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

1 Optum is a brand used by United Behavioral Health and its affiliates.
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**
- Connecticut
- Illinois
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- Rhode Island
- Vermont
- Wisconsin

**CMS L33975**
- Florida
- Puerto Rico
- Virgin Islands

**CMS L34183**
- Kentucky
- Ohio

**CMS L34570**
- North Carolina
- South Carolina
- Virginia
- West Virginia

If services are delivered in another state, please apply the Optum Level of Care Guidelines.

**Coverage Indications, Limitations and/or Medical Necessity**

**Indications (CMS L33624, 33975, 34183, 34570)**

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, 33975, 34183, 34570)**

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 (CMS L33924, 34183, 34570).

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.

**Admission Criteria: Severity of Illness (CMS L33624, 33975, 34183, 34570)**

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 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 (CMS L34570).

**Discharge Criteria: Intensity of Service (CMS L33624, 33975, 34183, 34570)**

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, 34183).

**Discharge Criteria: Severity of Illness (CMS L33624, 33975, 34183, 34570)**

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 (CMS L33624, 33975, 34183, 34570)**

Failure to provide documentation to support the necessity of test(s) or treatment(s) may result in denial of claims or services under Sections 1862(a)(1)(A) and 1833 of Title XVIII of the Social Security Act. 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 under Title XVIII of the Social Security Act, Section 1862(a)(1)(A):
  - 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 under Title XVIII of the Social Security Act, Section 1862(a)(1)(A):
- 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 L33975, 34183).

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, 33975, 34183, 34570).

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, 33975, 34183, 34570).

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, 33975, 34183, 34570).

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, 33975, 34183, 34570).

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, 33975, 34183, 34570).
• 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, 33975, 34183, 34570).
• 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 L33975, 34570).

Progress Notes (CMS L33624, 33975, 34183, 34570)
• 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, 34183, 34570).

REFERENCES


REVISION HISTORY

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