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.

PSYCHIATRIC PARTIAL HOSPITALIZATION

1 Optum is a brand used by United Behavioral Health and its affiliates.
Psychiatric partial hospitalization is a distinct and organized intensive psychiatric outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in order to avoid inpatient care through this type of ambulatory care. The Medicare psychiatric partial hospitalization benefit was established and is intended to furnish services in lieu of inpatient psychiatric care. Partial Hospitalization requires admission and certification of need by a psychiatrist or physician (MD/DO) trained in the diagnosis and treatment of psychiatric illness. Partial hospitalization programs (PHPs) differ from inpatient hospitalization in the lack of 24-hour observation, and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient’s involvement (CMS L33626 L34196).

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Program providing primarily social, recreational, or diversionary activities are not considered partial hospitalization (CMS L33972).

### APPLICABLE STATES

**CMS L33626**
- Connecticut
- Illinois
- Maine
- Massachusetts
- Minnesota
- New Hampshire
- New York
- Rhode Island
- Vermont
- Wisconsin

**CMS L33972**
- Florida
- Puerto Rico
- Virgin Islands

**CMS L34196**
- Kentucky
- Ohio

If services are delivered in another state, please apply the Optum Level of Care Guidelines.
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY

Indications (CMS L33626, L34196)

Patients admitted to a PHP must be under the care of a physician who is knowledgeable about the patient and certifies the need for partial hospitalization. The patient or legal guardian must provide written informed consent for partial hospitalization treatment. The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction must be of an acute nature and not a chronic circumstance.

Patients eligible for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would require inpatient hospitalization. There must be reasonable expectation of improvement in the patient’s disorder and level of functioning as a result of active treatment. Active treatment directly addresses the presenting problems requiring admission to the PHP. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psycho-educational groups pertinent to the patient’s illness. Medical and psychiatric diagnostic evaluation and medication management are also integral to active treatment. The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program. If a substance abuse disorder is also present, the program must be prepared to appropriately treat the co-morbid substance abuse disorder (dual diagnosis patients). A program primarily comprised of activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare.

Indications (CMS L33972)

PHPs work best as part of community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patient served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified Community Mental Health Center (CMHC).

Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

A program primarily comprised of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients, whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

The following are facilities eligible for reimbursement for partial hospitalization services and the associated physician supervision requirements of each:

- Outpatient hospital - Partial hospitalization services rendered within a hospital outpatient department are considered “incident to” a physician’s (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP offsite, the services must be rendered under the direct personal supervision of a physician (MD/DO) [or non-physician practitioner]. Direct supervision means that the physician [or non-physician practitioner] must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.
Community mental health center (CMHC) - The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Social Security Act. Health Care Finance Administration definition of a CMHC is based on Section 1916 (c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in Section 1861(ff) of the Act.

The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a PHP, as a patient under the influence would not be capable of actively participating in his/her psychiatric treatment program. A physician must provide supervision and evaluation of the patient’s treatment and the extent to which the therapeutic goals are being met.

Admission Criteria: Intensity of Services (CMS L33626, L34196)
In general patients should be treated in the least intensive and restrictive setting which meets the needs of their illness. Patients admitted to a PHP do not require the 24-hour-per-day level of care provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the PHP and must not be a danger to themselves or others.

At the same time a PHP level of care must be necessary to prevent inpatient hospitalization, and there must be evidence of failure at or inability to benefit from a less intensive outpatient program.

The acute psychiatric condition being treated by a PHP must require active treatment, including a combination of services such as intensive nursing and medical intervention, psychotherapy, occupational and activity therapy. Patient must require PHP services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.

Admission Criteria: Severity of Illness (CMS L33626, L34196)
Patients admitted to a PHP generally must have an acute onset or decompensation of covered mental disorder, as defined by the DSM which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary structured program, but not so severe that patients are incapable of participating in and benefiting from an active treatment program, and able to be maintained outside the program. For patients who do not meet this degree of severity of illness, and for whom PHP services are not necessary, professional services may be medically necessary, even though partial hospitalization services are not.

Patient admitted for treatment to a PHP will not be in immediate/imminent danger to self, others, or property, but there may be a recent history of self-mutilation, serious risk taking, or other self-endangering behavior.

