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Contractors Policy No:
96-08-R1

Contractor Number
00190

Contractor Type
Fiscal Intermediary

LCD Title
Partial Hospitalization Programs

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CMS National Coverage Policy

- Establishment of national policy supercedes all previous contractor policy statements, including Local Medical Policy coverage guidelines.
- 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 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Primary Geographic Jurisdiction
Maryland
Washington, DC

Secondary Geographic Jurisdiction
Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, Washington state, and Wyoming

CMS Region
Region III

CMS Consortium
Northeast

Original Policy Effective Date
04/28/1996

Original Policy Ending Date
N/A

Revision Effective Date
08/30/2005

Revision Ending Date
N/A

Indications and Limitations of Coverage and/or Medical Necessity

Description:

- A partial hospitalization program is:
    - A program that is furnished by a hospital or Community Mental Health Center (CMHC) on an outpatient basis,

- A distinct and organized intensive ambulatory treatment service offering less than 24 hour daily care, and;
- A program that encompasses a variety of psychiatric treatment modalities designed for patients with significant impairments resulting from a psychiatric, emotional, or behavioral disorder and who require coordinated, intensive, comprehensive, and multi-disciplinary treatment not generally provided in an outpatient clinic setting.

- The purpose of a partial hospitalization program is as follows;
    - To provide a more intensive psychiatric treatment program that will improve or maintain a patient's level of functioning and reduce or control a patient's symptoms to prevent relapse or hospitalization, and;
- A partial hospitalization program for Medicare purposes is a comprehensive structured program that utilizes a multi-disciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

Indications

- Partial hospitalization program services must meet the following requirements:

1. Authorized Entities: A partial hospitalization program (PHP) is a program that is furnished by a hospital to its outpatients or by a CMHC. It must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care.

- Special Requirements: Section 1866(e)(2) of the "Act" recognizes CMHCs as "providers of services", but only for furnishing partial hospitalization services.
- If a hospital has an off-site location that is not authorized by the state Board of Licensing and Certification to be part of the hospital, Medicare requires that a physician be present and immediately available on the premises at all times while such services are being performed.
- Partial Hospitalization Programs should not be confused with Day Care Programs that primarily provide social and /or recreational, custodial care and respite services.
- Skilled Nursing Facilities (SNF) cannot have a Partial Hospitalization Program.

2. Licensing and Certification: CMHCs that provide partial hospitalization program services must the requirements of S 1916©(4) of the Public Health Service Act (as specified in subsection B. 1) and meet applicable licensing or certification requirements for the state of Maryland and the District of Columbia.
3. Billing: In order for proper payment to be made, providers are required to component bill for any service provided under the Partial Hospitalization Benefit. Component billing require that a HCPCS Code (if appropriate), Revenue Code, and charge must identify each service provided. Component billing assures that only those partial hospitalization services are paid by the Program. For coverage purposes, the key to whether a particular type or group of services and activities may be covered depends primarily on the services provided in the program and how the services are being used in the care of patients as they relate to the treatment plan and objective goals. Hospitals and CMHCs should bill monthly using the appropriate revenue code.

*The number of units billed for each revenue code cannot surpass the number of days the beneficiary attended in the Partial Hospitalization Program. ***Correcton:** Components units billed should represent each service documented in the medical record. If the patient attended 24 group sessions in 15 days, the units for revenue code "915" should show "24". Units billed **can exceed** the number of days that a patient attended the program. Units billed should match services and documentation in the medical record.

(Correction effective 2/19/96.)

CONDITION CODE **41** *must be placed in Items 24-30 of the UB-92 to indicate that the claim is for Partial Hospitalization services (not applicable to CMHC billing.)*

REVENUE CODE 912 IS NO LONGER AN ACCEPTABLE CODE FOR MEDICARE BILLING.

4. Certification: A physician who is directing care or who is regularly involved in the beneficiary's care periodically reviews the treatment plan and patient's progress in meeting the goals of the plan every 31 days certifies that:
   - The individual would require acute inpatient psychiatric care if the partial hospitalization services were not provided, and
   - The services were furnished while under the care of a physician, and
   - The services were furnished under a written Plan of Treatment. Assessment of patient risk (s) of coronary artery disease;

Stamped signatures are ***NOT*** acceptable. The certification must be signed by the physician upon admission to the Partial Hospitalization Program. Recertification statements are required to be signed every thirty-one (31) days thereafter by the physician who reviews the plan of care. A psychologist is not considered a physician for the purpose eof establishing a certification or recertification.

CMS has indicated the language that is to be used on the certification. They have not indicated the format; therefore, the provider must design their own form and the forms must be maintained in the medical record.

