Medicare

Provider Reimbursement Manual
Part 1, Chapter 30, Non-PPS Hospitals and Distinct Part Units

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 465 **Date: September 2014**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3001.5 - 3001.6	30.7-30.8 (2 pp.)	30.7-30.8 (2 pp.)
3001.7 - 3001.9	30.11-30.12 (2 pp.)	30.11-30.12 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* - Upon Implementation of ICD-10

This transmittal contains language-only changes for updating ICD-10 language in the Provider Reimbursement Manual. There are no new policies in this transmittal. Specific policy changes have been announced previously in various communications

Section 3001.6 Specific Criteria for Psychiatric Units is updated to include the ICD-10 chapter that describes mental and behavioral disorders and DSM version 4.

Section 3001.9 Cancer Hospitals is updated in subsection B to delete an old (1994) reference to ICD-9 diagnoses that are considered to reflect neoplastic disease, with no replacement text.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

Hospitals that specialize in rehabilitation and meet the length of stay criterion as long term hospitals are eligible for a long term hospital exclusion and do not have to meet the special criteria established for rehabilitation hospitals.

3001.5 Psychiatric and Rehabilitation Units.--An excluded psychiatric unit must meet the general criteria for units as listed in items A through M and all of the specific criteria for psychiatric units in §3001.6. An excluded rehabilitation unit must meet the general criteria for units in items A through M and all of the specific criteria for rehabilitation units in §3001.7. The general criteria for the units follow.

A. The unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the PPS.

B. The unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. The unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. (However, the medical records of unit patients need not be physically separate from the records of patients in the acute care part of the hospital, and it is not necessary to create a second medical record when a patient is moved from the acute care part of the hospital to the excluded unit, or vice versa. The record must indicate the dates of the admission and discharge for patients of the unit.) The unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the unit.

D. If State law provides special licensing requirements for psychiatric or rehabilitation units, the unit must be licensed in accordance with the applicable requirements.

E. The hospital's utilization review plan must include separate standards for the type of care offered by the unit.

F. The beds assigned to the unit must be physically separate from (i.e., not commingled with) beds not included in the unit.

G. The hospital must have enough beds not excluded from the PPS to permit the provision of adequate cost information, as specified in Chapter 23.

H. The unit and the hospital in which it is located must be serviced by the same fiscal intermediary.

I. The unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. The accounting system of the hospital in which the unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

K. The cost report for the hospital must include the costs of the unit, cover a single fiscal period, and reflect a single method of cost apportionment.

L. As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit must be fully equipped and staffed and must be capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the PPS.

These criteria are used to determine whether a part of a hospital qualifies for exclusion from PPS. An excluded unit must be established as a separate cost entity for cost reporting purposes, using the criteria in §2336.1A through D for this purpose.

If a hospital wishes to have a unit excluded from PPS for a cost reporting period, it must notify its intermediary before the start of the period of the particular areas it has designated as the unit and of the square footage and number of beds in the unit. This notice must be sent to the intermediary at the same time notice is sent to the RO regarding the request for exclusion (see §3001) and must identify the designated space through the use of room numbers and/or bed numbers. After the initial designation, changes in the amount of the space occupied by the unit or in the number of beds in the unit are recognized for purposes of the exclusion only at the start of a cost reporting period.

Compliance with the criteria in items H, I, and J may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the intermediary, that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion, if approved, applies.

3001.6 Specific Criteria for Psychiatric Units.--

A. The unit must admit only patients whose admission to the unit is required for active treatment, whose treatment is of an intensity that can be provided only in an inpatient hospital setting, and whose condition is described by a psychiatric principal diagnosis contained in:

- the *Fourth* Edition of the American Psychiatric Association Diagnostic and Statistical Manual;
- Chapter 5 (Mental Disorders) of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); *or*
- *Chapter 5 (Mental and BehavioralDisorders) of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), upon implementation of ICD-10.*

B. The unit must furnish, through the use of qualified personnel, psycho-logical services, social work services, psychiatric nursing, occupational therapy, and recreational therapy.

C. The unit must maintain medical records that permit determination of the degree and intensity of 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. Medical records must meet the following criteria:

- o The identification data must include the inpatient's legal status;

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 accepted 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. 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.

3001.7 Specific Criteria for Rehabilitation Units.--

A. Except as provided in subsection B, the unit must have treated, during its most recent 12 month cost reporting period (i.e., the period immediately preceding the period for which the exclusion would be effective), an inpatient population that meets the requirement in §3001.2B.

B. For the first cost reporting period in which a currently participating hospital seeks exclusion of a new rehabilitation unit, it may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §3001.2B, instead of showing that it has treated such a population during its most recent 12 month cost reporting period. For purposes of this provision, a unit is considered new only if the hospital has not previously sought exclusion for any rehabilitation unit and has obtained approval for added bed capacity under its State licensure and its approved Medicare provider agreement. A unit of a currently participating hospital that includes some beds that were previously licensed and certified and some new beds is recognized as a new rehabilitation unit only if more than one-half of the beds are new.

A hospital that has not previously participated in the Medicare program and seeks exclusion of a rehabilitation unit may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §3001.2B, instead of showing that it has treated such a population during its most recent 12 month cost reporting period. The written certification is effective for the first full 12 month cost reporting period that occurs after the hospital becomes a Medicare participating hospital and 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 first regular 12 month cost reporting period of Medicare participation.

For purposes of this section, a hospital that has undergone a change of ownership or leasing is considered to have not participated previously in the Medicare program.

C. The unit must meet the requirements in §3001.2C through F.

D. The unit must have a director of rehabilitation who has the qualifications described in §3001.2G and provides services to the unit and its inpatients for at least 20 hours per week. If a rehabilitation unit serves both inpatients and outpatients through a single integrated unit, the time spent by the director in performing administrative duties for the entire unit counts toward the direction requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

3001.8 Expansion of Excluded Rehabilitation Units.--

A. Except as provided in subsection B, if a hospital expands its excluded rehabilitation unit by adding beds, the medical condition of the patients treated in the added beds during the most recent 12 month cost reporting period must be taken into account in determining whether the requirement in §3001.7A is met.

B. A hospital that has an excluded rehabilitation unit may obtain approval for added bed capacity under State licensure and under its approved Medicare provider agreement and may seek to add new beds to its existing excluded unit for the first 12 month cost reporting period during which the new beds are used to provide inpatient care. The hospital may provide a written certification that the inpatient population the new beds are intended to serve meets the requirement in §3001.2B, instead of showing that those beds were used to treat such a population during the unit's most recent 12 month cost reporting period.

For purposes of this provision, new beds are defined as additional beds for which the hospital has obtained approval for increasing its bed capacity under both State licensure and its approved Medicare provider agreement. For cost reporting periods beginning on or after October 1, 1991, an adjustment to payments for the period is made (as described in §3001.10) if the inpatient population of the added beds does not actually meet the requirements of §3001.2B for the period.

3001.9 Cancer Hospitals.--

A. A hospital is an excluded cancer hospital if it meets all of the following criteria:

o The hospital 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;

o The hospital demonstrates that the entire facility is organized primarily for treatment of and research on cancer (i.e., the facility is not a subunit of a general acute care hospital or university-based medical center);

o The hospital 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.); *and*