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 PARTIAL HOSPITALIZATION

The following describes Medicare covered psychiatric partial hospitalization according to existing Local Coverage Determinations (LCDs).

- Psychiatric Partial Hospitalization is a distinct and organized intensive psychiatric treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions in an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting (CMS Benefit Policy Manual, Chapter 6, Section 70.3, Retrieved, April, 2017).

APPLICABLE STATES

Psychiatric Partial Hospitalization

- Psychiatric Partial Hospitalization coverage is only applicable when delivered in the following States/jurisdictions at the time this guideline was written (CMS Psychiatric Partial Hospitalization Local Coverage Determinations, 2017):
There are currently no NCDs or LCDs for Psychiatric PHP that describe coverage or non-coverage for the following States/regions. Please apply the Optum Level of Care Guidelines when making medical necessity decisions for members in these States/regions:

- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Delaware
- Hawaii
- Idaho
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maryland
- Michigan
- Mississippi
- Missouri
- Montana
- Nebraska
- New Mexico
- Nevada
- North Carolina
- North Dakota
- Ohio
- Oregon
- Oklahoma
- Pennsylvania
- South Carolina
- South Dakota
- Texas
- Utah
- Virginia
- Washington
- West Virginia
- Wyoming
- Wyoming

**Benefits**

Benefits include the following services:
- Diagnostic evaluation and assessment
Treatment planning
Referral services
Medication management
Psychotherapy
Crisis intervention

Behavioral Health care services or supplies are provided when needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine (Medicare.gov, Glossary, 2015)

**Limitations and Exclusions**

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's Evidence of Coverage/Summary of Benefits. When the requested service or procedure is limited or excluded from the enrollee’s EOC, or is otherwise defined differently, it is the terms of the enrollee’s EOC/SB that prevails.

**Additional Information**

The lack of a specific exclusion for coverage for a service does not imply that the service is covered.

No payment can be made for certain items and services, when the following conditions exist Chapter 16, Section 10, 20 & 110, Retrieved April, 2017):

- Not reasonable and necessary: Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve functioning are not covered.
- Custodial care: Personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the intermediary or carrier considers the level of care and medical supervision required and furnished. It does not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.
- Excluded Investigational Devices or Procedures: These items and procedures include any procedure, study, test, drug, equipment or facility still undergoing study and which is generally not accepted as standard therapy in the medical community where alternative therapy exists.

The following are examples of services that are limited or excluded. Please note these exclusions may vary by State/region as indicated. The following list may not be all-inclusive:

- PHP programs that provide primarily social, recreational, or diversionary activities, custodial or respite care.
- PHP programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization (e.g., programs for the chronically mentally ill).
- PHP for patients who are otherwise psychiatrically stable or require medication management only.
- PHP services to patients in an inpatient setting.
- Meals, transportation, and vocational training.
- PHP for patients who require 24-hour supervision because of the severity of their mental disorder or their safety or security risk.
- PHP for patients with multiple absences or who are persistently non-compliant.
- PHP for 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.
- PHP for patients who have met the criteria for discharge from the PHP program, or who require inpatient hospitalization.
- CPT codes 90875 and 90876 – Biofeedback (LCD L34309).
- CPT code 90849 – multiple family group therapy (LCD L33972).
Psychiatric Partial Hospitalization Criteria

- Active PHP treatment must be delivered to directly address the presenting problems precipitating admission. Active treatment consists of clinically recognized therapeutic interventions including individual, group and family psychotherapies pertinent to the patient’s illness. Medical and psychiatric diagnostic evaluation and medication management are also integral to active treatment. If a substance abuse disorder is also present, the program must be prepared to appropriately treat the co-morbid substance abuse disorder (CMS Benefit Policy Manual, Chapter 6, Section 70.3).

Admission Criteria

One of the following criteria must be met (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS PHP LCDs, 2017):

- The patient is being discharged from an inpatient hospital setting and PHP services are to be provided in lieu of continued inpatient treatment; or
- In the absence of PHP, the patient would be at reasonable risk of requiring inpatient hospitalization

AND

All of the following criteria must be met (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS PHP LCDs, 2017):

- The patient is under the care of a physician who certifies the need for the intensive, structured combination of active treatment services provided by a PHP.
- The patient does not require 24-hour per day level of care provided in an inpatient setting.
- The patient has an adequate support system to sustain/maintain him/herself outside of the PHP.
- The patient is not in imminent danger to him/herself or others, although there may be recent history of self-mutilation, serious risk taking, or other self-endangering behavior.
- In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness. In order to be admitted to a PHP program there must be evidence of an inability to benefit from a less intensive outpatient program.
- The patient requires a minimum of 20 hours per week of active treatment, as evidenced by an acute onset or decompensation of a mental disorder which severely and acutely interferes with multiple areas of daily life including social, vocational, and/or educational functioning.
- There is a reasonable expectation of improvement of the patient’s condition and level of functioning as a result of active PHP treatment.
- The patient is able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of services provided by the PHP program.
- The degree of functional impairment is severe enough to require a multidisciplinary intensive, structured program, but not so limiting that the patient cannot benefit from participating in an active treatment program.
- The patient requires PHP services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses (CMS LCD L34196, 2017).
- The patient’s Global Assessment of Function is below 40 according to the DSM-IV-TR (CMS LCD L34196, 2017).