CERTIFICATION AND LANGUAGE:
"I certify that partial hospitalization services are medically necessary to improve or maintain (circle one) the patient's condition and functional level and to prevent relapse or hospitalization".

Signature______________________ Date__________________

5. Reasonable and Necessary: In general, to be covered, the services must be reasonable and necessary for the diagnosis or active treatment of a patient's condition that cannot be accomplished I a less intensive setting. The services must be for the purpose of diagnostic study or they must be reasonably be expected to improve or maintain the patient's condition and to prevent relapse of hospitalization. If Partial Hospitalization placement is for the purpose of diagnostic studies and more that 5 days is requested, the record must clearly be based on patient, facility, provider, or programmatic convenience is not considered reasonable and is not covered.

The need for services must be documented in a current psychiatric evaluation that details the reason for admission, the patient's prior level of functioning, detailed previous treatment attempts to control symptoms, prior psychiatric hospitalization(s) and any other pertinent information regarding the medical/mental condition of the patient. The record must document the empirical basis on which clinical judgment is being made and that discontinuing placement I a PHP would result in relapse or hospitalization. Patients who suffer from chronic mental disorder must have an acute change or precipitating event that warrants admission to a PHP.

6. Individual Treatment Plan: Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the devices to be furnished and detail measurable relevant goals and objectives.

- The individual treatment plan should outline a specific proposed discharge plan, which would describe the transition to the next level of care.
- The individual treatment plan must be developed or established within the first 7 days of a patient's participation in the program. Periodic reviews of the treatment plan are to be performed at least every 31 days.

AMISSION CRITERIA:
The patient meets the following:

- The patient had symptoms and/or behavior manifestations of a mental disorder that interferes with social, vocational, and/or educational functioning. Such dysfunction must be either the result of an acute psychiatric disorder of an acute exacerbation of a chronic circumstance.
- The patient does not require 24-hour care and has an adequate support system outside the hospital setting while not actively engaged in the program.
- The patient is not judged to be dangerous to self or others and has adequate control of his/her behavior.
- The patient has failed at or is not capable of benefiting from intensive outpatient treatment.
- Active professional monitoring and psychiatric medical treatment of the pathologic behavior, mind and/or thought disorder is essential to prevent inpatient treatment.

In addition to the above, despite the degree of emotional impairment present, the patient must gave ***sufficient intact cognitive functioning*** to benefit from active treatment program.

DISCHARGE/TRANSITIONING CRITERIA:
Hospitals and Community Mental Health Centers (CMHCs) providing partial hospitalization programs should utilize specific criteria for transitioning the patient to a less intensive level of care. These specific factors should be noted in the individual treatment plan, such as:

- Lack of participation or ability to participate in the treatment program, or
- Improvement in clinical condition or manifestations whereby the patient can now benefit from and participate in a less intense level of care, or
- The patient's clinical condition has deteriorated to the point of requiring a more intense level of treatment for safety, security, evaluation, and stabilization.

Partial hospitalization program (PHP) transitioning must be documented with a decrease in frequency and intensity of services. Documentation may include:

- Doctor's orders
- Progress notes
- Treatment summaries (weekly/monthly)
- Treatment Plan

The following are services that may be covered when provided as components of a PHP:

1. Individual and/or Group Therapy: With physicians, psychologists, psychiatrists, or other mental health professionals licensed or certified by the state of Maryland and the District of Columbia. State regulations governing partial hospitalization services should be used to determine which mental health professionals are authorized by state law to provide individual and group therapy in a partial hospitalization program. In those states where there are no regulations governing partial hospitalization services, only professionals who are certified or licensed by the state to provide individual or group therapy or who possess a relevant Master's Degree and are supervised by a person licensed by the state would be covered.

- There should be **no more than 8 to 10 patients in any group therapy session**.

2. Occupational Therapy Services: Must require the skills of a qualified occupational therapist (OT) and be performed by (1) a qualified therapist; or (2) a certified occupational therapy assistant (COTA) under general supervision of the OT; or (3) other personnel under direct supervision of the OT.

- Occupational therapy must be billed using a 43x revenue code and must meet all rehabilitative coverage requirements as outlined in the Medicare Hospital Manual, CMS Pub. 10, Section 210.9.

3. Drugs and Biologicals: Fumished for therapeutic purposes only if they are of a type that cannot be self-administered. (IM)

- If medication management is not done within the program, the program physician, if not the attending physician, should discuss the medications and any changes with the patient's private physician. The medications and any changes should be noted in the medical record.

4. Services of Social Workers: Trained psychiatric nurses and other staff trained to work with psychiatric patients.

5. Individualized Activity Therapies: These activities must be individualized and essential for treatment of the patient's diagnosed condition and should be directly related to skill development (e.g., communication, coping skills, problem solving, ADL skills). The activity therapy and the rationale for therapeutic application should be demonstrated in the treatment plan with specific, measurable treatment goals.

