

Contractor Name

Wisconsin Physicians Service

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Psychiatric Inpatient Hospitalization

Contractor's Determination Number

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f) (1) (A) (i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from the Centers for Medicare and Medicaid Services (CMS) sources.

Title XVIII of the Social Security Act (SSA):

Section 1812(a)(1) Inpatient hospital services defined.

Section 1812(b)(3) Lifetime limit of 190 days for inpatient psychiatric benefit days.

Section 1814(4) Medical Records document that services were furnished while the individual was receiving intensive treatment, admission and related services for a diagnostic study, or equivalent services requirement.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1835(a) Physician certification as a requirement.

Section 1861(a), 1861(c), and 1861(f) "Spell of illness", "inpatient psychiatric hospital services", "psychiatric hospital", "medical and other health services" defined.

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Code of Federal Regulations:

42 CFR Section 164.501 defines psychotherapy notes.

42 CFR Section 409.62 describes the lifetime maximum on inpatient psychiatric care.

42 CFR Section 410.32 indicates that diagnostic tests may only be ordered by treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

42 CFR Section 411.4(a) states that the Medicare Program does not pay for services if the beneficiary has no legal obligation to pay.

42 CFR Section 411.4(b) states that the Medicare Program does not pay for services if the services are paid for directly or indirectly by a governmental entity.

42 CFR Parts 412 and 413 page 66938 regarding primary diagnosis for IPF and substance abuse.

45 CFR Part 164.508 (a)(2) uses and disclosures for which authorization is required; authorization required: psychotherapy notes.

CMS Publications:

CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4:

10 Certification and Recertification by Physicians for Hospital Services – General

10.1 Failure to Certify or Recertify for Hospital Services

10.2 Who May Sign Certification or Recertification

10.4 Inpatient Hospital Services Certification and Recertification

10.5 Selection by Hospital of Format and Method for Obtaining Statement

10.9 Inpatient Psychiatric Hospital Services Certification and Recertification

10.20.2 Timing for Certification and Recertification for a Beneficiary Admitted Before Entitlement

CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 5:

20.3 Definition of Psychiatric Hospital

20.4 Certification of Parts of Institutions as a Psychiatric Hospital

20.5 Part of a Psychiatric Institution as a Psychiatric Hospital

20.6 General Hospital Facility within a Psychiatric Hospital

20.7 Part of a General Hospital as a Psychiatric Hospital

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 2:

10 Covered Inpatient Psychiatric Hospital Services

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CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 4:

- 10 Inpatient Psychiatric Benefit Days Reduction
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- 30 Reduction for Psychiatric Services in General Hospitals
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- 50 Inpatient Psychiatric Hospital Services – Lifetime Limitation

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16:

- 50.3.1 Application of Exclusion to State and Local Government Providers

CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1:

- 30.4 Electrosleep Therapy
- 30.5 Transcendental Meditation – Not Covered
- 70.1 Consultations with a Beneficiary's Family and Associates
- 130.1 Inpatient Hospital Stays for the Treatment of Alcoholism
- 130.3 Chemical Aversion Therapy for Treatment of Alcoholism
- 130.4 Electrical Aversion Therapy for Treatment of Alcoholism (Electroversion Therapy, Electro-shock Therapy, Noxious Faradic Stimulation)
- 130.6 Treatment of Drug Abuse (Chemical Dependency)
- 130.8 Hemodialysis for Treatment of Schizophrenia – Not Covered
- 160.25 Multiple-Seizure Electroconvulsive therapy (MECT) – Not Covered
- 230.4 Diagnosis and Treatment of Impotence

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1:

- 10.4 Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3:

- 30.1 Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part units

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29:

- 30 Where to Appeal and Initial Determinations
- 40 Part A Appeals Procedures

CMS Publication 100-20, *One-Time Notification Manual*, Transmittal No. 98, Change Request #3343, July 23, 2004, revises Change Request #3194 by changing the effective date for the discontinuation of revenue code 0910 to dates of service on or after October 16, 2003.

CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Transmittal No. 39, Change Request #5129, June 9, 2006, updates Inpatient Psychiatric Prospective payment System and new time frame requirements for physicians to recertify that the patient continues to need active treatment on a daily basis.

CMS Program Memorandum, Transmittal No. AB-02-164, Change Request No. 2022, November 8, 2002, provides processing requirements for claims for Medicare beneficiaries in State of Local Custody Under a Penal Authority.

Primary Geographic Jurisdiction

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands

MAC A: Iowa, Missouri, Nebraska, Kansas

Secondary Geographic Jurisdiction

Oversight Region

Original Determination Effective Date

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Inpatient psychiatric hospitalization provides twenty four (24) hours of daily care in a structured, intensive, and secure setting for patients who cannot be safely and/or adequately managed at a lower level of care. This setting provides daily physician (MD/DO) supervision, twenty-four (24) hour nursing/treatment team evaluation and observation, diagnostic services, and psychotherapeutic and medical interventions.

Inpatient psychiatric care may be delivered in a Psychiatric Hospital, a Psychiatric Hospital Acute Care Unit within a Psychiatric Institution, or a Psychiatric Inpatient Unit within a General Hospital as defined in CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 5, Sections 20.3, 20.4, 20.5, 20.6, and 20.7 and 42 CFR 412.2.

Indications:

Medicare patients, admitted to inpatient psychiatric hospitalization, must be under the care of a physician who is knowledgeable about the patient. The physician must certify/recertify (see “Documentation Requirements” section) the need for inpatient psychiatric hospitalization. The patient must require “active treatment” of his/her psychiatric disorder. The patient or legal guardian must provide written informed consent for inpatient psychiatric hospitalization in accord with state law. If the patient is subject to involuntary or court-ordered commitment, the services must still meet the requirements for medical necessity in order to be covered by Medicare.

Admission Criteria (Intensity of Service):

The patient must require intensive, comprehensive, multimodal treatment including 24 hours per day of medical supervision and coordination because of a mental disorder. The need for 24 hours of supervision may be due to the need for patient safety, psychiatric diagnostic evaluation, potential severe side effects of psychotropic medication associated with medical or psychiatric comorbidities, or evaluation of behaviors consistent with an acute psychiatric disorder for which a medical cause has not been ruled out.

