Local Coverage Determination (LCD): Psychiatric Inpatient Hospitalization (L33975)

Contractor Information

<table>
<thead>
<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09101 - MAC B</td>
<td>J - N</td>
<td>Florida</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09201 - MAC B</td>
<td>J - N</td>
<td>Puerto Rico</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Virgin Islands</td>
</tr>
</tbody>
</table>

LCD Information

Document Information

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>Original Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33975</td>
<td>For services performed on or after 10/01/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Original ICD-9 LCD ID</th>
<th>Revision Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L28950</td>
<td>For services performed on or after 08/15/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LCD Title</th>
<th>Revision Ending Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospitalization</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed LCD in Comment Period</th>
<th>Retirement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source Proposed LCD</th>
<th>Notice Period Start Date</th>
<th>Notice Period End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CPT only copyright 2002-2018 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The Code on Dental Procedures and Nomenclature (Code) is published in Current Dental Terminology (CDT). Copyright © American Dental Association. All rights reserved. CDT and CDT-2016 are trademarks of the American Dental Association.
Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Inpatient psychiatric hospitalization provides twenty four (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 physician (MD/DO) supervision, twenty-four (24) hour nursing/treatment team evaluation and observation, diagnostic services, and psychotherapeutic and medical interventions.

Patients admitted to inpatient psychiatric hospitalization must be under the care of a physician. The physician must certify/recertify (see “Documentation Requirements” section) 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):

The patient must require intensive, comprehensive, multifaceted 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.

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.

The following parameters are intended to describe the severity of illness and intensity of service that characterize a patient appropriate for inpatient psychiatric hospitalization. These criteria do not represent an all-inclusive list and are intended as guidelines.

Admission Criteria (Severity of Illness):
Examples of inpatient admission criteria include (but are not limited to):

- Threat to self requiring 24-hour professional observation (i.e., 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/or immediate threat to life, limb, or bodily function).

- Threat to others requiring 24-hour professional observation (i.e., 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 the risk of the patient taking action on them.

- Acute disorder/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.

- A patient with a dementia disorder 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 may include increasing severity of psychiatric condition or symptom, noncompliance with medication regimen due to the severity of psychiatric symptoms, inadequate clinical response to psychotropic medications or severity of psychiatric symptoms that an outpatient psychiatric treatment program is not appropriate.

Active Treatment:

The italicized text in this portion of the policy is quoted verbatim from CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Sections 20, 20.1, 20.1.1, 20.1.2, and 30:

For services in a hospital 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. Refer to 42 CFR 482.61 on “Conditions of Participation for Hospitals” for a full description of what constitutes active treatment (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 20).

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” (CMS Publication 100-02, Medicare Benefit
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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 20.1.2).

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 adjacentive 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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 20.1.2).

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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 20.1.2).

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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30).

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" (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.1).

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 (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.1).

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." (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 2, Section 30.1).

Discharge Criteria (Intensity of Service):
Patients in inpatient psychiatric care may be discharged to a less intensive level of outpatient care. A less intensive level of service would be considered when patients 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.

**Discharge Criteria (Severity of Illness):**

Patients whose clinical condition improves or stabilizes, who no longer pose an impending threat to self or others, and who do not require 24-hour observation available in an inpatient psychiatric unit should be discharged to outpatient care. In addition, patients who are persistently unwilling or unable to participate in active treatment of their psychiatric condition, would also be appropriate for discharge.

The following services 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 or the ability to improve functioning;
- Vocational training;
- Medical records that fail to document the required level of physician supervision and treatment planning process;
- Electrosleep therapy (CMS Publication 100-03, Chapter 1, Section 30.4);
- Electrical Aversion Therapy for treatment of alcoholism (CMS Publication 100-03, Chapter 1, Section 130.4);
- Hemodialysis for the treatment of schizophrenia (CMS Publication 100-03, Chapter 1, Section 130.8);
- Transcendental Meditation (CMS Publication 100-03, Chapter 1, Section 30.5);
- Multiple Electroconvulsive Therapy (MECT) (CMS Publication 100-03, Chapter 1, Section 160.25).

