Psychiatric Inpatient Hospitalization

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Introduction & Instructions for Use

Introduction

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum®.

Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

If there is an absence of any applicable Medicare statutes, regulations, National or Local Coverage Determinations offering guidance, Optum utilizes adopted external criteria as follows:

- Level of Care Utilization System (LOCUS):
    - Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages eighteen and older.
- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII):
    - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists used to make determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.
    - Access the CALOCUS-CASII Criteria here
- Early Childhood Service Intensity Instrument (ECSII):
    - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make determinations and to provide level of service intensity recommendations for children ages 0-5.
    - Access the ECSII Criteria here
- Optum Supplemental Clinical Criteria: developed criteria based on "acceptable clinical literature"
    - Electroconvulsive Therapy (ECT)
    - National criteria used to make clinical determinations for ECT.
- National criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make coverage determinations regarding experimental and investigation services and treatments. Optum Behavioral Clinical Policies:
    - Complementary and Alternative Medicine (CAM) Treatments
    - Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT)
    - Neurofeedback
    - Transcranial Magnetic Stimulation
    - Wilderness Therapy
- *Optum utilizes The ASAM Criteria to supplement the Medicare National Coverage Determinations (NCDs 130.1-130.7) for Alcohol and Substance Abuse Treatment to ensure consistency in making medical necessity determinations.*
    - Access the ASAM Criteria *here*

Use of The ASAM Criteria to supplement the general provisions outlined under 42 CFR 422.101(b)(6)(i) provides clinical benefits that are highly likely to outweigh any clinical harms from delayed or decreased access to items or services.

Specifically, The ASAM Criteria are consulted when the NCDs do not fully address the type of treatment or appropriate treatment setting that will likely lead to improvement of the member's condition. The ASAM Criteria are also consulted due to the comprehensive six-dimension analysis to determine if comorbid medical, mental health and substance related factors add to the evidence for services not offered in the NCDs.

These criteria represent current, widely used treatment guidelines developed by organizations representing clinical specialties, or Optum developed criteria based on "acceptable clinical literature" according to 422.101(b)(6)(i). Optum selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. Optum uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning. The use of such criteria is highly likely to outweigh any clinical harms from delayed or decreased access to care.

Psychiatric Inpatient Hospitalization

Inpatient psychiatric hospitalization provides 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, 24-hour nursing/treatment team evaluation and observation, diagnostic services, and psychotherapeutic and medical interventions (Centers for Medicare and Medicaid Services [CMS], Local Coverage Determinations [LCD] (CMS L33624, 2019; L33975, 2021; L34183, 2023; L34570, 2019).

Inpatient psychiatric care may be delivered in a psychiatric acute care unit within a psychiatric institution, or a psychiatric inpatient unit within a general hospital (CMS L33624, 2019; L34183, 2023; L34570, 2019).

Applicable States

This Medicare Coverage Summary is applicable to the following States/jurisdictions.

(CMS L33624/A56865)

- Connecticut
- Illinois
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- Rhode Island
- Vermont
- Wisconsin

(CMS L33975/A57726)

- Florida
- Puerto Rico
- Virgin Islands

(CMS L34183/A57052)

- Kentucky
- Ohio

(CMS L34570/A56614)

- Alabama
- Georgia
- North Carolina
- South Carolina
- Tennessee
- Virginia
- West Virginia

Coverage, Indications, Limitations and/or Medical Necessity

Indications (CMS L33624, 2019; L34183, 2023; L34570, 2019)

- 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. 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.

(CMS L33975, 2021)

- Patients admitted to inpatient psychiatric hospitalization must be under the care of a physician. The physician must certify/recertify 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.

