Overview of select behavioral health programs

Agenda

Overview of select behavioral health programs:
- Laws and rules governing behavioral health programs
- Recent enforcement actions

Inpatient psychiatry hospitalization services:
- Medicare conditions of payment
- Potential risks and leading practices
- Case study
- Monitoring plans & leading practices

Outpatient psychiatry hospitalization services:
- General outpatient services
- Partial hospitalization programs (PHP)
- Common challenges and leading practices

Discussion/questions

Appendix: Additional details on Medicare requirements and State-specific requirements
Partial hospitalization programs (PHPs)

- Also called “day programs”
- Outpatient programs that patients attend for six or more hours a day, every day, or most days of the week
- Commonly offer group therapy, educational sessions, and individual counseling for psychiatric illnesses and/or substance abuse
- Part of a hospital’s services or freestanding

Psychiatric hospitals
- Treat mental illnesses exclusively, although they address medical conditions
- Might provide drug and alcohol rehabilitation services, as well as psychotherapy
- Might have specialty units for eating disorders, geriatric concerns, child and adolescent services, as well as substance abuse services

Psychiatric hospitals
- Treating patients with a psychiatric disorder and/or other medical conditions
- Not very common
- Some offer mental health services, whereas others offer drug and alcohol rehabilitation services
- Some hospitals might provide a broad range of services

General medical and surgical hospitals
- General hospital with a psychiatric inpatient unit and/or a substance abuse unit
- Not very common
- Provide medical services that would not be available in a free-standing psychiatric hospital

General medical and surgical hospitals
- Treat mental health care and provide services to those who do not want or cannot afford inpatient care
- May offer some medical and surgical services
- May offer inpatient and outpatient care
- May have specialty units for eating disorders, geriatric concerns, child and adolescent services, as well as substance abuse services

Partial hospitalization programs (PHPs)
- Also called “day programs”
- Outpatient programs that patients attend for six or more hours a day, every day, or most days of the week
- Commonly offer group therapy, educational sessions, and individual counseling for psychiatric illnesses and/or substance abuse
- Part of a hospital’s services or freestanding

Inpatient psychology services
- Involve an overnight or longer stay
- Some are based in community mental health centers; others are located in general hospitals where individuals visit an outpatient clinic for an appointment

Inpatient psychology services
- Commonly offer group therapy, educational sessions, and individual counseling for psychiatric illnesses and/or substance abuse
- Part of a hospital’s services or freestanding

Laws and rules governing behavioral health programs

- False Claims Act
- State-specific insurance regulations
- Federal law
- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual
- CMS National Coverage Determinations (NCD)
- Medicare Administrative Contract (MAC) – Local Coverage Determination
- Medicare Managed Care Manual
- Department of Mental Health (DMH)
- Medicaid
- Medicaid Managed Care Manual
- Medicaid Benefit Policy Manual
- Medicare Claims Processing Manual

Recent enforcement actions – Inpatient psychiatric facilities

Recent CMS approved audit topic for Medicare RACs

As of 8th September 2017, one of the recent Centers for Medicare and Medicaid Services (CMS) approved audit topics include Inpatient Psychiatric Facility Services – Complex Review. Inpatient hospital services furnished in an inpatient psychiatric facility will be reviewed to determine that services were medically reasonable and necessary. Further, Inpatient Psychiatric Facility Outlier Payments were a new addition to the 2017 Office of the Inspector General (OIG) Workplan.
Recent enforcement actions – Outpatient psychiatric facilities

Medicare compliance review article

**Treatment plans cause denials in Targeted Probe and Educate (TPE) outpatient psychiatric audit**

- Outpatient mental health services are a target of TPE across the country
- To get out of the TPE process, the payment error rate would need to be at or below 15%
- Concerns around treatment plans:
  - Outdated/missing signatures
  - Credentials missing from the electronic signature

**Audit Process**

- Initial audit performed by Medicare Administrative Contractor (MAC) on outpatient psychiatric claims sample

- A payment error rate of more than 15%, will result in TPE

- Educational call with nurse reviewer from the MAC - opportunity to have a conversation and talk specifically about findings on specific claims

- Second audit performed on claims 45-55 days after the education calls

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Inpatient psychiatry hospitalization services

**Condition of Medicare payment for inpatient psychiatry services**

- Conditions of Payment are rules, regulations, or requirements that must be met for a healthcare provider to request and receive reimbursement, lawfully, from a Federal healthcare coverage provider (e.g., Medicare, Medicaid, and TRICARE)

- Failure to comply with a condition of payment can result in a denial of the claim for payment. If the payment has already been made, the amount paid on the claim is considered an overpayment

The following slides outline Medicare Conditions of Payment requirements for the following:

- Inpatient services of hospitals other than psychiatric hospitals
- Inpatient psychiatric hospitals
§412.3 Admission orders

Admission order

Requirements:
The inpatient admission order must state that the beneficiary should be formally admitted for hospital inpatient care, and must be furnished at or before the time of the inpatient admission by a physician or other qualified practitioner*.

