

Psychiatric Hospitals Accreditation

Issue Date: July 14, 1993

Authority: [32 CFR 199.6\(b\)\(4\)\(i\)](#) and [\(b\)\(4\)\(iv\)](#)

Revision: C-13, November 15, 2017

1.0 ISSUE

Psychiatric hospitals accreditation.

2.0 DESCRIPTION

A psychiatric hospital is an institution which is engaged primarily in providing services to inpatients for the diagnosis and treatment of mental disorders.

3.0 POLICY

In order for the services of a psychiatric hospital to be covered, the hospital shall comply with the provisions outlined in [32 CFR 199.6\(b\)\(4\)\(i\)](#). All **freestanding** psychiatric hospitals shall be **currently** accredited under the Joint Commission's (**TJC's**) **Accreditation Manual for Hospitals** (AMH) standards, **or an accrediting organization approved by the Director, Defense Health Agency (DHA)**, in order for their services to be cost-shared. In the case of those psychiatric hospitals that are not Joint Commission-accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by **TJC**, the Director, **DHA**, or a designee, may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the Joint Commission. For further information on accreditation of psychiatric hospitals refer to [32 CFR 199.6\(b\)\(4\)\(iv\)](#).

TRICARE Policy Manual 6010.60-M, April 1, 2015

Chapter 11, Section 2.6

Psychiatric Hospitals Accreditation

FIGURE 11.2.6-1 PROGRAM INFORMATION NEW PSYCHIATRIC HOSPITAL PENDING ACCREDITATION, OCHAMPUS FORM 759

PROGRAM INFORMATION NEW PSYCHIATRIC HOSPITAL PENDING ACCREDITATION		FACILITY NO. _____	
		DATE _____	
The information collected will assist the government in determining whether your facility can be considered an approved source of care for payment purposes under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The information will also aid the government in assisting CHAMPUS beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.			
1. FACILITY NAME		2. FACILITY ADDRESS	
3. IS YOUR FACILITY ADDRESS DIFFERENT FROM YOUR MAILING ADDRESS OR THE ADDRESS WHERE PAYMENTS ARE SENT? <input type="checkbox"/> YES (INDICATE ADDRESS) <input type="checkbox"/> NO			
4. TELEPHONE NUMBER ()		5. NAME AND TITLE OF CHIEF ADMINISTRATOR	
6. ORGANIZATIONAL STRUCTURE: <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SINGLE OWNER <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> GROUP PRACTICE OR CORPORATION ASSOCIATION		7. TYPE OF OWNERSHIP: <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE <input type="checkbox"/> PRIVATE <input type="checkbox"/> PRIVATE <input type="checkbox"/> NOT-FOR-PROFIT <input type="checkbox"/> FOR PROFIT	
8. FOR ADMISSIONS OR ACCEPTANCE INTO YOUR PROGRAM ARE THERE RESTRICTIONS BASED ON AN INDIVIDUAL'S RACE, COLOR, OR NATIONAL ORIGIN? <input type="checkbox"/> YES <input type="checkbox"/> NO		9. AFTER ADMISSION ARE PATIENTS TREATED EQUALLY WITHOUT REGARD TO RACE, COLOR OR NATIONAL ORIGIN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. TOTAL NUMBER OF UNITS IN YOUR FACILITY?		11. INDICATE HOW YOUR FACILITY RESTRICTS ADMISSIONS BY: SEX _____ AGE _____ GEOGRAPHIC AREA _____	
12. IS THE COURSE OF TREATMENT FOR ALL PATIENTS PRESCRIBED AND SUPERVISED BY A PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO (EXPLAIN YOUR ARRANGEMENTS FOR PHYSICIANS SERVICES)			
13. INDICATE THE SYSTEM(S) USED TO EVALUATE THE FACILITY'S PROGRAM: CONTRACTUAL EVALUATION AND/OR PROGRAMMATIC CONSULTATION <input type="checkbox"/> YES <input type="checkbox"/> NO		UTILIZATION REVIEW <input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> NONE <input type="checkbox"/> N.A. PATIENT REPRESENTATIVE <input type="checkbox"/> YES <input type="checkbox"/> NO PATIENT, FAMILY OR STATE ADVISORY COMMITTEE <input type="checkbox"/> ACTIVELY <input type="checkbox"/> NOT ACTIVELY	
14. PATIENT INFORMATION:		NUMBER OF LICENSED BEDS	NUMBER OF PATIENTS DURING THE LAST TWELVE MONTHS
		_____	_____
15. PROVIDE THE FOLLOWING ADDITIONAL INFORMATION: a. Copy of state or local operating license. b. A copy of your Medicare Certification Letter. c. A copy of all correspondence with the accrediting organization. d. Most recent state or local fire and health inspection reports. e. Schedule of rates and charges for all services (Would charges for CHAMPUS beneficiaries differ from the charges incurred by others? If so, explain). f. A current brochure, pamphlet, etc., describing your overall program.			
16. NAME OF FACILITY REPRESENTATIVE		17. SIGNATURE	18. DATE

- END -