(CMS L33624, 2019)

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 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.
- 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):
  - Threat to self or others requiring 24-hour professional observation;
    - Suicidal ideation or gesture within 72 hours prior to admission.
    - Self-mutilation (actual or threatened) within 72 hours prior to admission.
    - Chronic and continuing self-destructive behavior (e.g., bulimic behaviors, substance abuse) that poses a significant and immediate threat to life, limb, or bodily function.
  - Threat to others requiring 24-hour professional observation:
    - Assaultive behavior threatening others within 72 hours prior to admission.
    - Significant verbal threat to the safety of others within 72 hours prior to admission.
  - Command hallucinations directing harm to self or others where there is risk of the patient taking action on them.
  - 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.
  - Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
  - For patients with a dementia disorder for evaluation of treatment of a psychiatric comorbidity (e.g., risk of suicide, violence, severe depression) warranting inpatient admission.
  - 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.
  - 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.
  - Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care. Reasons for failure of outpatient treatment could include:
    - Increasing severity of psychiatric symptoms;
    - Noncompliance with medication regiment due to the severity of psychiatric symptoms;

- Inadequate clinical response to psychotropic medications;
- 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 use of mild tranquilizers or sedatives solely for the purpose of relieving anxiety or insomnia would not constitute active treatment.
- 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.

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 would be considered when patients are no longer require 24-hour observation for safety, diagnostic evaluation, or treatment as described above. These patients would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services, rendered and billed by appropriate providers.
- It may be appropriate for some patients to receive an unsupervised pass to leave the hospital for a brief period in order to assess their readiness for outpatient care.

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 should be stepped down to outpatient care. Patients who are persistently unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge.

Qualified Providers

1. 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)
   2. Doctor of Osteopathy (DO)

   Nonphysician Clinical Practitioners:

   1. Clinical Psychologists
   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.*
   3. Licensed/certified clinical social workers (CSWs), master's-prepared social workers with additional clinical training AND licensure or state certification.
   4. Occupational Therapists.

   *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:

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

- Failure to provide documentation to support the necessity of test(s) or treatment(s) may result in denial of claims or services. This includes medical records.
  - That don't support the reasonableness and necessity of service(s) furnished;
  - In which the documentation is illegible; or
  - Where medical necessity for inpatient psychiatric services is not appropriately certified by the physician.
- The following do not represent reasonable and medically necessary inpatient psychiatric services:
  - Services which are primarily social, recreational or diversion activities, or custodial or respite care;
  - Services attempting to maintain psychiatric wellness for the chronically mentally ill;
  - Treatment of chronic conditions without acute exacerbation;
  - Vocational training;
  - Medical records that fail to document the required level of physician supervision and treatment planning process;
  - Electrosleep therapy;
  - Electrical Aversion Therapy for treatment of alcoholism;
  - Hemodialysis for the treatment of schizophrenia;
  - Transcendental Meditation;
  - Multiple Electroconvulsive Therapy (MECT).
- It is not reasonable and medically necessary to provide inpatient psychiatric hospital services to the following types of patients:
  - Patients who require primarily social, custodial, recreational, or respite care;
  - Patients whose clinical acuity requires less than 24 hours of supervised care per day;
  - Patients who have met the criteria for discharge from inpatient hospitalization;
  - Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment;
  - Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode;
  - 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;
  - Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration.

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

(CMS L33975, 2021)

Admission Criteria (Intensity of Service)

- The patient must require intensive, comprehensive, multifaceted 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 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.
- 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.
- 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):
  - Threat to self, requiring 24-hour professional observation (i.e., suicidal ideation or gesture within 72 hours prior to admission, self-mutilation (actual or threatened) within 72 hours prior to admission, 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).
  - Threat to others requiring 24-hour professional observation (i.e., assaultive behavior threatening others within 72 hours prior to admission, significant verbal threat to the safety of others within 72 hours prior to admission).
  - Command hallucinations directing harm to self or others where there is the risk of the patient taking action on them.
  - Acute disorder/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.
  - Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
  - A patient with a dementia disorder for evaluation or treatment of a psychiatric comorbidity (e.g., risk of suicide, violence, severe depression) warranting inpatient admission.
  - 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.
  - 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.
  - Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care. Reasons for the failure of outpatient treatment may include increasing severity of psychiatric condition or symptom, noncompliance with medication regimen due to the severity of psychiatric symptoms, inadequate clinical response to

psychotropic medications or severity of psychiatric symptoms that an outpatient psychiatric treatment program is not appropriate.