Timing and signature requirement:
Verbal/telephone order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner prior to discharge.

If an electronic order was not signed/cosigned by the physician, as applicable, the entire medical record should be reviewed for alternative admit language.

* A “qualified practitioner” is someone who is licensed; has admitting privileges at the hospital as permitted by State law; is knowledgeable about the patient’s hospital course, medical plan of care, and current condition; and acts in accordance with scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

§424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities

Physician certification

As a condition of payment for hospital inpatient services under Medicare Part A, CMS is requiring, only for long-stay cases and outlier cases, separate physician certification of the medical necessity that such services be provided on an inpatient basis.

The signed physician certification is considered, along with other documentation in the medical record, as evidence that hospital inpatient service(s) were reasonable and necessary.

Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) for cases that are 20 inpatient days or more, or are outlier cases only if a physician certifies or recertifies the following:

- The reasons for continued hospitalization
- The estimated time the patient will need to remain in the hospital
- The plans for post hospital care, if appropriate

Sources: Code of Federal Regulations, Conditions for Medicare Payment 42 CFR Section 424.13, Parts A and B. Center for Medicare & Medicaid Services, Transmittal 234 Clarification of Admission Order and Medical Review Requirements, March 10, 2017; Medicare Benefit Policy Manual, Chapter 1 Section 10.2 – Hospital Inpatient Admission Order and Certification.
§424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities (cont’d)

Timing:
The certification must be signed and documented no later than 20 days into the hospital stay.

Signature requirement:
Certifications must be signed by the physician.

Format:
As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician’s statement could indicate that the individual’s medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

Sources: Code of Federal Regulations, Conditions for Medicare Payment 42 CFR Section 424.13, Parts A and B. Center for Medicare & Medicaid Services, Transmittal 234 Clarification of Admission Order and Medical Review Requirements, March 10, 2017; Medicare Benefit Policy Manual, Chapter 1 Section 10.2 – Hospital Inpatient Admission Order and Certification.

Inpatient psychiatry hospitalization services
Distinct part units

Inpatient psychiatric Facilities – Medicare requirements overview
Why are inpatient psychiatry requirements different from general inpatient requirements?

The purpose of Inpatient Psychiatric Facility (IPF) Medicare Requirements is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage.

IPFs are certified under Medicare as inpatient psychiatric hospitals and their documentation/content requirements are different from general inpatient documentation requirements because the care furnished in inpatient psychiatric facilities is often purely custodial and thus not covered under Medicare.

For purposes of payment for IPF under Medicare Part A, required conditions of payment requirements (including admission order, certification, recertification(s) (where required)) must be met.

Medicare Part A pays for inpatient services in an IPF only if a physician certifies and recertifies the need for services consistent with the Medicare requirements for inpatient services of inpatient psychiatric facilities.

Medical record documentation must support the physician’s certification / recertification statement.

Sources: Code of Federal Regulations, Conditions for Medicare Payment 42 CFR Section 424.11, Parts A – C (Requirements for Inpatient services of Inpatient Psychiatric Facilities); Medicare Benefits Policy Manual, Chapter 2, Section 30.2 – Certification and Recertification Requirements.
§424.14 Requirements for inpatient services of inpatient psychiatric facilities

<table>
<thead>
<tr>
<th>Initial certification</th>
<th>Recertification*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content requirements:</strong></td>
<td><strong>Content requirements:</strong></td>
</tr>
<tr>
<td>(1) The physician must certify -</td>
<td>(1) The recertification must indicate that -</td>
</tr>
<tr>
<td>(a) Inpatient psychiatric services were furnished since the previous certification or recertification, and continues to be necessary for the patient's condition or for diagnostic study.</td>
<td>(a) Inpatient psychiatric services furnished since the previous certification or recertification, and continue to be necessary for the patient's condition or for diagnostic study.</td>
</tr>
<tr>
<td>(b) The hospital records show that the services furnished were diagnostic/treatment services, and are necessary to evaluate the patient's condition or for diagnostic study, or regular services.</td>
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<tr>
<td>(c) The patient continues to need, on a daily basis, active treatment furnished directly by a licensed professional in psychiatry, social work, or psychology.</td>
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</tr>
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</table>

**Timing and signature requirements:**
- Certification is required at the time of admission or as soon thereafter as is reasonable and practicable and must be recorded in the medical record prior to discharge.
- Recertification must be completed and documented in the medical record within 72 hours of hospitalization. Subsequent recertifications are required at least every 30 days after the prior recertification, but may be less frequently than every 30 days after the prior recertification.

