

b. 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 II.G.10.a.(1), above, is classified as a cancer hospital and is excluded from the TRICARE/CHAMPUS DRG-based payment system beginning with its first cost reporting period beginning on or after January 1, 1991, if it meets the criterion set forth in paragraph II.G.10.a.(1), above, and the hospital is--

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

(2) 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 II.G.10.a.(3), above.

11. Hospitals outside the 50 states, the District of Columbia, and Puerto Rico. A hospital is excluded from the TRICARE/CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

H. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE/CHAMPUS provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system and which otherwise meets TRICARE/CHAMPUS requirements but which is not a Medicare-participating provider (having completed a HCFA-1561, Health Insurance Benefit Agreement, and a HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement with TMA. These agreements will be signed and maintained by the contractor on behalf of TMA. By completing the participation agreement, the hospital agrees to accept the TRICARE/CHAMPUS-determined allowable amount as payment in full for its services. The TRICARE/CHAMPUS-determined allowable amount will be based on the TRICARE/CHAMPUS DRG-based payment system for services subject to this system and on the hospital's billed charges (as described in Chapter 13, Section 6.2) for services exempt from the TRICARE/CHAMPUS DRG-based payment system. Any hospital which does not participate in Medicare and does not complete a participation agreement with TMA will not be considered an authorized provider under

TRICARE/CHAMPUS, and no payment can be made for services it renders to TRICARE/CHAMPUS beneficiaries. The intent of the agreement is to ensure that payment is made under the TRICARE/CHAMPUS DRG-based payment system - not to limit services available to TRICARE/CHAMPUS beneficiaries. Therefore, services provided before the agreement is signed by the hospital can be reimbursed, so long as the contractor has a signed agreement before payment is made. These participation agreements will be completed only upon request of the hospital to the contractor. A copy of the participation agreement is in Chapter 13, Addendum 1.

- END -