Active Treatment

- For services in an inpatient psychiatric facility 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. Please refer to 42 CFR 482.61 on “Conditions of Participation for Hospitals” for a full description of what constitutes active treatment.
  - 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”.
  - The services 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.
  - 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.
  - 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.
  - 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. Interpretation of “at least once a week” means that the physician will evaluate the therapeutic program at least weekly, whereas it is generally the standard of practice that a physician sees the patient five to seven times a week during an acute care hospitalization.
  - 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.
- 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".

Discharge Criteria (Intensity of Service)

- Patients in inpatient psychiatric care may be discharged to a less intensive level of outpatient care. A less intensive level of service would be considered when patients no longer require 24-hour observation for safety, diagnostic evaluation, or treatment as described above. These patients would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services, rendered and billed by appropriate providers.

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 require 24-hour observation available in an inpatient psychiatric unit should be discharged to outpatient care. In addition, patients who are persistently unwilling or unable to participate in active treatment of their psychiatric condition, would also be appropriate for discharge.

Limitations

- The following services do not represent medically reasonable and necessary inpatient psychiatric services and coverage is excluded:
  - Services which are primarily social, recreational or diversion activities, or custodial or respite care;
  - Services attempting to maintain psychiatric wellness for the chronically mentally ill;
  - Treatment of chronic conditions without acute exacerbation or the ability to improve functioning;
  - Vocational training;
  - Medical records that fail to document the required level of physician supervision and treatment planning process;
  - Electrosleep therapy;
  - Electrical Aversion Therapy for treatment of alcoholism (CMS IOM Publication 100-03, Chapter 1, Section 130.4);
  - Hemodialysis for the treatment of schizophrenia (CMS IOM Publication 100-03, Chapter 1, Section 130.8);
  - Transcendental Meditation (CMS IOM Publication 100-03, Chapter 1, Section 30.5);
  - Multiple Electroconvulsive Therapy (MECT) (CMS IOM Publication 100-03, Chapter 1, Section 160.25).
- It is not medically reasonable and necessary to provide inpatient psychiatric hospital services to the following types of patients, and coverage is excluded:
  - Patients who require primarily social, custodial, recreational, or respite care;
  - Patients whose clinical acuity requires less than twenty-four (24) hours of supervised care per day;
  - Patients who have met the criteria for discharge from inpatient hospitalization (i.e., patients waiting for placement in another facility);
  - Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment;
  - Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode. The treatable psychiatric symptoms/problem(s) must exceed any medical problems for the patient to be placed in an inpatient psychiatric unit;
  - 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 IOM Publication 100-03, Chapter 1, Section 130.1 and 130.6, respectively);
  - Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration (i.e., court ordered admission not meeting medical necessity criteria);

- Patients admitted by a court order or whose admission is based on protocol and do not meet admission criteria (i.e., admissions based on hospital, legal, local, or state protocols do not preclude the patient from meeting the medical necessity for admission to an inpatient psychiatric hospital).

(CMS L34183, 2023)

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 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.
- 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):
  - Threat to self-requiring 24-hour professional observation
    - suicidal ideation or gesture within 72 hours prior to admission
    - self-mutilation (actual or threatened) within 72 hours prior to admission
    - 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.
      - Threat to others requiring 24-hour professional observation:
        - assaultive behavior threatening others within 72 hours prior to admission.
        - significant verbal threat to the safety of others within 72 hours prior to admission.
        - Command hallucinations directing harm to self or others where there is the risk of the patient taking action on them.
        - 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.
        - Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
        - 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.
        - 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.
        - 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.
        - 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:
          - Increasing severity of psychiatric symptoms;
          - Noncompliance with medication regimen due to the severity of psychiatric symptoms;
          - Inadequate clinical response to psychotropic medications;
          - 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

