CMS Local Coverage Determination (LCD) of Psychiatric Hospitalization for Massachusetts, New York, and Rhode Island

L33624

Indications and Limitations of Coverage

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 in a lower level of care. This setting provides daily physician supervision, twenty four (24) hour nursing/treatment team evaluation and observation, diagnostic services, and psychotherapeutic and medical interventions. Services rendered to Medicare beneficiaries must be authorized by the state in which they practice, to render such services. While non-licensed trainees may provide psychotherapyservices as part of a training program, those services rendered by individuals not licensed or authorized by the state will be considered not medically necessary, and may contribute to denial of inpatient claims.

Inpatient psychiatric care may be delivered in a Psychiatric Hospital, a Psychiatric Hospital Acute Care Unit within a Psychiatric Institution, or a Psychiatric 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.*

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 the need for inpatient psychiatric hospitalization. The patient must require "active treatment" of his/her psychiatric disorder. Such factors as diagnosis, length of hospitalization, and the degree of function 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 with an individualized program of treatment of 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 on *"Conditions of Participation for Hospitals"* (CMS Publication 100-02, *Medicare Benefit Policy Manual, Chapter 2, Section 30.3)*.

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. 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.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following must be met: 1. Patient must require intensive, comprehensive multimodal treatment including 24 hours per day of medical supervision and coordination because of a mental disorder. 2. Must require services at levels of frequency and intensity exceeding which may be rendered in an outpatient setting 3. Must exhibit threat to self and others exhibited by, but not limited to (within 72 hours of admission): a) Suicidal ideation b) Self-mutilation 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 d) Threat or assaultive behavior e) Command hallucinations directing harm to self or others f) Acute disordered/bizarre behavior or psychomotor agitation or retardation that interferes with activities of daily	**All of the following must be met:** 1. Member continues to meet all admission criteria 2. Patient has an individualized treatment or diagnostic plan 3. Ongoing treatment is expected to reasonably improve the patient's condition 4. Patient continues to require active treatment to improve symptoms 5. Medication evaluation and trials have been completed when appropriate 6. Treatment cannot occur at a less intensive level of care	**Any of the following must be met:** 1. Patient no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive 2. Patient no longer requires 24 hour observation for safety, diagnostic evaluation, or treatment 3. Patient's clinical condition has improved and stabilized and no longer poses a danger to self or others 4. Patient is persistently unwilling or unable to participate in active treatment of their psychiatric condition 5. Patient or parent/guardian withdraws consent for treatment and patient does not meet criteria for involuntary/ mandated treatment. 6. Active Treatment is no longer occurring 7. Patient is not making progress toward goals, nor is there expectation of any progress.

living so that patient cannot function at a less intensive level of care g) Cognitive impairment due to a mental health disorder that endangers the welfare of the patient or others h) Dementing disorder with a psychiatric comorbidity (e.g. risk of suicide, violence, severe depression) i) A mental disorder causing major disability in social, interpersonal, occupational, and/or educational functioning that is leading to dangerous or life-threatening functioning that can only be addressed in an acute inpatient setting j) Inability to maintain adequate nutrition or self-care 4) Severity and acuity of symptoms have the likelihood of response to treatment **Exclusions:** 1) Patient symptoms are the result of a medical condition that requires a medical/surgical setting 2) Patient's primary problem is a physical health problem without a concurrent major psychiatric episode 3) Only activities prescribed to the patient are diversionary		

4) Services are primarily recreational, social, diversion, custodial, or respite 5) Services attempting to maintain psychiatric wellness for the chronically mentally ill 6) Treatment of chronic conditions without acute exacerbation 7) Vocational training 8) Patients with alcohol or substance use problems who do not have a combined need for "active treatment" 9) Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration		

Additional Administrative Criteria for Medicare Coverage of Inpatient Hospitalization	Not Included in this policy
• See CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3 for payment for professional services rendered by the physician • See CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1 for period of time covered by the physician's certification and active treatment • See CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1 for definitions of active treatment and supervision of a physician • See CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section	1) Life Time Limits and Spell of Illness Limits as defined by CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapters 3 and 4 2) Notice to Beneficiaries as described in CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Sections 60 – 60.1.1 3) Psychiatric Advance Directives as defined in 42 CFR Section 482.13(b)(3). 4) Chemical or Physical Restraints, Seclusion, or Behavior Management addressed in 64 FR 36070, July 2, 1999. 5) Certification of Facilities as defined in CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual,*

30.2.2.1 for program's definition of active treatment and coverage for services rendered to patients who have conditions that ordinarily result in progressive physical and/or mental deterioration • Services rendered to Medicare beneficiaries must be provided by individuals licensed or otherwise authorized by the state in which they practice • Failure to provide documentation to support the necessity of tests or treatment may 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. o Medical records that do not support the reasonableness and necessity of service(s) furnished o Illegible documentation o Where medical necessity for inpatient psychiatric services is not appropriately certified by a physician • Physician visits to a patient must involve a face to face encounter; if only a team conference of discussion with staff, this cannot be billed to carrier	Chapter 5, Sections 20.3, 20.4, 20.5, 20.6, and 20.7 6) Items and Services Furnished, Paid, or Authorized by Government Entities as defined by CMS Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16, Section 50.3.1. 7) Items and Services Furnished by Physicians Under Part B