The acute psychiatric condition being evaluated or treated by an inpatient psychiatric hospitalization must require active treatment, including a combination of services such as intensive nursing and medical intervention, psychotherapy, occupational and activity therapy. Patients must require inpatient psychiatric hospitalization services at levels of intensity and frequency exceeding what may be rendered in an outpatient setting, including psychiatric partial hospitalization. There must be evidence of failure at, inability to benefit from, or unacceptable risk in an outpatient treatment setting. Claims for care delivered at an inappropriate level of intensity will be denied.

Physician visits to a patient must involve a face-to-face encounter. If the facility portion of inpatient psychiatric services is denied as not medically necessary this does not mean that the physician service is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in an inpatient psychiatric facility is not medically necessary.

The following parameters are intended to describe the severity of illness and intensity of service that characterize a patient appropriate for inpatient psychiatric hospitalization. These criteria do not represent an all-inclusive list and are intended as guidelines.

Admission Criteria (Severity of Illness):

Examples of inpatient admission criteria include (but are not limited to):

1. Threat to self requiring 24-hour professional observation
 - a) suicidal ideation or gesture within 72 hours prior to admission
 - b) self mutilation (actual or threatened) within 72 hours prior to admission
 - c) chronic and continuing self destructive behavior (e.g., bulimic behaviors, substance abuse) that poses a significant and/or immediate threat to life, limb, or bodily function.
2. Threat to others requiring 24-hour professional observation:
 - a) assaultive behavior threatening others within 72 hours prior to admission.
 - b) significant verbal threat to the safety of others within 72 hours prior to admission.
3. Command hallucinations directing harm to self or others where there is the risk of the patient taking action on them.

4. Acute disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living (ADLs) so that the patient cannot function at a less intensive level of care during evaluation and treatment.
5. Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
6. For patients with a dementing disorder for evaluation or treatment of a psychiatric comorbidity (e.g., risk of suicide, violence, severe depression) warranting inpatient admission.
7. A mental disorder causing major disability in social, interpersonal, occupational, and/or educational functioning that is leading to dangerous or life-threatening functioning, and that can only be addressed in an acute inpatient setting.
8. A mental disorder that causes an inability to maintain adequate nutrition or self-care, and family/community support cannot provide reliable, essential care, so that the patient cannot function at a less intensive level of care during evaluation and treatment.
9. Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care. Reasons for the failure of outpatient treatment could include:
 - a) Increasing severity of psychiatric symptoms;
 - b) Noncompliance with medication regimen due to the severity of psychiatric symptoms;
 - c) Inadequate clinical response to psychotropic medications;
 - d) Due to the severity of psychiatric symptoms, the patient is unable to participate in an outpatient psychiatric treatment program.

NOTE: For all symptom sets or diagnoses, the severity and acuity of symptoms and the likelihood of response to treatment, combined with the requirement for an intensive, 24-hour level of care, are the significant factors in determining the necessity of inpatient psychiatric treatment.

Active Treatment:

The *italicized* text in this portion of the policy is quoted verbatim from CMS Publication.

The period of time covered by the physician's certification is referred to a period of active treatment. This period should include all days on which inpatient psychiatric hospital services were provided because of the individual's need for active treatment (not just the days on which specific therapeutic or diagnostic services were rendered). For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time or it may include a period of observation, either in preparation for or as a follow-up to therapy, while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean the patient is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his/her condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1).

For services in a hospital to be designated as "active treatment," they must be:

- *provided under an individualized treatment or diagnostic plan;*

- *reasonably expected to improve the patient's condition or for the purpose of diagnosis; and*
- *supervised and evaluated by a physician.*

Such factors as diagnosis, length of hospitalization, and the degree of functional limitation, while useful as general indicators of the kind of care most likely being furnished in a given situation, are not controlling in deciding whether the care was active treatment. Refer to 42 CFR 482.61 on "Conditions of Participation for Hospitals" for a full description of what constitutes active treatment (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1).

The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. Thus, an isolated service (e.g., a single session with a psychiatrist, or a routine laboratory test) not furnished under a planned program of therapy or diagnosis would not constitute active treatment, even though the service was therapeutic or diagnostic in nature. The plan of treatment must be recorded in the patient's medical record in accordance with 42 CFR 482.61 on "Conditions of Participation for Hospitals" (CMS Publication 100-02, Medicare benefit policy Manual, Chapter 2, Section 30.3).

The services provided must reasonably be expected to improve the patient's condition or must be for the purpose of diagnostic study. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms that necessitated hospitalization and improve the patient's level of functioning (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.3.2).

The types of services which meet the above requirements would include not only psychotherapy, drug therapy, and shock therapy, but also such adjunctive therapies as occupational therapy, recreational therapy, and milieu therapy, provided the adjunctive therapeutic services are expected to result in improvement (as defined above) in the patient's condition. If the only activities prescribed for the patient are primarily diversional in nature (i.e., to provide some social or recreational outlet for the patient, it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy (or one of the other adjunctive therapies) is involved, it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3).

In accordance with the above definition of "improvement," the administration of antidepressant or tranquilizing drugs which are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definition are met). However, the administration of a drug or drugs does not of itself necessarily constitute active treatment. Thus, the use of mild tranquilizers or sedatives solely for the purpose of relieving anxiety or insomnia would not constitute active treatment (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3).

Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation

should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews--at least once a week (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3). Although, it is a CMS requirement that the physician see the patient at least once per week, this is a dated reference, referring to a time when patients were hospitalized for long periods of time. The current standard of practice is that the physician usually sees the patient five times per week. Physician visits to a patient must involve a face-to-face encounter.

When the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed (based on consultations and conferences with therapists, review of the patient's progress as recorded on his medical record and his periodic conversations with the patient) active treatment would be indicated. The treatment furnished the patient should be documented in the medical record in such a manner and with such frequency as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient, such services would be reimbursable under the medical insurance program (See 42 CFR 482.61(c) and 42 CFR 482.61(d) on Conditions of Participation) (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3).

The program's definition of active treatment does not automatically exclude from coverage services rendered to patients who have conditions that ordinarily result in progressive physical and/or mental deterioration. Although patients with such diagnosis will most commonly be receiving custodial care, they may also receive services which meet the program's definition of active treatment (e.g., where a patient with Alzheimer's disease or Pick's disease received services designed to alleviate the effects of paralysis, epileptic seizures, or some other neurological symptom, or where a patient in the terminal stages of any disease received life supportive care). A period of hospitalization during which services of this kind were furnished would be regarded as a period of active treatment (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1).