- For services in an IPF (Inpatient Psychiatric Facility) 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. 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 electroconvulsive therapy, but also such therapeutic activities as occupational therapy, recreational therapy, and milieu therapy, provided the therapeutic activities 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 that 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 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.)
- 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 the medical record and the physician's periodic conversations with the patient), active treatment would be indicated. A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Medicare 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. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.3).

- 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 facility services were provided because of the individual's need for active treatment (not just the days on which specific therapeutic or diagnostic services are 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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1).
- 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).
- 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 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 would be considered when patients no longer require 24-hour observation for safety, diagnostic evaluation, or treatment as described above. These patients would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services, rendered and billed by appropriate providers. It may be appropriate for some patients to receive an unsupervised pass to leave the hospital for a brief period in order to assess their readiness for outpatient care.

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 should be stepped down to outpatient care. Patients who are persistently unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge.

Qualified 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:
    - Medical Doctor (MD)
    - Doctor of Osteopathy (DO)
  - Nonphysician Clinical Practitioners:
  - Clinical Psychologists

- 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
- Licensed/certified clinical social workers (CSWs), master's-prepared social workers with additional clinical training AND licensure or state certification
- Occupational Therapists

  * 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:
  - Marriage and Family Therapists (MFTs).
  - Registered Therapists and Certified Alcohol and Drug Counselors.
  - Recreational Therapists.
  - Registered pharmacists who may provide individual medication counseling and periodic educational groups
  - 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:
  - Unlicensed psychology interns are not considered to be a covered provider of service.
  - 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.
  - 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

- Failure to provide documentation to support the necessity of test(s) or treatment(s) may result in denial of claims or services, this includes medical records:
  - that do not support the reasonableness and necessity of service(s) furnished;
  - in which the documentation is illegible; or
  - where medical necessity for inpatient psychiatric services is not appropriately certified by the physician.
  - The following services do not represent reasonable and medically necessary inpatient psychiatric services and coverage is excluded:
    - Services which are primarily social, recreational or diversion activities, or custodial or respite care;
    - Services attempting to maintain psychiatric wellness for the chronically mentally ill;
    - Treatment of chronic conditions without acute exacerbation;
    - Vocational training;
    - Medical records that fail to document the required level of physician supervision and treatment planning process;
    - Electrosleep therapy (CMS Publication 100-03, Chapter 1, Section 30.4);
    - Electrical Aversion Therapy for treatment of alcoholism (CMS Publication 100-03, Chapter 1, Section 130.4);
    - Hemodialysis for the treatment of schizophrenia (CMS Publication 100-03, Chapter 1, Section 130.8);
    - Transcendental Meditation (CMS Publication 100-03, Chapter 1, Section 30.5);
    - Multiple Electroconvulsive Therapy (MECT) (CMS Publication 100-03, Chapter 1, Section 160.25).
    - It is not reasonable and medically necessary to provide inpatient psychiatric hospital services to the following types of patients, and coverage is excluded:
      - Patients who require primarily social, custodial, recreational, or respite care;

- Patients whose clinical acuity requires less than twenty-four (24) hours of supervised care per day;
- Patients who have met the criteria for discharge from inpatient hospitalization;
- Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment;
- Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode;
- 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);
- Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration.
- Listing an ICD-10-CM code in the Mental Disorders category does not assure coverage of the specific service. Upon medical review, coverage criteria specified in this Local Coverage Determination shall be applied to the entire medical record to determine medical necessity.
- 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 the service is specifically excluded from Medicare coverage by statute.

