**INTRODUCTION**

Medicare Coverage Summaries synopsize guidance provided in CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), and are used to make medical necessity determinations for Medicare behavioral health benefits managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

In the event that CMS does not provide a NCD or a LCD for a particular State, jurisdiction, condition or service, Optum’s Level of Care Guidelines should be used for medical necessity decisions along with the member’s benefit plan.

**Before using this guideline, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.**

**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, Local Coverage Determinations (CMS LCDs), 2017).

- 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 Benefit Policy Manual, Chapter 2, Section 10. Retrieved June, 2017).
APPLICABLE STATES

Medicare coverage for Psychiatric Inpatient services is only covered when delivered in the following States/jurisdictions at the time this guideline was written (CMS LCDs, 2017):

- Connecticut
- Florida
- Illinois
- Kentucky
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- North Carolina
- Ohio
- Puerto Rico
- Rhode Island
- South Carolina
- Vermont
- Virginia
- Virgin Islands
- West Virginia
- Wisconsin

There are no Psychiatric Inpatient LCDs that describe coverage or non-coverage for the following States/regions. Please apply the Optum Inpatient Level of Care Guidelines when making medical necessity decisions for members in the following States:

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Delaware
- Georgia
- Hawaii
- Idaho
- Indiana
- Iowa
- Kansas
- Louisiana
- Michigan
- Maryland
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Jersey
- New Mexico
- North Dakota
- Northern Mariana Islands
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Utah
- Texas
- Washington
- Wyoming
Psychiatric Inpatient Hospitalization Service Criteria

- Admission Criteria
  - 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 LCDs, 2017). The following active treatment, intensity of service and severity of illness criteria must be met:

- Active Treatment
  - Services provided in the hospital must be “active” as outlined in the CMS Benefit Policy Manual, Chapter 2, Section 30.2.2 (Retrieved March, 2017). To be designated as “active” services must be:
    - Provided under an individualized treatment or diagnostic plan;
    - Reasonably expected to improve the patient’s condition or the purpose of diagnosis; and
    - Supervised and evaluated by a physician.

- Intensity of Service
  - The patient must require intensive, comprehensive, multimodal treatment including 24 hours per day of medical supervision and coordination due to the patient’s DSM diagnosis.
    - The need for 24 hours of supervision may be due to the need for patient safety, psychiatric diagnostic evaluation, potential severe side effects or 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 (CMS LCDs, 2017).
    - The acute psychiatric condition being evaluated or treated by an inpatient unit must require active treatment, including a combination of services such as intensive nursing and medical intervention and psychotherapy. The patient must require services exceeding what may be rendered in an outpatient setting, including partial hospitalization (CMS LCDs, 2017).

- Severity of Illness
  - In addition to the intensity of service, at least one of the following severity of illness criteria must be met (CMS LCDs, 2017):
    - Threat to self, requiring 24-hour professional observation.
      - Suicidal ideation or gesture within 72 hours prior to admission; or
      - Self-mutilation (actual or threatened) within 72 hours prior to admission; or
      - 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; or
      - 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 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 psychiatric disorder that endangers the welfare of the patient or others.
    - For patients with a dementing disorders 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.

- Continued Stay Criteria
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 patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel (CMS Publication, Medicare General Information, Eligibility, and Entitlement, 100-01, Chapter 4, Section 10.9).

Discharge Criteria

- Patients that meet the discharge criteria for intensity and severity of illness would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services (CMS LCDs, 2017).
- Patients in inpatient care may be discharged by stepping down to a less intensive level of outpatient care. Stepping down to a less intensive level of service than inpatient hospitalization could be considered when patients no longer require 24-hour observation for safety, diagnostic evaluation or treatment as described in the admission criteria.
- Patients whose clinical condition improves or stabilizes, who no longer pose an impending threat to self or others, and who do not still require 24-hour observation available in an inpatient psychiatric unit would be appropriate for a lower level of care in an outpatient setting. Patients whom are persistently unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge.
- If 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.
- When the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

Clinical Best Practices

Evaluation

- The initial psychiatric evaluation with medical history and physical examination should be performed within 24 hours of admission, but in no case later than 60 hours of admission in order to establish medical necessity for psychiatric inpatient hospitalization services.
- In order to support the medical necessity of admission, documentation in the initial psychiatric evaluation must include:
  - A medical history;
  - Past medical history
  - Current medical history including medications
  - A record of mental status;
  - Current medications
  - Evidence of failure at or inability to benefit from outpatient treatment (lower level of care)
  - Past psychiatric history
  - History of substance abuse
  - Family, vocation, social history
  - The onset of illness and the circumstances leading to admission;
  - Description of illness or exacerbation of chronic illness
  - A Description of attitudes and behavior;
    - General appearance and behavior, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self-harm and harm to others, insight, judgment, capacity for activities or activities of daily living (ADL's)
  - Estimate intellectual functioning, memory functioning, and orientation; and
  - An inventory of the patient's assets in descriptive, not interpretative fashion (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.2)
  - A physical examination and other necessary diagnostic evaluations should be completed to the extent possible and as indicated by the patient's clinical presentation to rule out medical/neurological causes of psychiatric symptomatology. Several conditions should be treated in a medical setting as opposed to a psychiatric setting. Examples include: potentially life-threatening drug overdose, anticholinergic delirium, and neuroleptic malignant syndrome, among many others.
A team approach may be used in developing the initial psychiatric evaluation and the plan of treatment (see “Plan of Treatment” section below), but the physician (MD/DO) must personally document the mental status examination, physical examination, diagnosis, and certification. It will not always be possible to obtain all the suggested information at the time of evaluation. In such cases, the limited information that is obtained and documented must still be sufficient to support the need for an inpatient level of care.

Physician orders should include:
- 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).

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 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 Plan of Treatment is the tool used by the physician and multi-disciplinary treatment team to implement the physician-ordered services and move the patient toward the expected outcomes and goals. The Plan of Treatment is a requirement.
- 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.
- 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
  - Based upon the problems identified in the physician’s diagnostic evaluation, psychosocial and nursing assessments.
- The plan of treatment 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 discharge plan must include recommendations for appropriate services concerning follow-up or aftercare as well as a brief summary of the patient’s condition upon discharge.
- It is expected as a matter of good quality of care that careful discharge planning occur to enable a successful transition to outpatient care.
REFERENCES

HISTORY/REVISION INFORMATION

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