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 twenty-four (24) hours of supervised care per day;
- Patients who have met the criteria for discharge from inpatient hospitalization (i.e., patients waiting for placement in another facility);
- 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. The treatable psychiatric symptoms/problem(s) must exceed any medical problems for the patient to be placed in an inpatient psychiatric unit;
- 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. (CMS Publication 100-03, Chapter 1, Section 130.1 and 130.6, respectively);
- Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration (i.e., court ordered admission not meeting medical necessity criteria);
- Patients admitted by a court order or whose admission is based on protocol and do not meet admission criteria (i.e., admissions based on hospital, legal, local, or state protocols do not preclude
Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x Hospital Inpatient (Including Medicare Part A)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

011X Room & Board - Private (One Bed) - General Classification
012X Room & Board - Semi-private Two Beds – General Classification
015X Room & Board - Ward - General Classification
090X Behavioral Health Treatment/Services – General Classification
0911 Behavioral Health Treatment/Services - Rehabilitation
0912 Behavioral Health Treatment/Services - Partial Hospitalization - Less Intensive
0913 Behavioral Health Treatment/Services - Partial Hospitalization - Intensive
0914 Behavioral Health Treatment/Services - Individual Therapy
0915 Behavioral Health Treatment/Services - Group Therapy
0916 Behavioral Health Treatment/Services - Family Therapy
0917 Behavioral Health Treatment/Services - Bio Feedback
0918 Behavioral Health Treatment/Services - Testing
0919 Behavioral Health Treatment/Services - Other Behavioral Health Treatments

CPT/HCPCS Codes

Group 1 Paragraph:
N/A

Group 1 Codes:

<table>
<thead>
<tr>
<th>Group 1 Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000 Not Applicable</td>
</tr>
</tbody>
</table>

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:
N/A

Group 1 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information
N/A
General Information

Associated Information

Documentation Requirements

General Documentation Requirements

Documentation that supports medical necessity and active treatment may take many forms. Documentation requirements are intended to help providers identify the documentation elements that will best support the medical necessity of the services rendered. It is not expected that all items in the documentation requirements will appear in every record. Upon medical review, the IPF record will be reviewed as a whole, and services may be denied only if there is insufficient documentation to support the medical necessity of the claim.

Medical record documentation should be legible, and meet the criteria contained in this policy. For the purposes of compliance with this policy, the patient's medical records may be maintained in hardcopy, electronic copy, or microfiche. Medical records must be made available, as hard copies, upon request. The diagnoses listed on the claim must be supported in the medical record documentation.

Certification/Recertification - General Requirements

Payments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the inpatient stay. Appropriate supporting material may be required. The physician certification or recertification statement must be based on a current evaluation of the patient's condition (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10).

For patients admitted to a general hospital, regardless of whether the patients are under PPS, a physician certification is not required at the time of admission for patient services. For services continued over a period of time or for a day outlier case... a physician must certify or recertify the continued need for the services at specified intervals (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10). (See also CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9.)

If a hospital fails to obtain the required certification and recertification statements in an individual case, program payments may not be made in that case (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.1).

If the hospital’s failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he/she objects in principle to the concept of certification and recertification), the hospital may not bill the program or the beneficiary for covered items or services. The provider agreement precludes the hospital from charging the patient for covered items and services (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.1).

A certification or recertification statement must be signed by the attending physician responsible for the case or by another physician who has knowledge of the case and is authorized to do so by the attending physician, or by a member of the hospital's medical staff who has knowledge of the case (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.2).

Ordinarily for purposes of certification and recertification, a “physician” must meet the definition in Chapter 5, Section 70 and 70.3 (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.2).

A certification and recertification statement must contain the following information:

- An adequate written record of the reason for either:
  - Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study; or
  - Special or unusual services for cost outlier cases for hospitals under PPS,
- The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases,
the period of time for which the special or unusual services will be required; and

- Any plans for posthospital care (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.4).

The individual hospital determines the method by which certifications and recertifications are to be obtained and the format of the statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.5).

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary to determine that the certification and recertification requirements are, in fact, met. The certification or recertification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate form could be used. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.5).

**Certification/Recertification - Inpatient Psychiatric Certification/Recertification**

The requirements for physician certification and recertification for inpatient psychiatric facility services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification requirement. In accordance with 42 CFR 424.14, all IPFs (distinct part units of acute care hospitals, CAH's, and psychiatric hospitals) are required to meet the following certification and recertification requirements. 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 a knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. The first recertification is required as of the 12th day of 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 Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

There is also a difference in the content of the certification and recertification. In certification the physician is required to document 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 (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

The physician recertification should satisfy all of the requirements noted below: (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either: (a) treatment which could reasonably be expected to improve the patient's condition; or, (b) diagnostic study; (2) 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 (3) Effective July 1, 2006, physicians will also be required to recertify that 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 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required. The provider may adopt any method that permits verification of all the IPFs requirements to continue treatment. For example, the recertification may be entered on provider generated forms, in progress notes, or in the records (relating to the stay in question) and must be signed by a physician. (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

Claim denials may not be made for failure to use a certification or recertification form or failure to use particular language or format, provided that the medical record demonstrates that the content requirements given at Pub. 100-02, Medicare Benefit Policy Manual, Chapter 2, §30.2.1 are met. (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

For convenience, the period covered by the physician's certification and recertification is referred to [as] a period during which the patient was receiving active treatment. If the patient remains in the hospital but 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 even though the patient has not yet exhausted his/her benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment"
thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

If an individual is admitted to a hospital (including a psychiatric hospital) before he/she is entitled to hospital insurance benefits (for example, before attainment of age 65), no certification is required as of the date of admission or entitlement. Certifications and recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he/she became entitled. (The time limits for certification and recertification are computed from the date of entitlement instead of the date of admission.) (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 20.2).