Reasonable and Necessary Services (CMS L33972)
These programs of services provides for the diagnosis and active, intensive treatment of the individual’s serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual’s condition and functional level and prevent relapse and hospitalization. A particular individual covered service as intervention, expected to maintain or improve the individual’s condition and prevent relapse, may also be included within the plan of care, but the overall intent of the patient program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.
Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the PHP and must not be an imminent danger to themselves or others. Patients admitted to a PHP generally have an acute onset or decompensation of a covered condition as defined by the current edition of the DSM which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient’s presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for who partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services may be medically necessary, even though partial hospitalization services are not.

The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder which severely interferes with multiple areas of daily life including social, vocational, and/or educational functioning. Such dysfunction must be an acute illness or exacerbation of a chronic illness (acute in nature).

Patients with a diagnosis of psychosis must be aggressively treated with psycho-pharmacological agents to reduce symptoms that may impede benefit from the services provided by a PHP. Partial stabilization allowing the patient to participate in insight-oriented therapy should be clearly documented. For example, a patient may interact in a one to one session rather than in a group therapy setting initially. It would be expected patient progression would be toward the group settings.

**Frequency and Duration of Services (L33972)**

There are no specific limits on length of time that services may be covered. There are many factors that affect the outcomes of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria to determine whether with continued treatment there is a reasonable expectation of improvement.

When participation in a therapeutic program produces no further functional improvement or movement toward the initial or revised goals documented in the treatment plan, the patient is deemed to have reached maximal improvement at which point further participation in the program is no longer subject to coverage.

Patients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient’s clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

**Discharge Criteria: Intensity of Services (CMS L33626, L34196)**

Patients in PHPs may be discharged by either stepping up to an inpatient level of care, or stepping down to a less intensive level of outpatient care. Inpatient admission would be required for patients need 24hour supervision because of probability for self-harm, harm to others, or inability to care for self outside the hospital. Stepping down to a less intensive level of service that partial hospitalization would be considered when patients no longer require a multidisciplinary and multimodal program as described above. These patients would become outpatients and individual mental health services could then be billed by appropriate providers. PHPs must have program availability of at least 20 hours per week. Patients admitted to a PHP must require a minimum of 20 hours per week of therapeutic services as evidenced by their plan of care. Although there may be occasions of unavoidable absences to a day of PHP participation, patient participation in the program four days per week, with a total of 20 hours per week of program services as specific in the plan of care, is the minimum level of active treatment at which it would be reasonable and necessary for a patient to participate in a PHP. Absences from the PHP and their cause must be documented in the medical record.
**Discharge Criteria: Severity of Illness (CMS L33626, L34196)**

Patients who clinical condition improves or stabilizes and who cannot benefit from or do not still require the intensive, multimodal treatment available in a PHP should be stepped down to outpatient care. Patients unwilling or unable to participate in a PHP would also be appropriate for discharge.

**Limitations (CMS L33626, L34196)**

The following do not represent reasonable and necessary partial hospitalization services and coverage is excluded under Section 1862(a)(1)(A) of the Social Security Act:

- Day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, e.g., day care programs for the chronically mentally ill;
- Treatment of chronic conditions without acute exacerbation;
- Services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
- Vocational training.

The following are excluded from the scope of partial hospitalization services as defined in Section 1861(ff) of the Social Security Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation;
- Professional physician services, physician assistant services, and clinical psychologist services.

It is not reasonable and necessary to provide partial hospitalization services to the following types of patients and coverage is excluded under Section 1862(a)(1)(A) of the Social Security Act:

- Patients who cannot or refuse to participate (due to their behavioral, cognitive, or emotional status, e.g., individuals with persistent substance abuse, moderate to severe mental retardation, or organic brain syndrome) with active treatment of their mental disorder, or who cannot tolerate the intensity of a PHP;
- Patients who require 24-hour supervision because of the severity of their mental disorder or their safety or security risk;
- Patients who require primarily social, custodial, recreational, or respite care;
- Patients with multiple absences or who are persistently non-compliant;
- Patients who not participate in active treatment for a minimum of 3 hours per day, 4 days per week;
- Patients whose plan of care does not support the need for active treatment for a minimum of four days per week, with a total of 20 hours per week of program services;
- Patients who have met the criteria for discharge from the PHP, or who require inpatient hospitalization.