Other Comments

- For claims submitted to the Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS Administrators, LLC to process their claims.
- Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.
- Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.
- 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-physician 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 Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)
- This policy does **NOT** address the following issues:
  - Lifetime Limits and Spell of Illness Limits to psychiatric hospitalization services as defined by the CMS Publication 100-02, Medicare Benefit Policy Manual, Chapters 3 and 4. 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 lifetime limit or spell of illness limit for psychiatric hospitalization services.
  - Notice to Beneficiaries as described in CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Sections 60 – 60.1.1.
  - 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.
  - 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.
  - 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.
  - 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 in or by a participating State or local government hospital, including a psychiatric or tuberculosis 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 or by State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals.
- 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. Notices to beneficiaries' requirements apply. 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. Physician visits to a patient must involve a face-to-face encounter. Physician visits that only comprise team conferences or discussion with staff cannot be billed to the carrier.

(CMS L34570, 2019)

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 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.
- 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):
  - Threat to self or others requiring 24-hour professional observation
    - Suicidal ideation or gesture within 72 hours prior to admission.
    - Self-mutilation (actual or threatened) within 72 hours prior to admission.
    - Chronic and continuing self-destructive behavior (e.g., bulimic behaviors, substance abuse) that poses a significant and immediate threat to life, limb, or bodily function.
  - Threat to others requiring 24-hour professional observation:
    - Assaultive behavior threatening others within 72 hours prior to admission.
    - Significant verbal threat to the safety of others within 72 hours prior to admission.
  - Command hallucinations directing harm to self or others where there is risk of the patient taking action on them.
  - 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.
  - Cognitive impairment (disorientation or memory loss) due to an acute Axis I disorder that endangers the welfare of the patient or others.
  - For patients with a dementia disorder for evaluation of treatment of a psychiatric comorbidity (e.g., risk of suicide, violence, severe depression) warranting inpatient admission.
  - 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.
  - 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.
  - Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care. Reasons for failure of outpatient treatment could include:
    - Increasing severity of psychiatric symptoms;

- Noncompliance with medication regiment due to the severity of psychiatric symptoms;
- Inadequate clinical response to psychotropic medications;
- 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

- For services in an inpatient psychiatric facility 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 are for the purpose of diagnosis;
  - and
  - Supervised and evaluated by a physician.

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 would be considered when patients are no longer require 24-hour observation for safety, diagnostic evaluation, or treatment as described above. These patients would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services.

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 should be stepped down to outpatient care. Patients who are persistently unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge.

Limitations

- Failure to provide documentation to support the necessity of test(s) or treatment(s) may result in denial of claims or services. This includes medical records:
  - That don't support the reasonableness and necessity of service(s) furnished;
  - In which the documentation is illegible; or
  - Where medical necessity for inpatient psychiatric services is not appropriately certified by the physician.
  - The following do not represent reasonable and medically necessary inpatient psychiatric services and coverage is excluded:
    - Services which are primarily social, recreational or diversion activities, or custodial or respite care;
    - Services attempting to maintain psychiatric wellness for the chronically mentally ill;
    - Treatment of chronic conditions without acute exacerbation;
    - Vocational training;
    - Medical records that fail to document the required level of physician supervision and treatment planning process;
    - Electrosleep therapy;
    - Electrical Aversion Therapy for treatment of alcoholism;
    - Hemodialysis for the treatment of schizophrenia;
    - Transcendental Meditation;
    - Multiple Electroconvulsive Therapy (MECT).
- It is not reasonable and medically necessary to provide inpatient psychiatric hospital services to the following types of patients, and coverage is excluded:
  - Patients who require primarily social, custodial, recreational, or respite care;
  - Patients whose clinical acuity requires less than 24 hours of supervised care per day;
  - Patients who have met the criteria for discharge from inpatient hospitalization;
  - Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment;
  - Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode;

- 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;
- Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration.
- Coverage criteria specified in this Local Coverage Determination (L34570) shall be applied to the entire medical record to determine medical necessity.