**Delayed/Lapsed Certification/Recertification**

IPFs are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications will be honored where, for instance, there have been an oversight or lapse, and a legitimate reason for the delay as noted in Pub. 100-01, §20.1. Denial of payment for lack of the required certification and recertification is considered a technical denial, which means a statutory requirement has not been met. Consequently, if an appropriate certification is later produced, the denial shall be overturned. Reopenings of technical denial decisions may be initiated by the contractor or the provider.

In addition to compliance with the appropriate certification and recertification content requirements, delayed certification and recertification must include an explanation for the delay and any medical or other evidence which the IPF considers relevant for purposes of explaining the delay. The IPF will determine the format of the delayed certifications and recertifications, and the method by which they are obtained. A delayed certification may be included with one or more recertifications on a single signed document. Separate signed documents for each delayed certification and recertification are not required as they would be if timely certification and recertification had been completed. For all IPF services, a delayed certification may not extend past discharge. IPF certification or recertification documentation may only be signed by a physician.

**Initial psychiatric evaluation**

The initial psychiatric evaluation with medical history and physical examination should be performed within 24 hours of admission in order to establish medical necessity for psychiatric inpatient hospitalization services. The documentation should include:

- Patient’s chief complaint or description of acute illness or exacerbation of chronic illness requiring admission;

- Current and past psychiatric history (if available), including evidence of failure at or inability to benefit from a less intensive, outpatient program; prior level of function; history of substance abuse; and any suicidal ideations.

- Current and past medical history (if available);

- Family, vocational and social history (if available);

- 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-10-CM/DSM-IV-TR™ diagnoses, including all five axes of the multiaxial assessment as described in the DSM-IV-TR™.

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) or non-physician practitioner 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.
Plan of Treatment:

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. Although the Plan of Treatment is a requirement, the format and specific items to be included are up to the provider. Documentation of the parameters below is suggested to support the medical necessity for the inpatient services throughout the patient’s stay.

• 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 should be
  - based upon the problems identified in the physician’s diagnostic evaluation, psychosocial and nursing assessments.

• 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.

• 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 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.

Progress Notes:

General:

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:

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:

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.

NOTE: 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(e) of the Title XVIII of the Social Security Act. This includes medical records that do not support the medical necessity of the services, illegible documentation, or incomplete documentation.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision

FCSO reference LCD number – L28971

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000. **Significance of Source:** This specialty organization publication provides definitions and background information regarding psychiatric diagnoses.


Hermann RC, Leff HS, et al. Selecting process measure for quality improvement in mental healthcare. The Evaluation Center @HSRI July 2002. Retrieved March 31, 2005 from the World Wide Web: http://www.cqaimh.org/toolkit.website.pdf **Significance of Source:** This publication is a toolkit designed to help healthcare organizations to identify and select measures for use in quality assessment and improvement activities related to mental healthcare.

Merck Manual of Diagnosis and Therapy, Section 15. Retrieved April 7, 2005 from the World Wide Web: http://www.merck.com/pubs/mmanual/section15/chapter194/194a.htm. **Significance of Source:** This section of the compendium presents information related to psychiatric disorders requiring emergency evaluation and treatment.

Revision History Information

<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation</th>
<th>Reason(s) for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/15/2016</td>
<td>R3</td>
<td>09/22/2016 - The following Revenue codes were deleted: 0909 was deleted</td>
<td>• Revisions Due To Bill Type or Revenue Codes</td>
</tr>
<tr>
<td>08/15/2016</td>
<td>R2</td>
<td>Revision Number: 1 Publication: July 2016 Connection LCR A2016-004 Explanation of Revision: Based on CR 9522 (Transmittal 98) (Clarification of Inpatient Psychiatric Facilities [IPF] Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification) the LCD was revised to add/revise language in the</td>
<td>• Provider Education/Guidance</td>
</tr>
</tbody>
</table>
“Certification/Recertification – Inpatient Psychiatric Certification/Recertification” section of the LCD. The effective date of this revision is based on date of service.

10/01/2015 R1 The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD’s language and coding.

• Provider Education/Guidance

Associated Documents

Attachments
coding guidelines effec 10/1/15

Related Local Coverage Documents
N/A

Related National Coverage Documents
N/A

Keywords
N/A