**Reasons for Denial (CMS L33972)**

Examples of benefit category denials based in Sections 1861(ff), 1835(a)(2)(F) of the Social Security Act, for partial hospitalization services generally include the following:

- Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, where there is no risk or relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or
- Patients who are otherwise psychiatrically stable or require medication management only.
The following services are excluded from the scope of partial hospitalization services defined in 1861(ff) of the Social Security Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation; and
- Vocational training.

The following examples represent reasonable and necessary denials for partial hospitalization services, and coverage is excluded under 1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or
- Treatment of chronic conditions without acute exacerbation or symptoms that place the individual at risk of relapse or hospitalization.

**CLINICAL BEST PRACTICES**

Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require psychiatric inpatient hospitalization if the partial hospitalization services were not provided and must include an attestation that the services are furnished while the individual is under the care of a physician, and that the services are furnished under an individualized written plan of care (CMS L33626, L34196).

Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric needs for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization (CMS L33972).

A physical examination upon admission (if not done within the past 30 days and/or not available from another provider) must be included in the medical record (CMS L33972).

An initial psychiatric evaluation with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalization services. If the patient is being discharged from an inpatient psychiatric admission to a PHP, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable (CMS L33626, L34196).

In order to support the medical necessity of admission to the PHP, the documentation in the initial psychiatric evaluation should include 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 including documentation of an adequate support system to sustain/maintain the patient outside the PHP;
- 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 (if not done within the past 30 days and available for inclusion in the medical record);
• 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 PHP;

• ICD/DSM diagnosis;

• The treatment plan, including long and short-term goals related to active treatment of the reason for admission and types, amount, duration, and frequency of therapy services, including activity therapy, required to address the goals (CMS L33626, L34196).

Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient’s response to treatment (CMS L33626, L34196).

Treatment goals should be designed to measure the patient’s response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of active therapy to maintain the individual’s condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services (CMS L33972).

An individualized formal treatment plan must be signed and dated by a physician and established within 7 days of admission to the program, and must include the following:

• 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 active treatment provided by the PHP; and

• Documentation listing treatment goals under the individualized plan, modalities or therapy and/or services rendered including amount, frequency and planned duration (CMS L33972).

The frequency of treatment plan updates is always contingent upon an individual patient’s needs. The treatment planning updates must be based on the physician’s periodic consultation with therapists and staff, review of medical records, and patient interviews. A treatment plan review or “team” conference should take place a minimum of every 2 weeks to review and update the treatment plan, medication changes, and patient’s response to treatment modalities (CMS L33972).

The treatment plan should be reviewed according to the changing needs of the patient’s acute psychiatric illness, but never less than every 31 days. The treatment plan should be reviewed more frequently if the severity of the clinical condition or changes in the clinical condition of the patient (e.g., change of medication) make it reasonable to do so. The long and short-term goals described in the treatment plan are the basis for evaluating the patient’s response to treatment. Treatment goals should be designed to measure the response to treatment, for this relationship will be used in determining whether services are medically necessary. The treatment goals should be measurable, functional, time-framed, and directly related to the reason for admission. The treatment plan must include the specific treatments ordered, including reference to psychotropic medication management, the expected timeframes and outcomes for each treatment, and the discharge plan (CMS L34196).

Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial (CMS L33972).
It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Patient progress may be small or not be measurable at each session, however a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity. Code 90821-Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient; should only be used in exceptional instances. Additional documentation must be maintained in the patient’s record to show medical necessity for this length of therapy in the acute setting. Code 90849 (multiple family psychotherapy) is generally non-covered. Such group therapy is directed to the effect of the patient’s condition on the family and does not meet standards of being part of the personal service to the patient. (CMS L33972).

The first physician recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days. The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

- The patient’s response to the therapeutic interventions provided by the PHP;
- The patient’s psychiatric symptoms that continue to place the patient at risk of hospitalization; and
- Treatment goals for coordination of services to facilitate discharge for the PHP (CMS L33626, L33972, L34196).

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria to determine whether with continued treatment there is a reasonable expectation of improvement (CMS L33972).

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient’s return to a higher level of functioning in the least restrictive environment (CMS L33972).

REFERENCES


HISTORY/REVISION INFORMATION

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