Local Coverage Determination (LCD)

Psychiatric Inpatient Hospitalization

L33975

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Document Note

Posted: 8/5/2021
Revision History #R7 should say that the LCD was revised not the article.

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands

LCD Information

Document Information

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N/A

CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for Psychiatric Inpatient Hospitalization. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for Psychiatric Inpatient Hospitalization and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

Internet Only Manual (IOM) Citations:

- CMS IOM Publication 100-01, *Medicare General Information, Eligibility, and Entitlement*,
    - Chapter 4, Section 10.9 Inpatient Psychiatric Facility Services Certification and Recertification
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*,

    - Chapter 2 Inpatient Psychiatric Hospital Services
    - Chapter 4 Inpatient Psychiatric Benefit Days Reduction and Lifetime Limitation
    - Chapter 5 Lifetime Reserve Days
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*,
    - Chapter 1, Part 2, Section 130.1 Inpatient Hospital Stays for the Treatment of Alcoholism
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
    - Chapter 1, Section 40.4 Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement, Section 50.1.3 Signature on the Request for Payment by Someone Other Than the Patient, Section 50.2.1 Inpatient Billing From Hospitals and SNFs, Section 50.2.2 Frequency of Billing for Providers Submitting Institutional Claims With Outpatient Services, Section 60.5 Coding That Results from Processing Noncovered Charges, Section 80.3.2.2 Consistency Edits for Institutional Claims, and Section 90 Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
    - Chapter 2, Section 30.6 Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data
    - Chapter 3, Section 10.3 Spell of Illness and Section 20 Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*,
    - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Federal Register References:

- CFR, Title 42, Volume 2, Chapter IV, Part 412.23 Excluded hospitals: Classifications, Part 412.27 Excluded psychiatric units: Additional requirements, Part 412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities, and Part 412.405 Preadmission services as inpatient operating costs under the inpatient psychiatric facility prospective payment system

- CFR, Title 42, Volume 5, Chapter IV, Part 482.60 Special provisions applying to psychiatric hospitals, Part 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals, and Part 482.62 Condition of participation: Special staff requirements for psychiatric hospitals.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

History/Background and/or General Information

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 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.

Covered Indications

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., bulemic 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:

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. Please refer to 42 CFR 482.61 on “Conditions of Participation for Hospitals” for a full description of what constitutes active treatment.

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”.

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.

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 adjunctive 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.

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.

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. 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”.

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 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”.

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.

Limitations

The following services do not represent medically reasonable and 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;

- Electrical Aversion Therapy for treatment of alcoholism (CMS IOM Publication 100-03, Chapter 1, Section 130.4);
- Hemodialysis for the treatment of schizophrenia (CMS IOM Publication 100-03, Chapter 1, Section 130.8);
- Transcendental Meditation (CMS IOM Publication 100-03, Chapter 1, Section 30.5);
- Multiple Electroconvulsive Therapy (MECT) (CMS IOM Publication 100-03, Chapter 1, Section 160.25).

It is not medically reasonable and 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 IOM 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 the patient from meeting the medical necessity for admission to an inpatient psychiatric hospital).

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this LCD, the general requirements for medical necessity as stated in

CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Summary of Evidence
N/A

Analysis of Evidence (Rationale for Determination)
N/A

General Information

Associated Information
Please refer to the related Local Coverage Article: Billing and Coding: Psychiatric Inpatient Hospitalization (A57726) for documentation requirements, utilization parameters and all coding information as applicable.

Sources of Information
First Coast Service Options, Inc. 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.

American Psychiatric Association Practice Guidelines (2004). American Psychiatric Press, Inc.

Anderson AJ, Micheels P, et al. Criteria based voluntary and involuntary psychiatric admissions modeling. *International Journal of Psychosocial Rehabilitation* 1998; 2(2):176-188.

Goldman RL, Weir CR, et al. Validity of utilization management criteria for psychiatry. *Am J Psychiatry* 1997; 154:349-354.

Hermann RC, Leff HS, et al. Selecting process measure for quality improvement in mental healthcare. The Evaluation Center @HSRI July 2002.

Merck Manual of Diagnosis and Therapy, Section 15.

Bibliography

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
01/01/2021	R7	Article revised and published on 07/08/2021 effective for dates of service on and after 01/01/2021 to remove reference to the CMS IOM Publication 100-03, Chapter 1, Section 30.4 under the 'Limitations' section for the 6th bullet for Electrosleep therapy in response to the CMS CR 12254. Minor formatting changes have also been made.	• Other (Revision based on CR 12254)
11/28/2019	R6	Revision Number: 5 Publication: November 2019 Connection LCR A2019-005 Explanation of Revision: Based on Change Request (CR) 10901, the LCD was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue	• Other (Revision based on CR 10901)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		Codes," "CPT/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. In addition, the Social Security Act, Code of Federal Regulations, and IOM reference sections were updated. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	
01/24/2019	R5	Revision Number: 4 Publication: February 2019	• Other (Revisions based on review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		Connection LCR A2019-002 Explanation of Revision: Based on a review of the LCD, grammatical and formatting errors were corrected throughout the LCD. The effective date of this revision is based on process date. In addition, it was determined that some of the italicized language in the “Coverage Indications, Limitations, and/or Medical Necessity” and “Documentation Requirements” sections of the LCD do not represent direct quotations from some of the CMS sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources. The effective date of this revision is based on date of service. 01/24/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields	

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		included on the LCD are applicable as noted in this LCD.	
08/15/2016	R4	10/02/2018: This LCD version is approved to allow local coverage documents to be related to the LCD.	• Other
08/15/2016	R3	09/22/2016 - The following Revenue codes were deleted: 0909 was deleted	• Revisions Due To Bill Type or Revenue Codes
08/15/2016	R2	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 "Certification/Recertification – Inpatient Psychiatric Certification/Recertification"	• Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		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

N/A

Related Local Coverage Documents

Articles

A57726 - Billing and Coding: Psychiatric Inpatient Hospitalization

Related National Coverage Documents

NCDs

130.1 - Inpatient Hospital Stays for Treatment of Alcoholism

Public Versions

Updated On	Effective Dates	Status	
07/02/2021	01/01/2021 - N/A	Currently in Effect	You are here

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A