Discharge:

Patients that meet the discharge criteria for intensity and severity of illness would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services, rendered and billed by appropriate providers. In certain cases, it may be appropriate for a patient to receive an unsupervised pass to leave the hospital for a brief period in order to assess their readiness for outpatient care.

Discharge Criteria (Intensity of Service):

Patients in inpatient psychiatric care may be discharged by stepping down to a less intensive level of outpatient care. Stepping down to a less intensive level of service than inpatient hospitalization could be considered when patients no longer require 24-hour observation for safety, diagnostic evaluation, or treatment as described above.

Discharge Criteria (Severity of Illness):

Patients whose clinical condition improves or stabilizes, who no longer pose an impending threat to self or others, and who do not still require 24-hour observation available in an inpatient psychiatric unit would be appropriate for a lower level of care in an outpatient setting. Patients whom are persistently unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge (see regulations for active treatment participation).

Qualified Inpatient Psychiatric Service providers:

For Medicare coverage, inpatient psychiatric diagnostic and psychotherapy services rendered to Medicare beneficiaries must be provided by individuals licensed or otherwise authorized by the state in which they practice, to render such services. While non-licensed trainees may provide psychotherapy services as part of a training program, those psychotherapy services rendered by individuals not licensed or authorized by the state will be considered not medically necessary, and may contribute to the denial of inpatient psychiatric claims. The majority of psychotherapy services must be provided by licensed personnel to assure a satisfactory patient outcome and Medicare coverage. Non-physician practitioners, licensed or authorized by the state, may perform duties within their scope of practice, such as individual and/or group psychotherapy, family counseling, occupational therapy, and diagnostic services. Providers of inpatient psychiatric services may include:

Physicians:

1. Medical Doctor (MD) (See Title XVIII of the Social Security Act, Section 1861[r].)
2. Doctor of Osteopathy (DO) (See Title XVIII of the Social Security Act, Section 1861[r].)

Non-physician Clinical Practitioners:

1. Clinical Psychologists (See Title XVIII of the Social Security Act, Sections 1861[s] [2] [M] and 1861[hh] [2] [ii].)
2. Clinical Nurse Specialists (CNSs), Adult Psychiatric and Mental Health Nurse Practitioners, or other master's-prepared nurses with appropriate mental health training and/or experience (See Title XVIII of the Social Security Act, Sections 1861[s] [2] [K] [ii] and 1861[aa] [5] [B].)
3. Licensed/certified clinical social workers (CSWs), master's-prepared social workers with additional clinical training AND licensure or state certification (See Title XVIII of the Social Security Act, Sections 1861[s] [2] [N] and 1861[hh] [1].)
4. Occupational Therapists (See Title XVIII of the Social Security Act, Section 1861[g] and 42 CFR Sections 440.110 and 484.4.)

Medicare requires nurses who provide psychiatric diagnostic evaluation and psychotherapy services to have special training and/or experience beyond the standard curriculum required for an RN. Such nurses should have one or more of the following credentials: MS/MSN – Master of Science in Psychiatric Nursing (or its equivalent); CNS – Clinical Nurse Specialist in Adult Psychiatric and Mental Health Nursing; NP – Adult Psychiatric and Mental Health Nurse Practitioner.

- These requirements do not apply to the standard nursing services rendered to psychiatric inpatients such as nursing evaluations, passing medications, psychiatric education and training services, and milieu interventions.

Other Providers Licensed or Otherwise Authorized by the State:

1. Marriage and Family Therapists (MFTs).
2. Registered Therapists and Certified Alcohol and Drug Counselors.
3. Recreational Therapists.
4. Registered pharmacists who may provide individual medication counseling and periodic educational groups
5. Other licensed or certified mental health practitioners whose scope of practice requires a specific level of supervision (e.g., Psychological Assistants, MFT interns and non-licensed/certified master's degree in social work may provide services within the limits of state scope of practice, licensure, and regulations).

Other Comments Related to Qualified Providers:

1. Unlicensed psychology interns are not considered to be a covered provider of service.

2. Supervision of trainees must at least meet the state-mandated supervision requirements. Such supervision need not occur on the inpatient psychiatric unit but must be documented and documentation must be maintained in the hospital and available for inspection upon request by Medicare or submitted to Medicare when requested.
3. Routine services provided as a part of the care of psychiatric inpatients, oftentimes performed by bachelor degree level psychiatric technicians, under the direction of the nursing service, need to conform to local state licensing or certification requirements, if any.

NOTE: Limits of local, state or federal scope of practice acts, legislation, and licensure regulations apply to all practitioners within an inpatient psychiatric treatment unit. In all cases, the most restrictive limit shall apply (e.g., who may or may not perform individual or group psychotherapy, and for what conditions).

Limitations:

1. Failure to provide documentation to support the necessity of test(s) or treatment(s) will result in denial of claims or services under Sections 1862(a) (1) (A) and 1833(e) of the Title XVIII of the Social Security Act. This includes medical records:
 - a) that do not support the reasonableness and necessity of service(s) furnished;
 - b) in which the documentation is illegible; or
 - c) where medical necessity for inpatient psychiatric services is not appropriately certified by the physician.

2. The following services do not represent reasonable and medically necessary inpatient psychiatric services and coverage is excluded under Title XVIII of the Social Security Act, Section 1862(a)(1)(A):
 - a) Services which are primarily social, recreational or diversion activities, or custodial or respite care;
 - b) Services attempting to maintain psychiatric wellness for the chronically mentally ill;
 - c) Treatment of chronic conditions without acute exacerbation;
 - d) Vocational training;
 - e) Medical records that fail to document the required level of physician supervision and treatment planning process;
 - f) Electrosleep therapy (CMS Publication 100-03, Chapter 1, Section 30.4);
 - g) Electrical Aversion Therapy for treatment of alcoholism (CMS Publication 100-03, Chapter 1, Section 130.4);
 - h) Hemodialysis for the treatment of schizophrenia (CMS Publication 100-03, Chapter 1, Section 130.8);
 - i) Transcendental Meditation (CMS Publication 100-03, Chapter 1, Section 30.5);
 - j) Multiple Electroconvulsive Therapy (MECT) (CMS Publication 100-03, Chapter 1, Section 160.25).

