

Medicare Benefit Policy Manual

Chapter 2 - Inpatient Psychiatric Hospital Services

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10 - Inpatient Psychiatric Facility Services

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

10.1 - Background

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

This section and its subsections provide instructions about the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). The IPF PPS replaces the existing reasonable cost/Tax Equity and Fiscal Responsibility Act (TEFRA) based payments subject to TEFRA limits under §1886 (b) of the Social Security Act (the Act) for discharges beginning on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at 42 CFR 412, Subpart N, provides payment for inpatient psychiatric treatment when provided to a patient in psychiatric hospitals, and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs). Psychiatric hospitals and psychiatric units that used to be paid reasonable-cost under TEFRA, §1886(b) of the Act, are now paid under the IPF PPS.

The term "inpatient psychiatric facility services" means inpatient hospital services furnished to a patient of an inpatient psychiatric facility. IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and CAHs.

10.2 - Statutory Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary—(1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), section 405(g) extended the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

10.3 - Affected Medicare Providers

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means, an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and staffing requirements in 42 CFR 412.27 for a “psychiatric hospital.”

The regulations at 42 CFR 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR 412.22 and 42 CFR 412.23(a), 42 CFR 482.60, 42 CFR 482.61, and 42 CFR 482.62, and units that meet the requirements specified in 42 CFR 412.22, 42 CFR 412.25, and 42 CFR 412.27.

The IPF PPS does not change the basic criteria for a hospital or hospital unit to be classified as a psychiatric hospital or psychiatric unit that is excluded from the hospital prospective payment systems under §1886(d) and §1886(g) of the Act, nor does it revise the survey and certification procedures applicable to entities seeking this classification.

The provider number ranges (Online Survey and Certification and Reporting System (OSCAR) number) for IPFs are from xx-4000 through xx-4499, xx-Sxxx, and xx-Mxxx. Note that this will change with the implementation of the National Provider Identifiers (NPI).

The following hospitals are not included in IPF PPS.

- Veterans Administration hospitals; See 42 CFR 412.22 (c).
- Hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403; Psychiatric hospitals (provider numbers xx-4000 - xx-4499) in the State of Maryland are paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital in Maryland identified by ‘S’ in the third position of the OSCAR number are waived from the IPF PPS, as are the acute hospital in which they are located. Currently there are no CAHs in Maryland.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under 42 CFR 402(a) of Pub.L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub.L. 92-603 (42 U. S. C. 1395b-1); IPFs in acute care hospitals that are paid in accordance with demonstration projects are paid in accordance with the demonstration project;
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. See 42 CFR 412.22(c).

Payments to foreign hospitals are made in accordance with the provisions set forth in 42 CFR 413.74.

20 - Admission Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

For all IPFs, a provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of comorbid diseases as well as the psychiatric diagnosis.

In addition, according to 42 CFR 412.27(a) and 42 CFR 482.61, distinct part psychiatric units of acute care hospitals and CAHs are required to admit only those patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification. Psychiatric hospitals are required to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons, according to 42 CFR 412.23(a).

30 - Medical Records Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The medical records maintained by an IPF must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution, according to 42 CFR 412.27 and 42 CFR 482.61.

In addition, consistent with sound clinical practice, all medical records, including progress notes and treatment plan, should be legible and complete, and should be promptly signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

30.1 - Development of Assessment/Diagnostic Data

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

- (1) The identification data must include the patient's legal status.
- (2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of comorbid diseases as well as the psychiatric diagnoses.
- (3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

30.2 - Psychiatric Evaluation

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Each patient must receive a psychiatric evaluation that must—

- (1) Be completed within 60 hours of admission;
- (2) Include a medical history;
- (3) Contain a record of mental status;
- (4) Note the onset of illness and the circumstances leading to admission;
- (5) Describe attitudes and behavior;
- (6) Estimate intellectual functioning, memory functioning, and orientation; and
- (7) Include an inventory of the patient's assets in descriptive, not interpretative fashion.

30.2.1 - Certification and Recertification Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

30.2.1.1 - Certification

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The certification that a physician must provide with respect to IPF services is required to include a statement that the services furnished can reasonably be expected to improve the patient's condition or for diagnostic study. The certification is required at the time of admission or as soon thereafter that is reasonable and practicable. See Pub.100-01, Medicare General Information, Eligibility and Entitlement Manual, chapter 4, §10.9, for certification requirements.

30.2.1.2 - Recertification

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

If the patient continues to require active inpatient psychiatric treatment, then a physician must recertify as of the 12th day of hospitalization (with subsequent recertifications

required at intervals established by the IPF's Utilization Review committee on a case-by-case basis, but no less frequently than every 30 days) that the services were and continue to be required for treatment that could reasonably be expected to improve the patient's condition, or for diagnostic study, and that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel. In addition, the hospital records should show that services furnished were intensive treatment services, admission or related services, or equivalent services. See Pub.100-01, Medicare General Information, Eligibility and Entitlement Manual, chapter 4, §10.9, for recertification requirements.

30.2.2 - Active Treatment

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Payment for IPF services is to be made only for "active treatment" that can reasonably be expected to improve the patient's condition. To assure that payment is made only under such circumstances, the law includes certain requirements that must be met before the services furnished in an IPF can be covered, including medical necessity and certification.

