[Categorical Listing] [Numerical Listing]

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

Jan 7 1998

MEMORANDUM FOR: ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Revision to Specialized Treatment Services Policy

References
a. ASD(HA) Memorandum "Specialized Treatment Services Program," dated October 18, 1995
b. ASD(HA) Memorandum "Concentration of Specialized Care," dated January 24, 1997 (Attached)

This memorandum is intended to clarify the current philosophy defining the Specialized Treatment Services (STS) Program. The STS program was initially established to enhance and concentrate care for complex, expensive medical problems in regional or national centers with proven records of excellence. Graduate Medical Education (GME) programs at these centers would be supported with an enhanced patient population, furthering their efforts to train for readiness. However, review and discussion with the Services during the application process suggest that in some circumstances the restrictive aspects of the STS program may no longer be in DoD's best interests. Therefore the above referenced policies will be amended to include a third category of facility designated a "Center of Excellence (COE)."

Circumstances may exist in which the continued provision of care for the DRGs listed in reference (b) in non-STS facilities is in the best interests of the beneficiaries, the facility, and the Service. In that instance a Center of Excellence shall be established. In order to be designated a COE the facility shall demonstrate:

a. Both volume and quality that support continued provision of the stated care. Performance within acceptable quality and volume parameters may be demonstrated by ACGME accreditation of affected residency training programs and/or citation of compliance with existing nationally recognized and accepted outcomes base standards.

b. That continued provision of the specific care contributes substantially to the readiness of the facility and providers, and,

c. That continued provision of the care will not compete with an established STS in its region; (i.e., a regional STS will retain the right of first refusal before a patient is referred to the COE.)

The request shall be routed through the Lead Agent and the Service Surgeon General who must certify that volume and quality criteria have been and will continue to be met by the COE. Final approval of designation will be made by DASD(CS).

Attached to this memorandum is a list of the DRGs covered by this policy revision and the minimum annual case volumes per facility required for COE designation. Facilities granted COE status shall be required to report annually their outcomes data, patient volumes and justification for continued designation as a COE to DASD(CS).

Facilities planning to apply for STS status, may do so. Package submission for STSs shall be in the format previously directed. Facilities applying for STS status in the twenty covered DRGs must be able to meet COE minimum standards. After approval from Health Affairs, a notice shall be published in the Federal Register establishing STS authority.

Facilities wishing only COE status, not currently an STS must adhere to HA policy (ref b) restricting the scope of practice in their facilities. Facilities with Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee(RRC) approved training programs that would be adversely affected by this restriction are exempted only for the period required for COE application review and decision, and only for those DRGs directly relevant to training programs.

Full application documentation from those facilities who have filed letters of intent to become COEs are due no later than March 1, 1998.

The point of contact for this issue is CAPT M. Orcutt at 703-695-6800.

Edward D. Martin

Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

Attachments:
As stated

HA Policy 98-008

DRG	Procedure	Annual Min # Procedures	GME Training Programs Affected*

001 & 003	Craniotomy	15	Neurosurg WRAMC/ NNMC
004	Spinal Procedures	15 for complex cases, such as Scoliosis procedures which cannot be otherwise coded. (many cases may be coded under another primary DRG such as 214 or 215)	
049	Major Head and Neck	6	Otolaryngology
104, 105 106, 107 110, 111	Cardiovascular Procedures and Coronary Bypass	(Standards have been set by the American Board of cardiothoracic Surgeons and HCFA at 150-250 procedures per year)	
191	Pancreas/Liver/Shunt	(Facility requirements exist)*	Gen Surg/ GI Fellowship/ or Transplantation at
209 & 491	Major Joint/Limb Reattach—lower and upper	30	Orthopedics 1
286	Adrenal/Pituitary	10	Gen Surg/ Neurosurg/Endo
357	Uterine/Adnexal	6 (with presence on Gyn HemeOnc specialist)	Ob/gyn; Hemeonc or Gyn Onc Fellowships

* Averaged 6 cases annual minimum must have full blood bank capability, ICU with intensivist, and at least two general surgeons

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