Continued Stay Criteria

All of the following criteria must be met (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017):

- The patient continues to meet admission criteria, active treatment is being delivered, and an individualized treatment plan directly addresses the reasons PHP services are being provided.
- There is a continuing seriousness of the patient’s psychiatric condition requiring continued active treatment in PHP that will likely result in relapse or hospitalization if PHP services are not provided.
- There is a continued reasonable expectation that the patient will make timely and significant practical improvement of the presenting acute symptoms as a result of PHP services.
- The member continues to require PHP treatment 20 hours per week, the minimum level of active treatment at this level of care.
- The provider is able to provide information as to:
  - The patient’s response to therapeutic interventions provided by the PHP;
  - The patients psychiatric symptoms that continue to place the patient at risk for hospitalization; and
  - Treatment goals for coordination of services to facilitate discharge from the PHP.
- Although progress may be small or not measurable at each session, there should be a trend of measurable improvement related to behavior, thought process and medication management (CMS LCD L34196, 2017).

Discharge Criteria

The patient may be discharged from PHP by either stepping up to an inpatient level of care, or stepping down to a less intensive level of outpatient care in the following situations (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017):

- Services are medically necessary

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• Patients are discharged to a higher level of care with there is a need for 24-hour supervision due to the probability of self-harm, harm to others, or inability to care for oneself outside of the hospital.

• Patients are discharged to a lower level of care when:
  o The patient’s clinical condition improves or stabilizes and does not continue to require the intensive, multimodal treatment available in a PHP.
  o The patient’s Global Assessment of Function is above 45 according to the DSM-IV-TR (CMS LCD L34196, 2017).

• In some cases, discharge is indicated when the patient refuses to participate in active treatment, or cannot tolerate the intensity of PHP.

Clinical Best Practices

Evaluation and Treatment Planning

• The initial psychiatric evaluation certified by a physician indicates that the patient would require inpatient psychiatric hospitalization if PHP services were not provided (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017).

• The evaluation should document the following (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017):
  o Description of acute illness or exacerbation of chronic illness requiring admission;
  o Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
  o Past psychiatric and medical history;
  o History of substance use;
  o Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside of the PHP;
  o 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 and capacity for activities of daily living;
  o Physical examination (if not done within the past 30 days and available for inclusion in the medical record);
  o Formulation of the patient’s status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement of the presenting acute symptoms as a result of PHP services;
  o The diagnosis and psychiatric need for PHP.

Treatment Plan

• PHP services must be furnished under an individualized written plan of care, established by the physician, which includes 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 Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017).

• Partial Hospitalization provides active treatment that incorporates an individualized treatment plan with coordinated services wrapped around the particular needs of the patient. PHP treatment includes a multidisciplinary team approach to patient care under the direction of a physician with a high degree of structure and scheduling. The treatment goals are measurable, functional, time-framed, medically necessary, and directly related to the reason for admission (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017).

• The treatment plan should describe (CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017):
  o How the plan will directly address the patient’s presenting symptoms and should be the basis for evaluating the patient’s clinical response.
  o Coordination of services
  o That the program is structured to meet the patient’s treatment needs.
  o The multidisciplinary team approach to patient care.
  o Efforts made to restore the patient to a higher level of functioning, prevent relapse and hospitalization, and enable discharge.
  o Modalities of therapy and/or services rendered including the amount, frequency and planned duration.

• The treatment plan updates are contingent upon an individual patient’s needs and must be based on the physician’s consultation with therapists, staff, review of medical records and patient interviews(CMS Benefit Policy Manual, Chapter 6, Section 70.3; CMS LCDs, 2017).

• A treatment team review of the plan should take place a minimum of every 2 weeks to review and update the treatment plan, medication changes, and the patient’s response to treatment modalities (CMS LCD L33972, 2017).

Discharge Planning
• Factors affecting length of treatment include the nature of the illness, prior history, the goals of treatment, and the patient’s response (CMS LCD L33972; 2017).
• 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 LCD L33972 2017).
• When participation produces no further improvement or movement towards the initial or revised documented goals, the patient is deemed to have reached maximal improvement at which point further participation in the program is no longer subject to coverage (CMS LCD L33972 2017).

REFERENCES


HISTORY/REVISION INFORMATION

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a The term “medically necessary” refers to health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.