- *Activity therapies, group activities, or other services and programs that are primarily recreational or are diversionary in nature, including psychiatric day treatment programs that consist entirely of activity therapies or which are primarily social, recreational, or diversionary in nature **are not covered**.*

- *Assertiveness training may be helpful to patients, but is not a covered service since it primarily is used to improve social and recreational functioning of the patient.*

6. Family Counseling: The primary purpose must be to treat the patient's condition.

7. Patient Training and Education: That is clearly reasonable and necessary for the care and treatment of the individual's mental disorder.

8. Diagnostic Services: For the purpose of diagnosing those individuals for who extended or direct observation is necessary to profile presenting symptoms and problems in the interest of developing a treatment plan.

Type of Bill Code(s)
13X, 14X (hospitals)
76X (Community Mental Health Center-CMHC)

Revenue Codes
250, 43X, 910, 914, 915, 916, 918, 942

CPT / HCPCS Codes
The HCPCS code should reflect the service performed.
Specific HCPCS codes were not included in the development of this policy.

Not Otherwise Classified (NOC)

ICD-9 Codes that Support Medical Necessity

Specific ICD-9-CM codes should reflect the patient's condition.

ICD-9-CM Codes That Do Not Support Medical Necessity

ICD-9-CM codes that do not reflect the patient's condition.

Documentation Requirements

- In order to assure that an effective medical review of PHP services can be performed, it is necessary for a provider to fumish documentation when requested by medical review.
- The required documentation elements for these services are:
  - A. Psychiatric history/assessment,
  - B. Current individualized, multidisciplinary treatment plan,
  - C. Progress notes for each therapeutic intervention as it relates to the treatment plan, and;
  - D. Evidence of physician supervision, evaluation, and certification.

DETAILED DOCUMENTATION ELEMENTS:

A. PSYCHIATRIC HISTORY/ASSESSMENT:

Since PHP encompasses a variety of psychiatric treatment modalities designed for patients with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment not generally provided in an outpatient clinic setting, a current psychiatric history/assessment is necessary. This psychiatric history/assessment must be within 48 hours of admission to the program. If the patient is admitted to a PHP within 7 days of discharge from an inpatient psychiatric stay, a discharge summary from the acute facility would meet this criteria.

The psychiatric history/assessment should include, but is not limited to:

- DSM-IV Multiaxial classification of the patient's diagnostic and functional status.
- Pertinent psychiatric history to include any history of psychiatric hospitalization, diagnoses, adequacy of adjustment in various life spheres (e.g., education, job history, social adjustment, etc.) Recent treatment attempts should be specifically described.
- A complete assessment of a patient's current cognitive, affective and behavioral status with reference to an individuated appreciation of these various aspects of a patient's life.
- Medical history and status.
- Treatment recommendations to include rationale and reference to patient's clinical psychiatric/medical status.

B. INDIVIDUALIZED MULTI-DISCIPLINARY TREATMENT PLAN:

For the services and interventions to be rendered, the treatment plan should specifically detail:

- Diagnosis(es),
- Discipline/team member responsible for rendering the treatment intervention,
- Type, amount, and frequency of the services to be provided,
- Estimated duration,
- Specific problems/symptoms, and;
- Measurable goals and objectives.

Treatment plans should contain a clear conceptualization of what changes in a patient's status will cause them to be discharged from the PHP. Moreover, it should be evident how the planned interventions are intended to obtain the desired outcomes. Goals must be specific, reasonable, and outcome oriented to each intervention provided. The absence of symptoms or complete remission are rare outcomes for

patients with severe psychiatric disorders and thus such goals would not be reasonable.

The documentation must substantiate the type of service being rendered. This also includes describing the specific type of group therapy that is being rendered and billed. Medicare does not pay for vocational counseling groups, field trips, general education classes, etc.

The plan must contain, but need not be limited to, the following:

- Diagnosis: i.e., DSM-IV.
- Type, amount, frequency, and duration of services to be provided. Example: Individual therapy: 1 hour 3x/week x 2 months.
- Specific problems/symptoms.
- Specific functional impairments.
- Specific causes of functional impairments (e.g., cognitive, communicative, emotional, psychosocial, behavioral).
- The specific expected functional outcome.
- Short term/long term goals related to the listed problems, symptoms, or impairments, including activity therapy, that are measurable, functional (i.e., related to ADL abilities), timeframed and directly related to long term goals.
- Medications, including dosages, negative and positive effects.
- Discharge planning to begin and be documented at the time of admission.

C. PROGRESS NOTES:

It is extremely important to remember that the patient is in the PHP setting to receive an intense level of treatment and the continued justification for this level of service must be documented.