3. It is not reasonable and medically necessary to provide inpatient psychiatric hospital services to the following types of patients, and coverage is excluded under Title XVIII of the Social Security Act, Section 1862(a)(1)(A):
 - a) Patients who require primarily social, custodial, recreational, or respite care;
 - b) Patients whose clinical acuity requires less than twenty-four (24) hours of supervised care per day;
 - c) Patients who have met the criteria for discharge from inpatient hospitalization;
 - d) Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment;

- e) Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode;
 - f) Patients with alcohol or substance abuse problems who do not have a combined need for "active treatment" and psychiatric care that can only be provided in the inpatient hospital setting. (CMS Publication 100-03, Chapter 1, Section 130.1 and 130.6, respectively);
 - g) Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration.
4. Listing an ICD-9-CM code in the Mental Disorders category (290-319) does not assure coverage of the specific service. Coverage criteria for medically reasonable and necessary services specified in this Local Coverage Determination shall be applied to determine appropriate reimbursement.
 5. Medicare contractors may automatically deny a claim without any manual review if a National Coverage Determination (NCD) or a Local Coverage Determination (LCD) specifies the circumstances under which a service is denied and those circumstances exist, or if the service is specifically excluded from Medicare coverage by statute.

When an admission is denied, services related to that admission will also be denied.

OTHER COMMENTS

1. Life Time Limits (CMS Publication, *Medicare Benefit Policy Manual*, 100-04, Chapter 4) and Spell of Illness Limits (CMS Publication, *Medicare Benefit Policy Manual*, 100-04, Chapter 3) to psychiatric hospitalization services. Nothing in this policy can be used to either expand or contract those limits; however, coverage may be denied for medical necessity reasons even though the beneficiary has not exhausted the life time limit or spell of illness limit for psychiatric hospitalization services.
2. Notice to Beneficiaries as described in CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 2, Sections 60-60.1.1. All requirements related to discharge and coverage notification as described in the Medicare interpretive manuals apply.
3. Psychiatric Advance Directives as defined in 42 CFR Section 482.13(b)(3). All requirements related to Psychiatric Advance Directives must be met as part of the Hospital Conditions of Participation for Patients Rights.
4. Chemical or Physical Restraints, Seclusion, or Behavior Management within a psychiatric plan of care. These issues are addressed extensively in the Hospital Patient's Rights Legislation published in 64 FR 36070, July 2, 1999. All applicable requirements described in this publication must be met.
5. Certification of Facilities as psychiatric hospitals, psychiatric Inpatient Units within a Psychiatric Institution, or Psychiatric Inpatient Units within a General Hospital as defined in CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 5, Sections 20.3, 20.4, 20.5, 20.6 and 20.7. All requirements described in the Medicare interpretive manuals apply.
6. Items and Services Furnished, Paid for or Authorized by Governmental Entities as defined by CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16, Section 50.3.1: *Payment may be made for items and services furnished by a participating State or local government hospital, including a psychiatric hospital, which serves the general community. A psychiatric*

hospital to which patients convicted of crimes are committed involuntarily is considered to be serving the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals.

7. Items and Services Furnished by Physicians Under Part B: Professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though psychiatric inpatient hospitalization services are not.
8. For outpatient settings other than CORFs, references to “physicians” throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physicians practitioners, with certain exceptions, may certify, order and establish the plan of care for Psychiatric Inpatient Services as authorized by State Law (See Sections 1861 (s)(2) and 1862 (a)(14) of the Title XVII of the Social Security Act; 42 CFR, Sections 410.7, 410.75, 410.76, and 419.22; 58 FR 18543, April 7, 2000).
9. For inpatient psychiatric units in critical access hospitals (CAHs) see CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 30.1 and Transmittal No. 276, Change Request 3399, August 13, 2004.

Coverage Topic

Mental Health Care (Inpatient)

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11X	Hospital-inpatient (including Part A)
12X	Hospital or home health visits (Part B only)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Please note that not all revenue codes apply to every type of bill. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

XX000 Not Applicable

CPT/HCPCS Codes

XX000 Not Applicable

ICD-9 Codes that Support Medical Necessity

The ICD-9-CM codes listed below represent conditions that often support medical necessity for inpatient psychiatric hospitalization. The list is not all inclusive. The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination. The codes selected are generally those codes that appear in the *ICD-9-CM* and that are also defined in the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV-TR™).

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Final Rule says substance abuse is rarely the primary diagnosis for inpatient psychiatric treatment, and in those rare cases, there are generally mitigating factors to justify why the patient cannot be treated in an outpatient setting. (42 CFR parts 412 and 413 pg. 66938). The principal diagnosis is not necessarily what brought a patient to the hospital, but ultimately, what the IPF treats the patient for as his/her principal problem while in the facility. To be covered as an inpatient hospital service, it must meet the criteria for being medically necessary.

290.11	Presenile dementia with delirium
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.3	Senile dementia with delirium
290.41	Vascular dementia, with delirium
290.42	Vascular dementia, with delusions
290.43	Vascular dementia, with depressed mood
291.0	Alcohol Withdrawal Delirium
291.3	Alcohol-induced psychotic disorder with hallucinations
291.5	Alcohol-induced psychotic disorder with delusions
291.81	Alcohol withdrawal
291.89	Other specified alcohol-induced mental disorders
291.9	Unspecified alcohol-induced mental disorders
292.11	Drug-induced psychotic disorder with delusions
292.12	Drug-induced psychotic disorder with hallucinations
292.81	Drug-induced delirium
292.84	Drug-induced mood disorder
292.89	Other specified drug-induced mental disorders
292.9	Unspecified drug-induced mental disorder
293.81 - 293.89	Psychotic disorder with delusions in conditions classified elsewhere - other Specified transient mental disorders due to conditions classified elsewhere, other
293.9	Unspecified transient mental disorder in conditions classified elsewhere
294.11	Dementia in conditions classified elsewhere with behavioral disturbance
295.01 - 295.04	Simple type schizophrenia subchronic state - simple type schizophrenia chronic state with acute exacerbation
295.11 - 295.14	Disorganized type schizophrenia subchronic state - disorganized type schizophrenia chronic state with acute exacerbation
295.21 - 295.24	Catatonic type schizophrenia subchronic state - catatonic type schizophrenia chronic state with acute exacerbation
295.31 - 295.34	Paranoid type schizophrenia subchronic state - paranoid type schizophrenia chronic state with acute exacerbation