Documentation Requirements

(CMS A56865, 2022/L33624)

- Documentation Requirements
  - 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.
  - The patient's medical record must contain documentation that fully supports the medical necessity for services included within the related LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
  - The reasons for admission must be clearly documented as stated by the patient or others significantly involved, or both.
  - Listing an ICD-10-CM code in the Mental Disorders category (F01- F99) does not assure coverage of the specific service. Upon medical review, coverage criteria specified in the related Local Coverage Determination shall be applied to the entire medical record to determine medical necessity.
  - 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 the service is specifically excluded from Medicare coverage by statute.

Inpatient Psychiatric Facility Services Certification and Recertification Requirements

- The physician's recertification should state:
  - That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
    - Treatment which could reasonably be expected to improve the patient's condition;
    - Diagnostic study;
  - 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
  - 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.
- 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).

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, the documentation in the initial psychiatric evaluation should include, whenever available, the following items:
  - Patient’s chief complaint;

- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive, outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history;
- 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 of daily living (ADLs);
- Physical examination;
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the psychiatric inpatient hospitalization services; and
- ICD-10-CM/DSM-5™ diagnoses, including all five axes of the multiaxial assessment as described in the DSM-5™.

- 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:
  - The types of psychiatric and medical therapy services and medications;
  - Laboratory and other diagnostic testing;
  - Allergies;
  - Provisional diagnosis(es); and
  - 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. Although the Plan of Treatment is a requirement, the format and specific items to be included are up to the provider. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient's stay.
  - This individualized, comprehensive, outcome-oriented plan of treatment should be developed:
    - within the first three (3) program days after admission;
    - by the physician, the multidisciplinary treatment team, the patient and;
    - should be based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
  - The treatment plan should include:
    - the specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
    - the expected outcome for each problem addressed; and
    - contain outcomes that are measurable, functional, time-framed, and directly related to the cause of the patient's admission.
  - 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.
  - 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. Each progress note should be legible, dated and signed, 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:
    - 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.

(CMS A57726, 2018/L33975)

- Documentation Requirements
    - All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
- The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
- The initial psychiatric evaluation with medical history and physical examination should be performed within 24 hours of admission in order to establish medical necessity for psychiatric inpatient hospitalization services. The documentation should include:
    - Patient's chief complaint or description of acute illness or exacerbation of chronic illness requiring admission;
    - Current and past psychiatric history (if available), including evidence of failure at or inability to benefit from a less intensive, outpatient program; prior level of function; history of substance abuse; and any suicidal ideations.
    - Current and past medical history (if available);
    - Family, vocational and social history (if available);
    - 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 of daily living (ADLs);
    - Physical examination;
    - Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the psychiatric inpatient hospitalization services; and
    - ICD-10-CM/DSM-V-TR™ diagnoses, including all five axes of the multiaxial assessment as described in the DSM-V-TR™.
- A team approach may be used in developing the initial psychiatric evaluation and the plan of treatment, but the physician (MD/DO) or non-physician practitioner 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.

- 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. Although the Plan of Treatment is a requirement, the format and specific items to be included are up to the provider. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient's stay.
  - This individualized, comprehensive, outcome-oriented plan of treatment should be developed:
    - within the first three (3) program days after admission;
    - by the physician, the multidisciplinary treatment team, and the patient; and
    - should be based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
  - The treatment plan should include:
    - the specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
    - the expected outcome for each problem addressed; and
    - contain outcomes that are measurable, functional, time-framed, and directly related to the cause of the patient's admission.
  - 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.
  - The initial treatment plan and updated plans must be signed by the physician or non-physician practitioner and those mental health professionals contributing to the treatment plan.
- 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. Each progress note should be legible, dated and signed, including 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 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 inferred from reading the physician progress notes.
- 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.

(CMS L34183, 2023)

- 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.
- The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Inpatient Psychiatric Facility Services Certification and Recertification Requirements

- The requirements for physician certification and recertification for inpatient psychiatric facility services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification

requirement. 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.