Progress notes must be written on a daily basis for each therapeutic intervention given and should reflect, but are not limited to:

- A brief summary of the therapeutic activity;
- Observation of the patient's status in relation to the specific problems, symptoms, and impairments, and responses in the course of the therapeutic contact; and
- The therapist's plans for any subsequent therapeutic contacts.

Progress notes should always reflect the patient's response to treatment as it relates to the treatment plan goals and objectives and present a clear picture of the patient's status. It is not sufficient for the writer to note that the patient participated in all groups.

Describe progress toward goals in measurable and functional terms.
Note: Functional improvement is considered to be the patient's increasing ability to perform activities of daily living outside of the direction or support of a therapist and/or a therapeutic environment.

Include a statement that describes the reason treatment has not been provided for a particular short-term goal.

The progress notes should reflect, but not be limited to:

- A brief summary of each specific group and/or therapy,
- Identification of what was done in each group,
- Identification of how the services specifically achieved progress towards the documented goal, and;
- Identification of how the patient reacted to the therapeutic interventions.

D. PHYSICLAN SUPERVISION, EVALUATION, AND CERTIFICATION:
Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The treatment planning updates must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. The frequency of these updates would always be contingent upon an individual patient's needs, but should occur no less frequently than once a week. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapists involved in the patient's treatment, see the patient periodically to evaluate the course of treatment, determine the extent to which treatment goals are being realized, and whether changes in direction or emphasis is needed.

Through the process of physician supervision and evaluation, the ongoing need for intensive PHP services must be supported by physician recertification every 31 days. If the ongoing need for interim PHP services is not warranted, based on the evaluation, the physician may recommend follow-up care after discharge from the PHP (i.e., outpatient program, support group, supervised day activity programs, etc.) or simply discharge the patient from the program.

Utilization Guidelines

- Standards and guidelines developed by the American Association for Partial Hospitalization specify that, at a minimum, the program should have available 20 hours of scheduled therapeutic programming extending over a minimum of five days per week.
- An average program day is between 4 and 6 hours.
- The length of stay in PHP is dependent upon the patient's psychiatric problems, clinical needs, and individual response to treatment.
- Many factors affect the outcome of treatment; among them are the nature of the illness, the prior history, the goals of treatment, and the patient's response. It is anticipated that the patient would be accepted into the PHP, treated, and then be transitioned to a less intense level of care.
- **Some patients may undergo a course of treatment that increases their level of functioning, but reach a point where further significant improvement cannot reasonably be expected. Continued coverage may be possible even though the condition has stabilized and treatment is primarily for the purpose of maintaining the present level of functioning, provided that continued treatment in a PHP is required to prevent relapse and/or hospitalization. Specific data justifying continued partial hospitalization treatment must be documented in such cases.**
- For many psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization can be an acceptable expectation of improvement. Improvement in this context is measured by comparing the effect of continuing treatment in a partial hospitalization setting versus treatment at a lower, less intensive level of care. Where there is a reasonable expectation based on specific clinical data that continuing treatment at a lower level of care would result in patient status deterioration to the point that hospitalization may be required, this criterion is met.
- When PHP services continue due to the likelihood of deterioration, documentation must support this likelihood of deterioration by referencing knowable factors; e.g., history of frequent hospitalizations, current life situational crisis that has precipitated clinical signs of decompensation, etc. The documentation must also support that the patient's condition warrants the intensity of the PHP as the patient demonstrates an inability to maintain goals without the comprehensive treatment provided by the PHP.

Other Comments

This policy does not reflect the sole opinion of the intermediary, carrier or Intermediary/Carrier

Medical Directors. Although the final decision rests with the intermediary/carrier, this policy was developed in cooperation with the Carrier Advisory Committee (CAC), which includes representatives from the appropriate specialties.

Sources of Information

Coverage Issue Manual, Section 35-14
Coverage Issue Manual, Section 80-1
Medicare Peer Review Organization Manual, CMS Pub. 19, Section 452
Medicare Hospital Manual, CMS Pub. 10, Section 23 0.5
Outpatient Physical Therapy Manual, CMS Pub. 9, Section 324
Program Memorandum Intermediaries, CMS Pub. 60A, Rev. A-95-8, 06-95.
Mutual of Omaha, Medicare Area, Local Medical Review Policy, December 1994.
BC/BS of New Jersey, Medicare Part A, Local Medical Review Policy, April 1995.
Standards and Guidelines for Partial Hospitalization, AAPH 1994.

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period

Revision History

Number	**Date**	**Change**
96-08-R1	08/30/2005	LMRP to LCD conversion.

THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE FROM OUR WEBSITE AT www.marylandmedicare.com

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