295.41 - 295.44	Schizophreniform disorder, subchronic - schizophreniform disorder, chronic with acute exacerbation
295.71 - 295.74	Schizoaffective disorder, subchronic - schizoaffective disorder, chronic with acute exacerbation
296.01 - 296.05	Bipolar I disorder, single manic episode, mild - bipolar I disorder, single manic episode, in partial or unspecified remission
296.21 - 296.25	Major depressive affective disorder single episode mild degree - major depressive affective disorder single episode in partial or unspecified remission
296.31 - 296.35	Major depressive affective disorder recurrent episode mild degree - major depressive affective disorder recurrent episode in partial or unspecified remission
296.41 - 296.45	Bipolar I disorder, most recent episode (or current) manic, mild - bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
296.51 - 296.55	Bipolar I disorder, most recent episode (or current) depressed, mild - bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
296.61 - 296.65	Bipolar I disorder, most recent episode (or current) mixed, mild - bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission
296.7	Bipolar I disorder, most recent episode (or current) unspecified
296.80	Bipolar disorder, unspecified
296.89	Other and unspecified bipolar disorders, other
296.90	Unspecified episodic mood disorder
297.1	Delusional disorder
297.3	Shared psychotic disorder
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
299.00	Autistic disorder, current or active state
299.10	Childhood disintegrative disorder, current or active state
299.80	Other specified pervasive developmental disorders, current or active state
299.90	Unspecified pervasive developmental disorder, current or active state
300.01	Panic disorder without agoraphobia
300.21	Agoraphobia with panic disorder
300.3	Obsessive-compulsive disorders
301.83	Borderline personality disorder
303.90	Other and unspecified alcohol dependence unspecified drinking behavior
307.1	Anorexia nervosa
307.51	Bulimia nervosa
308.3	Other acute reactions to stress
309.24	Adjustment disorder with anxiety
309.0	Adjustment Disorder with depressed mood
309.28	Adjustment disorder with mixed anxiety and depressed mood
309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.81	Posttraumatic stress disorder
311	Depressive disorder not elsewhere classified
312.34	Intermittent explosive disorder
780.09	Alteration of consciousness other
V62.84	Suicidal Ideation

Diagnoses that Support Medical Necessity

Those diagnoses reflected in the narrative section of Indications and Limitation of Coverage and/or Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Documentation Information

HCPCS codes not listed as “ICD-9 Codes That Support Medical Necessity” may be covered upon request to the Contractor Medical Director for individual consideration with supporting evidence of medical necessity in the specific case and must meet the specified criteria of this determination (Title XVIII of the Social Security Act, Section 1862[a][1][A].) The codes selected are generally those codes that appear in the ICD-9-CM and that are defined in the Diagnostic and Statistical Manual, fourth edition (DSM-IV-TR™).

Documentation that supports medical necessity and active treatment may take many forms. These documentation requirements are intended to help providers identify those documentation elements that will best support the medical necessity of the services they render. It is not expected that every item of these documentation requirements will appear in every record. Upon medical review, the IPF record will be reviewed as a whole, and services may be denied only if there is insufficient documentation to support the medical necessity of the claim, despite the presence of some missing or illegible documentation.

Medical record documentation must meet the criteria contained in this policy. Medical records must be made available, as hard copies, upon request of the Medicare contractor. The documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests and/or procedures. The diagnoses listed on the claim must be supported in the medical record documentation.

Required documentation for claim submission:

1. Physician certification for admission
2. Diagnosis according to the DSM IV and any comorbidity diagnoses
3. Progress notes from all providers of services
4. Recertification documentation
5. Initial psychiatric evaluation (see detailed requirements under Initial Psychiatric Evaluation)
6. Physician orders
7. Plan of treatment including discharge planning

Certification/ Recertification - General Requirements

Payments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the inpatient stay. Appropriate supporting material may be required. The physician certification or recertification statement must be based on a current evaluation of the patient's condition and authorized by the attending physician, or by a member of the hospital's medical staff who has knowledge of the case. Ordinarily for purposes of certification and recertification, a “physician” must meet the CMS physician definition (Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4, Section 10.2 and Chapter 5, Section 70 and 70.3 and Chapter 4, Section 10.2). (CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4, Section 10).

At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. The first recertification is required as of the 12th day of hospitalization. Subsequent recertifications will be required at intervals established by the hospitals utilization review committee (on a case-by-case), but no less frequently than every 30 days (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

For patients admitted to a general hospital, regardless of whether the patients are under PPS, a physician certification is not required at the time of admission for patient services. For services continued over a period of time or for a day outlier case... a physician must certify or recertify the continued need for the services at specified intervals (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10). (See also CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9.)

The individual hospital determines the method by which certifications and recertifications are to be obtained and the format of the statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.5).

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary to determine that the certification and recertification requirements are, in fact, met. The certification or recertification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate form could be used. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.5).

If an individual is admitted to a hospital (including a psychiatric hospital) before he/she is entitled to hospital insurance benefits (for example, before attainment of age 65), no certification is required as of the date of admission or entitlement. Certifications and recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he/she became entitled. (The time limits for certification and recertification are computed from the date of entitlement instead of the date of admission.) (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 20.2).

Certification/Recertification specific to Inpatient Psychiatric Hospitalization

The requirements for physician certification and recertification for inpatient psychiatric hospital services are similar to the requirements for certification and recertification for inpatient hospital services.

However, there is an additional certification requirement: At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with a knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. As a result, the first and second recertification for psychiatric hospital services correspond to the initial certification and first recertification requirements for inpatient hospital services (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

In accordance with 42 CFR 424.14, all IPFs (distinct part units of acute care hospitals, CAHs, and psychiatric hospitals) are required to meet the following certification and recertification requirements:

The required physician's statement should certify that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The physician's recertification should state:

- 1. That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
 - a. Treatment which could reasonably be expected to improve the patient's condition;*
 - b. Diagnostic study;**
- 2. The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services, and*
- 3. Effective July 1, 2006, physicians will also be required to include a statement recertifying that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel (CMS Publication, Medicare General Information, Eligibility, and Entitlement, 100-01, Chapter 4, Section 10.9).*

For convenience, the period covered by the physician's certification and recertification is referred to a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his/her benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

If a hospital fails to obtain the required certification and recertification statements in an individual case, program payments will not be made (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.1).

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he/she objects in principle to the concept of certification and recertification), the hospital may not bill the program or the beneficiary for covered items or services. The provider agreement precludes the hospital from charging the patient for covered items and services (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.1).

