
Medicare Program Integrity Manual

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal 2

Date: SEPTEMBER 15, 2000

CHANGE REQUEST 882

CHAPTERS AND SECTIONS REPLACED

<u>CHAPTER</u>	<u>SECTION</u>
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This revision manualizes Program Memorandum (PM) A-99-39, Change Request 882, dated September 1999.

MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE: Not Applicable

Section 15, Medical Review of Partial Hospitalization Claims, is a new section manualizing the medical review instruction in PM A-99-39, and includes the following subsections.

Section 15-1, General
Section 15-2, Bill Review Requirements
Section 15-3, Bill Review Process
Section 15-4, Reasons for Denial

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number apply only to the redlined material. All other material remains the same.

Program Integrity Manual

Chapter 6 - Intermediary MR Guidelines for Specific Services

- 15 -- Medical Review (MR) of Partial Hospitalization Claims
- 15-1 -- General
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CHAPTER 6 - Intermediary MR Guidelines for Specific Services

15 - Medical Review (MR) Of Partial Hospitalization Claims

15.1 - General

Effective immediately the following medical review instructions will be in place for all FIs for all types of review for partial hospitalization claims. HCFA's policy is based on the following citations:

The Social Security Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

The Social Security Act, §1861(ff) and 1832 (a) define the partial hospitalization benefit and provide for coverage of partial hospitalization in a hospital or CMHC setting.

The Social Security Act, §1861(s)(2)(B) references partial hospitalization in a hospital setting.

The Social Security Act, §1835 (a)(2)(F) references physician certification and plan of care.

The Social Security Act, §1833(e) requires services to be documented in order for payment to be made.

42 CFR 410.43, 410.110 and 424.24(e) set forth the conditions and exclusions for the partial hospitalization benefit.

HCFA Ruling 97-1 clarifies Limitation on Liability rules for appeals.

15.2 - Bill Review Requirements

FIs must conduct review of partial hospitalization bills in accordance with applicable MIM sections. For partial hospitalization services provided by CMHCs see MIM §3651 (medical review guidelines in 3920.1K3), §3604 (except §3651.C); MIM §3920.1K3 (documentation criteria for outpatient hospital psychiatric services in §3112.7C of the MIM manual). FI standard operating procedure for soliciting additional documentation, claim adjudication, and recoupment of overpayment. The following components should be used to help determine whether the services provided were accurate and appropriate.

A - Initial Psychiatric Evaluation/Certification

Upon admission, a certification by the physician must be made that the patient admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need 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 identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

B - Physician Recertification Requirements

1. Signature - The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

2. Timing - The first recertification is required as of the 18th calendar day following admission to the partial hospitalization program. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

3. Content - The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:

- The patient's response to the therapeutic interventions provided by the partial hospitalization program;
- 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 from the partial hospitalization program.

C - Treatment Plan

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. 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 the 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.

D - Progress Notes

Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan.

15.3 - Bill Review Process

For all selected claims, review medical documentation and determine whether the services provided were covered. The reviewer should apply the criteria in the following order (e.g., benefit category requirements, statutory exclusion from coverage, then reasonable and necessary) when making a payment determination. In order to be covered, a service must meet all three of the following criteria.

A - Make A Benefit Category Determination

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a partial hospitalization program must be under the care of a physician who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.

Patients meeting benefit category requirements for Medicare coverage of a partial hospitalization program comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care there must be evidence of the need for the acute, intense, structured combination of services provided by a partial hospitalization program. Recertification must address the continuing serious nature of the patient's psychiatric condition requiring active treatment in a partial hospitalization program.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations which 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.

B - Determine Services Are Not Statutorily Excluded From Coverage

Determine whether the services are excluded from coverage under any provision in §1862(a) of the Act. Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

1. Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors).
2. Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual.
3. Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients.
4. Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29).
5. Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals.
6. Family counseling services for which the primary purpose is the treatment of the patient's condition.
7. Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition.
8. Medically necessary diagnostic services.

Partial hospitalization services which 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. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a partial hospitalization program. 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 provided in a partial hospitalization program. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

C - Determine Services Provided Are Reasonable and Necessary

This program 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 or hospitalization. A particular individual covered service (described above) 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 partial 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 (e.g. intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a partial hospitalization program 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 partial hospitalization program. Patients admitted to a partial hospitalization program generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association, 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 whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in partial hospitalization programs 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.

15.4 - Reasons for Denial

A - Examples of benefit category denials based on §1861(ff) or §1835(a)(2)(F) of the Act, for partial hospitalization services generally include:

- 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 of 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.

Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

B - 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.

Coverage denials made under §1861(ff) are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

C - 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 partial hospitalization program; or

- Treatment of chronic conditions without acute exacerbation of symptoms which place the individual at risk of relapse or hospitalization.

Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply.