



United Behavioral Health

Medicare Coverage Summary: Psychiatric Inpatient Hospitalization

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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®¹.

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.

INPATIENT PSYCHIATRIC 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

¹ Optum is a brand used by United Behavioral Health and its affiliates.

and observation, diagnostic services, and psychotherapeutic and medical interventions (Centers for Medicare and Medicaid Services, Local Coverage Determinations (CMS L33624, 33975, 34183, 34570)).

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, 34183, 34570).

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/A57072

- Kentucky
- Ohio

CMS L34570/A56614

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

If services are delivered in another state, please apply the LOCUS criteria.

Coverage Indications, Limitations and/or Medical Necessity

Indications (CMS L33624, L33975, L34183, L34570)

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.

Admission Criteria: Intensity of Service (CMS L33624, L33975, L34183, L34570)

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 (L33924, L34183, L34570).

Active Treatment (CMS 33975)

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".

Admission Criteria: Severity of Illness (CMS L33624, L33975, L34183, L34570)

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.
 - 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 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 (CMS L33624, L34183, L34570).

Discharge Criteria: Intensity of Service (CMS L33624, L33975, L34183, L34570)

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 (CMS L33624, L34183).

Discharge Criteria: Severity of Illness (CMS L33624, L33975, L34183, L34570)

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 (CMS L33624, L34183)

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:

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

2. Supervision of trainees must at least meet the state-mandated supervision requirements. Such supervision need not occur on the inpatient psychiatric unit but must be documented and documentation must be maintained in the hospital and available for inspection upon request by Medicare or submitted to Medicare when requested.

3. Routine services provided as a part of the care of psychiatric inpatients, oftentimes performed by bachelor degree level psychiatric technicians, under the direction of the nursing service, need to conform to local state licensing or certification requirements, if any.

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

Limitations (CMS L33624, L33975, L34183, L34570)

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;
 - Patients admitted by a court order or whose admission is based on protocol and do not meet admission criteria (CMS L33975).
- 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 (CMS L34183).
 - A claim may be denied 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 (CMS L34183).

Clinical Best Practices

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 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 (CMS L34183).

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 be reasonably 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
- 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 hospital personnel (CMS L33624/A56865, L34183, L34570).

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. 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/DSM diagnoses (CMS L33624/A56865, L33975/A57726, L34183, L34570).

It will not always be possible to obtain 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 (CMS L33624/A56865, L33975/A57726, L34183, L34570).

The individualized, comprehensive, outcome oriented plan of treatment should be developed:

- Within the first 3 program days after admission;
- By the physician, the multidisciplinary team, and the patient, and should be;
- Based upon the problems identified by the physician's diagnostic evaluation, psychosocial and nursing assessments (CMS L33624/A56865, L33975/A57726, L34183, L34570).

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 (CMS L33624/A56865, L33975/A57726, L34183, L34570).
- 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. Lack of progress and its relationship to active treatment and reasonable expectation of improvement should be noted (CMS L33624/A56865, L33975/A57726, L34183, L34570).
- 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 (CMS L33624/A56865, L33975/A57726, L34183, L34570).

*Progress Notes (CMS L33624/A56865, L33975/A57726, L34183, L34570)

- 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.

- 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 L33624/A56865, L34183, L34570).

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REVISION HISTORY

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