30.2.2.1 - Principles for Evaluating a Period of Active Treatment

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

In the context of IPF services, emphasis is placed on the presence of active treatment and, therefore, this determination is the crucial one. Simply applying the skilled care definition for general hospitals is not sufficient for determining whether payment may be made since that definition does not take into account the patient's potential for improvement nor was it designed to permit the more sophisticated judgments required by the concept of active treatment. For services in an IPF 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, Conditions of Participation for Hospitals, for a full description of what constitutes active treatment.

The period of time covered by the physician's certification is referred to as a period of active treatment. This period should include all days on which inpatient psychiatric facility services were provided because of the individual's need for active treatment (not

just the days on which specific therapeutic or diagnostic services are 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.

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.

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 that 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.

30.2.3 - Services Supervised and Evaluated by a Physician (Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The types of services which meet the above requirements would include not only psychotherapy, drug therapy, and electroconvulsive therapy, but also such therapeutic activities as occupational therapy, recreational therapy, and milieu therapy, provided the therapeutic activities are expected to result in improvement 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 adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy, (or one of the other therapeutic activities 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.

In addition, the administration of antidepressant or tranquilizing drugs that are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definitions are met). However, the administration of a drug or drugs does not necessarily constitute active treatment.

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 psychiatric 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 per week.

When the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed (based on consultations and conferences with therapists, review of the patient's progress as recorded on the medical record and the physician's periodic conversations with the patient), active treatment would be indicated. A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Medicare Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient, such services would be reimbursable under the medical insurance program.

30.3 - Treatment Plan

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

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. The plan of treatment must be recorded in the patient's medical record in accordance with 42 CFR 482.61, Conditions of Participation for Hospitals.

30.3.1 - Individualized Treatment or Diagnostic Plan

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include—

- (1) A substantiated diagnosis;
- (2) Short-term and long-range goals;
- (3) The specific treatment modalities utilized;
- (4) The responsibilities of each member of the treatment team; and
- (5) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

The treatment furnished to the patient should be documented in the medical record in such a manner and with such frequency as to assure that all active therapeutic efforts are included, as well as provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it.

30.3.2 - Services Expected to Improve the Condition or for Purpose of Diagnosis

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The services provided 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.

30.4 - Recording Progress

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

As outlined above in §30 of this chapter, consistent with sound clinical practice, all medical records, including progress notes, should be legible and complete, and should be promptly signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

30.5 - Discharge Planning and Discharge Summary

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

40 - Personnel Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs must have adequate numbers of qualified professional and supportive staff, according to 42 CFR 412.27 and 42 CFR 482.62.

IPFs must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

- (1) Evaluate patients;
- (2) Formulate written individualized, comprehensive treatment plans;
- (3) Provide active treatment measures; and
- (4) Engage in discharge planning.

Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

40.1 - Director of Inpatient Psychiatric Services; Medical Staff (Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

- (1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
- (2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

40.2 - Nursing Services (Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.

- (1) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by

education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(2) The staffing pattern must insure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.

50 - Psychological Services

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF must provide or have available psychological services to meet the needs of the patients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures, according to 42 CFR 412.27 and 42 CFR 482.62.

60 - Social Services

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures, according to 42 CFR 412.27 and 42 CFR 482.62.

1. The director of the social work department or service must have a Master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a Master's degree in social work, at least one staff member must have this qualification.
2. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

70 - Therapeutic Activities

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

According to 42 CFR 412.27 and 42 CFR 482.62 IPFs must provide a therapeutic activities program.

(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.

80 - Benefit Application

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per 42 CFR 409.62. The 190-lifetime limitation does not apply to certified psychiatric distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. This limitation applies only to services furnished in a psychiatric hospital. This limitation does not apply to inpatient psychiatric services furnished in a distinct part psychiatric unit of an acute care hospital or CAH. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

The CWF keeps track of days paid for inpatient psychiatric services and informs the intermediary on claims where the 190-day limit is reached.

For a more detailed description, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §30.C. "Lifetime Inpatient Psychiatric Hospital Limitation" and chapter 4, §50 "Inpatient Psychiatric Hospital Services—Lifetime Limitation" for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services. For details concerning the pre-entitlement inpatient psychiatric benefit reduction provision see Pub. 100-02, Medicare Benefit Policy Manual, chapter 4, §§10 - 50.

90 - Benefits Exhaust

(Rev. 69; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Effective December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust and the benefits exhaust date will substitute for the discharge date. The claim will be paid either on the discharge date if the benefits are available or on benefit exhaust date if the discharge is after the benefits exhaust date. When the services actually are provided, the PRICER version used to price claims for the time will be used. No pay/110 TOBs are allowed instead of continually adjusting the claims (117 TOB) until actual discharge occurs once benefits exhaust.

Under the Tax Equity and Fiscal Responsibility Act (TEFRA), the Provider Statistical and Reimbursement (PS&R) report used the benefits exhaust date as the discharge date.

This changed when the IPF PPS was implemented, and the 'actual' discharge date was used. The days stay with the year they occurred, making it easier for the PS&R report (especially during the blend period) to settle the cost report. This means that:

- 1. Claims will be settled on the appropriate cost report;*
- 2. The appropriate PPS-TEFRA blend percentage will be paid;*
- 3. Patients with long lengths of stay will be counted on the correct PS&R report;
and*
- 4. The PRICER version used will be the one in effect at the time the services were provided.*

4. Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R69BP	04/27/2007	Change to the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Discharge Bill	12/03/2007	5474
R59BP	11/09/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
R56BP	11/03/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
R1BP	10/01/2003	Initial Publication of Manual	NA	NA