- 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 hospital's utilization review committee (on a case-by-case basis), but no less frequently than every 30 days.
- There is also a difference in the content of the certification and recertification statements. 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:
    - That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
        - Treatment which could reasonably be expected to improve the patient's condition;
        - Diagnostic study;
    - 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
    - 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.
- 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).
- **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, the documentation in the initial psychiatric evaluation should include, whenever available, the following items:
    - Patient's chief complaint;
    - Description of acute illness or exacerbation of chronic illness requiring admission;
    - Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive, outpatient program;
    - Past psychiatric and medical history;
    - History of substance abuse;
    - Family, vocational and social history;
    - 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 of daily living (ADLs);
    - Physical examination;
    - Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the psychiatric inpatient hospitalization services; and
    - ICD-10-CM/DSM-V-TR™ diagnoses, including all five axes of the multiaxial assessment as described in the DSM-V-TR™.
- 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.

Physicians Orders

- Physician orders should include, but are not limited to, the following items:
- The types of psychiatric and medical therapy services and medications;
- Laboratory and other diagnostic testing;
- Allergies;
- Provisional diagnosis(es); and
- 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. Although the Plan of Treatment is a requirement, the format and specific items to be included are up to the provider. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient's stay.
- This individualized, comprehensive, outcome-oriented plan of treatment should be developed:
  - within the first three (3) program days after admission;
  - by the physician, the multidisciplinary treatment team, and the patient; and should be
  - based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
- The treatment plan should include:
  - the specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
  - the expected outcome for each problem addressed; and
  - contain outcomes that are measurable, functional, time-framed, and directly related to the cause of the patient's admission.
- 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.
- 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. Each progress note should be legible, dated and signed, 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:
  - 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.

(CMS L34570, 2019)

- **Inpatient Psychiatric Facility Services Certification and Recertification Requirements:** There is a difference in the content of the certification and recertification statements. 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 each of the following:
  - that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
    - treatment which could reasonably be expected to improve the patient's condition; or
    - diagnostic study;
- 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
- 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.

- **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 after admission, in order to establish medical necessity for psychiatric inpatient hospitalization services. In order to support the medical necessity of admission, the documentation in the initial psychiatric evaluation should include, whenever available, the following items:
  - patient's chief complaint;
  - a description of the acute illness or exacerbation of chronic illness requiring admission;
  - current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
  - past psychiatric and medical history;
  - history of substance abuse;
  - family, vocational and social history;
  - 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 ADLs;
  - physical examination;
  - formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the psychiatric inpatient hospitalization services; and
  - diagnosis/diagnoses.
- 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:
  - the types of psychiatric and medical therapy services and medications;
  - laboratory and other diagnostic testing;
  - allergies;
  - provisional diagnosis(es); and
  - 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. Although the plan of treatment is a requirement, the format and specific items to be included are up to the provider. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient's stay.

- This individualized, comprehensive, outcome-oriented plan of treatment should be developed:
  - within the first 3 program days after admission;
  - by the physician, the multidisciplinary treatment team, and the patient; and
  - should be based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
- The treatment plan should include:
  - the specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
  - the expected outcome for each problem addressed; and
  - outcomes that are measurable, functional, time-framed, and directly related to the cause of the patient's admission.
- 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.
- The initial treatment plan and updated plans must be signed by the physician and those mental health professionals contributing to the treatment plan.

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- 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 (e.g., 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. Each progress note should be legible, dated and signed, 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.
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- Individual and Group Psychotherapy and Patient Education and Training Progress Notes:
  - 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), Created on 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.

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Revision History

Date	Summary of Changes
May 18, 2020	Annual Review
June 21, 2021	Annual Review
July 19, 2022	Annual Review
July 18, 2023	Annual Review
December 12, 2023	Interim Update: Added language to Introduction & Instructions for Use section per CMS Final Rule 2024 requirements; updated References section