Initial psychiatric evaluation

The initial psychiatric evaluation with medical history and physical examination should be performed within 24 hours of admission, but in no case later than 60 hours of admission in order to establish medical necessity for psychiatric inpatient hospitalization services.

In order to support the medical necessity of admission, documentation in the initial psychiatric evaluation must:

- (1) Be completed within 60 hours of admission;*
- (2) Include a medical history;*
 - Past medical history
 - Current medical history including medications
- (3) Contain a record of mental status;*
 - Current medications

- Evidence of failure at or inability to benefit from outpatient treatment (lower level of care)
 - Past psychiatric history
 - History of substance abuse
 - Family, vocation, social history
- (4) *Note the onset of illness and the circumstances leading to admission;*
- Description of illness or exacerbation of chronic illness
- (5) *Describe attitudes and behavior;*
- Mental Status Examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self-harm and harm to others, insight, judgment, capacity for activities or activities of daily living (ADL's)
- (6) *Estimate intellectual functioning, memory functioning, and orientation; and*
- Global Assessment of Functioning Score
- (7) *Include an inventory of the patient's assets in descriptive, not interpretative fashion.*
(CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 2, Section 30.2)

Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

1. *The identification data must include the patient's legal status.*
2. *A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of comorbid diseases as well as the psychiatric diagnoses.*
3. *The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.*
4. *The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.*
5. *When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.*

(CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 2, Section 30.1)

A physical examination and other necessary diagnostic evaluations should be completed to the extent possible and as indicated by the patient's clinical presentation to rule out medical/neurological causes of psychiatric symptomatology. Several conditions should be treated in a medical setting as opposed to a psychiatric setting. Examples include: potentially life-threatening drug overdose, anticholinergic delirium, and neuroleptic malignant syndrome, among many others.

A team approach may be used in developing the initial psychiatric evaluation and the plan of treatment (see "Plan of Treatment" section below), but the physician (MD/DO) must personally document the mental status examination, physical examination, diagnosis, and certification. It will not always be possible to obtain all the suggested information at the time of evaluation. In such cases, the limited information that is obtained and documented must still be sufficient to support the need for an inpatient level of care.

Physician Orders:

Physician orders should include, but are not limited to, the following items:

1. The types of psychiatric and medical therapy services and medications;
2. Laboratory and other diagnostic testing;
3. Allergies;
4. Provisional diagnosis(es); and

5. Types and duration of precautions (e.g., constant observation X 24 hours due to suicidal plans, restraints).

Plan of Treatment:

The Plan of Treatment is the tool used by the physician and multi-disciplinary treatment team to implement the physician-ordered services and move the patient toward the expected outcomes and goals. The Plan of Treatment is a requirement. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient's stay.

The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. The plan of treatment must be recorded in the patient's medical record in accordance with 42 CFR 482.61, Conditions of Participation for Hospitals (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.3) and 42 CFR 412.27, Excluded psychiatric units: Additional requirements.

1. This individualized, comprehensive, outcome-oriented plan of treatment should be developed:
 - a) within the first three (3) program days after admission;
 - b) by the physician, the multidisciplinary treatment team, and the patient; and should be
 - c) based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
2. The plan of treatment should include:
 - a) the specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
 - b) the expected outcome for each problem addressed; and
 - c) contain outcomes that are measurable, functional, time-framed, and directly related to the cause of the patient's admission.
3. Treatment plan updates should show the treatment plan to be reflective of active treatment, as indicated by documentation of changes in the type, amount, frequency, and duration of the treatment services rendered as the patient moves toward expected outcomes. Treatment plan updates should be documented at least weekly, as the physician and treatment team assess the patient's current clinical status and make necessary changes. Lack of progress and its relationship to active treatment and reasonable expectation of improvement should also be noted.
4. The initial treatment plan and updated plans must be signed by the physician and those mental health professionals contributing to the treatment plan.

Progress Notes

General:

A separate progress note should be written for each significant diagnostic and therapeutic service rendered and should be written by the team member rendering the service. Although each progress note may not contain every element, progress notes should include a description of the nature of the treatment service, the patient's status (behavior, verbalizations, mental status) during the course of the service, the patient's response to the therapeutic intervention and its relation to the long or short term goals in the treatment plan and include the credentials of the rendering provider. It should be clear from the progress notes how the particular service relates to the overall plan of care.

Physician Progress Notes:

Physician progress notes should be recorded at each patient encounter and contain pertinent patient history, changes in signs and symptoms, with special attention to changes to the patient's mental status, and results of any diagnostic testing. The notes should also include an appraisal of the patient's status and progress, and the immediate plans for continued treatment or discharge. The course of the patient's inpatient diagnostic evaluation and treatment should be able to be inferred from reading the physician progress notes.

Individual and Group Psychotherapy and Patient Education and Training Progress Notes:

Psychotherapy notes will not be requested for submission. 45 CFR Part 164.508 (a)(2) defines psychotherapy notes as notes recorded by a mental health professional that document or analyze the contents of a counseling session and that are separated from the rest of a medical record. Psychotherapy notes expressly exclude documentation of medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date. Physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information.

Also note that physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes. The provider is responsible for extracting the information needed to support that the claim is reasonable and necessary.

Individual and group psychotherapy and patient education and training progress notes should describe the service being rendered, (i.e., name of group, group type, brief description of the content of the individual session or group), the patient's communications, and response or lack of response to the intervention. Each progress note should reflect the particular characteristics of the therapeutic/educational encounter to distinguish it from other similar interventions.

Discharge Plan:

It is expected as a matter of good quality of care that careful discharge planning occur to enable a successful transition to outpatient care.

Appendices

Utilization Guidelines

Sources of Information and Basis for Decision

Wisconsin Physicians Service (WPS) does not guarantee the continued availability of web links provided in sources.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Significance of Source: This specialty organization publication provides definitions and background information regarding psychiatric diagnoses.

Anderson AJ, Micheels P, et al. Criteria based voluntary and involuntary psychiatric admissions modeling. International Journal of Psychosocial Rehabilitation 1998; 2(2):176-188. Retrieved May 22, 2003 from the World Wide Web: <http://www.psychosocial.com/research/vol.html>.

Significance of Source: This article provides background information regarding psychiatric admission criteria.

Gartner, L, Mee-Lee, D. The role and current status of patient placement criteria in the treatment of substance abuse disorders. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2002. DHHS Publication No. (SMA) 02-3684.

Significance of Source: This Treatment Improvement Protocol (TIP) provides information useful in ascertaining the appropriate level of care for patients with addictive disorders.

Goldman RL, Weir CR, et al. Validity of utilization management criteria for psychiatry. *Am J Psychiatry* 1997; 154:349-354. Retrieved May 22, 2003 from the World Wide Web:

<http://ajp.psychiatryonline.org/cgi/content/abstract/154/3/349>.

Significance of Source: This article studies the validity of psychiatric admission criteria.

Hart A, Hopkins C, eds. ICD-9-CM 2003, 9th Revision, Clinical Modification, Sixth Edition. Salt Lake City, UT: 2002.

Significance of Source: This text provides codes and definitions for psychiatric diagnoses and is designated by CMS as the coding system physicians and those providers that are required to submit codes must use for Medicare claims submission.

Hermann RC, Leff HS, et al. Selecting process measure for quality improvement in mental healthcare. The Evaluation Center @HSRI July 2002. Retrieved July 2, 2003 from the World Wide Web:

<http://www.cqaimh.org/toolkit.website.pdf>

Significance of Source: This publication is a tool kit designed to help healthcare organizations to identify and select measures for use in quality assessment and improvement activities related to mental healthcare.

McGovern J. Management of risk in psychiatric rehabilitation. *The Psychologist* 1996: pages 405-408. Retrieved May 22, 2003 from the World Wide Web:

<http://www.academicarmageddon.co.uk/library/MCG.htm>.

Significance of Source: This article provides a review of the assessment of the risk of self harm and harm to others.

Merck Manual of Diagnosis and Therapy, Section 15. Retrieved May 22, 2003 from the World Wide Web: <http://www.merck.com/pubs/mmanual/section15/chapter194/194a.htm>.

Significance of Source: This section of the compendium presents information related to psychiatric disorders requiring emergency evaluation and treatment.

Silka VR, Hauser MJ. Psychiatric assessment of the person with mental retardation. *Psychiatric Annals* March 1997; 27:3. Retrieved May 22, 2003 from the World Wide Web:

<http://www.psychiatry.com/mr/assessment.html>.

Significance of Source: This article reviews the psychiatric assessment of individuals with mental retardation.

Silver MS, Burak OR. Transfer of facility clients to inpatient psychiatry: eight criteria to consider. *Journal of Healthcare Quality* September/October 2002. Retrieved May 22, 2003 from the World Wide Web:

<http://www.allenpress.com/jhq/119/119.html>.

Significance of Source: This article reviews criteria for the transfer of patients with mental retardation to inpatient psychiatric facilities.

Soderberg, P, Tungstrom, S, and Armelius, B. (2005). Reliability of global assessment of functioning ratings made by clinical staff. *Psychiatric Services*, April 2005 (56) 4, p 434-438. Retrieved May 22, 2009 from the World Wide Web: <http://ps.psychiatryonline.org>.

Significance of Source: This article reviews the reliability of the GAF in measuring outcomes.

ValueOptions, Inc. Provider Handbook, Section III, Clinical criteria and clinical practice guidelines: adult mental health facilities and programs, Subsection 2.201 (Acute inpatient mental health [adult]). Retrieved May 22, 2003 from the World Wide Web:

<http://www.valueoptions.com/provider/handbook/three/302b.htm>.

Significance of Source: This section of the handbook outlines criteria required by this managed care organization for adult acute inpatient psychiatric admission.

Washington Peer Review Organization, General criteria set for non-physician review, Chapter 4 (Guidelines for rehabilitation, psych and addiction), revised 7/1/98 (acute psychiatric illness); revised 7/1/97 (addiction).

Significance of Source: This document provides the criteria used by this Quality Improvement Organization (QIO [formerly PRO]) for psychiatric hospitalization.

Texas Medical Foundation, QIO Criteria: Indications for Hospitalization.

Significance of Source: This document details the criteria for inpatient psychiatric admission that are required by this Quality Improvement Organization (QIO).

Other Medicare contractor (carrier and fiscal intermediaries Local Coverage Determinations (LCDs) and Wisconsin Physician Service Legacy A LCD for Inpatient Psychiatric Services expanded to create draft for the inclusion of Legacy A and MAC A coverage.

Advisory Committee Meeting Notes

Illinois	09/16/2009
Michigan	09/09/2009
Minnesota	09/24/2009
Wisconsin	09/25/2009
J5 MAC	10/08/2009
Open Meeting	08/19/2009

Start Date of Comment Period

10/08/2009

End Date of Comment Period

11/23/2009

Start Date of Notice Period

Revision History Number

Revision History Explanation

Reason for Change

Last Reviewed On Date

07/28/2009

Related Documents

See companion document, [Coding and Billing Guidelines for PSYCH-020 Psychiatric Inpatient Hospitalization](#)

LCD Attachments

Does this LCD contain a "Least Costly Alternative" Provision?

No

Other Versions

Inpatient Psychiatric Hospitalization- Supplemental Coding and Billing Article

Contractor Name

Wisconsin Physicians Service

Contractor Number

52280

5101

5201

5301

5401

Contractor Type

FI

MAC A

Article ID Number

PSYCH-020

Article Type

Billing and Coding

Key Article

Yes

Article Title

Inpatient Psychiatric Hospitalization

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Primary Jurisdiction

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands

MAC A: Iowa, Missouri, Nebraska, Kansas

Original Article Effective Date

Article Revision Effective Date

Article Text

The information in this supplemental instructions article (SIA) contains coding or other guidelines that complement the local coverage determination (LCD) for Inpatient Psychiatric Hospitalization. The LCD can be accessed on our contractor website at www.wpsmedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd.

Coding Guidelines:

General Guidelines for Submitting Claims for Carriers or Intermediaries or MAC Part A or Part B:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS (OCE) packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be printed on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient Services):

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ. The -GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Mac Part A, occurrence code 32 and the date of the ABN is required.

The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

For claims submitted to the carrier or Mac Part B:

See the “Other Comments” section of this SIA.

For claims submitted to the Fiscal Intermediary or MAC Part A:

Guidelines for claims submitted on UB-04 to the Fiscal Intermediary

Hospital Inpatient Claims:

- The hospital should report the patient’s principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For Inpatient hospital claims, the admitting diagnosis is required and should be recorded on FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions).

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient’s symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report the ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in the FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Bill Type Guidelines

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B) states that *no type of technical services, such as...a technical component of a diagnostic or screening service, is ever billed on TOB 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers...Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.*

Per CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B), only four types of services are billed on TOBs 71x and 73x: *Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052x; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910);...telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplemental payment...: 0521, 0522, 0524, 0525, 0527, and 0528 (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100[B]).

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Coverage Topic

Mental Health Care (Inpatient)

Coding Information

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11X	Hospital-inpatient (including Part A)
12X	Hospital or home health visits (Part B only)

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

Please note that not all revenue codes apply to every type of bill. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable codes.

Use of revenue code 0910 to report certain psychiatric/psychological treatment and services was discontinued by the National Uniform Billing Committee on 10/15/03. Revenue code 0900 will now be used in place of revenue code 0910 effective for claims with dates of service on or after October 16, 2003 (CMS Publication 100-20, *Medicare One-Time Notification Manual*, Transmittal No. 98, Change Request #3343, July 23, 2004).

All revenue codes billed on the inpatient claims for the dates of service in question may be subject to review.

XX000 Not Applicable

CPT/HCPCS Codes

The ICD-9-CM codes listed below represent conditions that often support medical necessity for inpatient psychiatric hospitalization. The list is not all inclusive. The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination. The codes selected are generally those codes that appear in the *ICD-9-CM* and that are also defined in the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV-TR™).

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Final Rule says substance abuse is rarely the primary diagnosis for inpatient psychiatric treatment, and in those rare cases, there are generally mitigating factors to justify why the patient cannot be treated in an outpatient setting. (42 CFR parts 412 and 413 pg. 66938). The principal diagnosis is not necessarily what brought a patient to the hospital, but ultimately, what the IPF treats the patient for as his/her principal problem while in the facility. To be covered as an inpatient hospital service, it must meet the criteria for being medically necessary.

290.11	Presenile dementia with delirium
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.3	Senile dementia with delirium
290.41	Vascular dementia, with delirium
290.42	Vascular dementia, with delusions
290.43	Vascular dementia, with depressed mood
291.0	Alcohol Withdrawal Delirium
291.3	Alcohol-induced psychotic disorder with hallucinations
291.5	Alcohol-induced psychotic disorder with delusions
291.81	Alcohol withdrawal
291.89	Other specified alcohol-induced mental disorders
291.9	Unspecified alcohol-induced mental disorders
292.11	Drug-induced psychotic disorder with delusions
292.12	Drug-induced psychotic disorder with hallucinations
292.81	Drug-induced delirium
292.84	Drug-induced mood disorder
292.89	Other specified drug-induced mental disorders
292.9	Unspecified drug-induced mental disorder
293.81 - 293.89	Psychotic disorder with delusions in conditions classified elsewhere - other Specified transient mental disorders due to conditions classified elsewhere, other
293.9	Unspecified transient mental disorder in conditions classified elsewhere
294.11	Dementia in conditions classified elsewhere with behavioral disturbance
295.01 - 295.04	Simple type schizophrenia subchronic state - simple type schizophrenia chronic state with acute exacerbation
295.11 - 295.14	Disorganized type schizophrenia subchronic state - disorganized type

	schizophrenia chronic state with acute exacerbation
295.21 - 295.24	Catatonic type schizophrenia subchronic state - catatonic type schizophrenia chronic state with acute exacerbation
295.31 - 295.34	Paranoid type schizophrenia subchronic state - paranoid type schizophrenia chronic state with acute exacerbation
295.41 - 295.44	Schizophreniform disorder, subchronic - schizophreniform disorder, chronic with acute exacerbation
295.71 - 295.74	Schizoaffective disorder, subchronic - schizoaffective disorder, chronic with acute exacerbation
296.01 - 296.05	Bipolar I disorder, single manic episode, mild - bipolar I disorder, single manic episode, in partial or unspecified remission
296.21 - 296.25	Major depressive affective disorder single episode mild degree - major depressive affective disorder single episode in partial or unspecified remission
296.31 - 296.35	Major depressive affective disorder recurrent episode mild degree - major depressive affective disorder recurrent episode in partial or unspecified remission
296.41 - 296.45	Bipolar I disorder, most recent episode (or current) manic, mild - bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission
296.51 - 296.55	Bipolar I disorder, most recent episode (or current) depressed, mild - bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission
296.61 - 296.65	Bipolar I disorder, most recent episode (or current) mixed, mild - bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission
296.7	Bipolar I disorder, most recent episode (or current) unspecified
296.80	Bipolar disorder, unspecified
296.89	Other and unspecified bipolar disorders, other
296.90	Unspecified episodic mood disorder
297.1	Delusional disorder
297.3	Shared psychotic disorder
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
299.00	Autistic disorder, current or active state
299.10	Childhood disintegrative disorder, current or active state
299.80	Other specified pervasive developmental disorders, current or active state
299.90	Unspecified pervasive developmental disorder, current or active state
300.01	Panic disorder without agoraphobia
300.21	Agoraphobia with panic disorder
300.3	Obsessive-compulsive disorders
301.83	Borderline personality disorder
303.90	Other and unspecified alcohol dependence unspecified drinking behavior
307.1	Anorexia nervosa
307.51	Bulimia nervosa
308.3	Other acute reactions to stress
309.24	Adjustment disorder with anxiety
309.0	Adjustment Disorder with depressed mood
309.28	Adjustment disorder with mixed anxiety and depressed mood

309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.81	Posttraumatic stress disorder
311	Depressive disorder not elsewhere classified
312.34	Intermittent explosive disorder
780.09	Alteration of consciousness other
V62.84	Suicidal Ideation

ICD-9 Codes that are Covered

XX000 Not Applicable.

ICD-9 Codes that are Not Covered

XX000 Not Applicable

Other Information

Other Comments

If the facility portion of inpatient psychiatric services is denied as not medically necessary this does not mean that the physician services is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in an inpatient psychiatric facility is not medically necessary. **Please refer to Medicare Part B publications, regulations, billing, and/or applicable LCDs for services that apply to Part B Medicare services.**

Physician visits to a patient must involve a face-to-face encounter. Physician visits that only comprise team conferences or discussion with staff can not be billed to the carrier.

These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated Wisconsin Physicians Service to process their claims.

Related Documents

Psychiatric Inpatient Hospitalization LCD