§482.61 Condition of participation: Special medical record requirements for psychiatric hospitals

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

§482.61 Conditions of participation: Special medical record requirements for psychiatric hospitals

<table>
<thead>
<tr>
<th>Assessment, Diagnosis and Active Treatment</th>
<th>Psychiatric Evaluation</th>
<th>Treatment Plan</th>
<th>Program goals and evaluation summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment:</strong></td>
<td><strong>Psychiatric Evaluation:</strong></td>
<td><strong>Treatment Plan:</strong></td>
<td><strong>Program goals and evaluation summary:</strong></td>
</tr>
<tr>
<td>A complete neurological examination and mental status examination recorded at the time of admission, as well as at intervals as indicated.</td>
<td>A psychiatric evaluation - Physical examination - Laboratory data and other diagnostic studies - Social, family, and work situation and history - A complete psychological examination recorded at the time of admission and at intervals as indicated.</td>
<td>Treatment plan must include:</td>
<td>- Recorded by a DM, DO, or PA - Maintained by the owner or operator of the facility for at least six years or for the duration of the patient's hospitalization.</td>
</tr>
<tr>
<td>The hospital records must indicate that the patient's treatment is consistent with the patient's diagnosis (coded by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.</td>
<td></td>
<td>- Treatment goals and interventions - Expected outcomes - Progress and treatment assessment - Treatment revision when indicated.</td>
<td></td>
</tr>
</tbody>
</table>

All medical records, including progress notes, should be legible and complete, and should be promptly recorded and signed by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.
## Potential risks and leading practices

### Potential risks of not meeting conditions of payment and leading practices

<table>
<thead>
<tr>
<th>Potential risks</th>
<th>Leading practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liability for False Claims and overpayments rests with the provider submitting the claim, so providers must become more familiar with billing guidelines, regulations, and status.</td>
<td>Conduct documentation review to support billing activities (e.g., coverage analysis and billing grid)</td>
</tr>
<tr>
<td>Loss of accreditation, certification and federal debarment resulting in Medicare funding loss and patient load decrease.</td>
<td>Perform periodic review of policies &amp; procedures</td>
</tr>
<tr>
<td>Diminished reputation and public relations issues.</td>
<td>Maintain clear delineation of roles and responsibilities</td>
</tr>
<tr>
<td>Difficulty in recruiting top faculty &amp; students.</td>
<td>Implement an on-going education plan for all stakeholders</td>
</tr>
<tr>
<td></td>
<td>Develop and implement an auditing and monitoring compliance roadmap</td>
</tr>
</tbody>
</table>

## Case study
Inpatient psychiatry distinct part unit – certification and recertification

Situation

- Need to assure that Provider’s certification and recertification for inpatient psychiatry services are complete and timely

Complication

- Inpatient psychiatry services provider without accurate or timely completed certification and recertification may be subject to nonpayment and/or penalties by regulators

Certification and recertification for inpatient psychiatry services accurately completed for all claims submitted to Medicare

Resolution

- Performed sample review to identify focused areas
- Redefined roles/responsibilities of nursing staff/case management and added additional resources
- Performed training for all clinicians, staff, and prepared checklists, guidelines, reference sheets, etc.
- Initiated bill hold and pre-bill monitoring prior to discharge by CM and post discharge by HIM/Billing
- Enhanced EMR system to include electronic certification process and proprietary manual at the start but now is for back-up use (job aid, training, testing, reporting, etc.)
- Conduct ongoing monitoring by compliance and case management

Impact

- Actionable opportunities for continued improvement identified
- Identification of claims which do not have documentation to support billing

Illustrative Medicare certification / recertification inpatient psych paper form

Illustrative Medicare conditions of payment monitoring check-list (Utilized by Case Management for pre-discharge record review)

- Patient name
- Date of birth
- Race
- Primary insurance
- Admission date
- Discharge date
- Length of stay
- Verbal/telephone order present (Date, time, ordering provider name, and RN notation)
- Valid Order Present - Signed prior to discharge (Date, time, provider name and signature)
- Valid Certification for Psych - Signed prior to discharge (Date, time, provider name and signature)
- Valid Recert Present (12th day, if applicable) - Signed on 12th day (Date, time, provider name and signature)
- Valid Recert Present (30th day, if applicable) - Signed on every 30th day since the last recertification (Date, time, provider name and signature)
- Valid Involuntary Hospitalization Form - Signed at the time of hospitalization as applicable (Confirm Box G is checked) (Date, time, provider name and signature)
- Initial Psychiatric Evaluation (Visit date, provider name, signature, date and time; Notes supporting medical necessity and expectation for improvements)
Monitoring and auditing plan

A continued monitoring and frequent auditing plan will ensure that claims submitted to governmental payors are compliant and will not be subject to denial or recoupment actions.

**Pre-bill**
- Reviewing content and timeliness of certification and recertification
- Assessment of documentation for conditions of payment and conditions of participation
- Training and documentation of training for providers and case management
- Case management’s focused review of inpatient stays longer than 12 days for medical necessity and post-acute placement

**Post-billing**
- Review of paid claims for compliance with payment and medical necessity requirements
- Monitoring of ADR or other audit requests from regulators and appropriate response preparation
- Continued training for providers and case management staff

Outpatient psychiatry hospitalization services

Medicare requirements for outpatient psychiatry services

Medicare Part B (Medical Insurance) helps cover mental health services and visits with these types of health professionals (deductibles and coinsurance may apply):
- Psychiatrist or other doctor (must accept assignment if they participate in Medicare)
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant

Sources: Centers for Medicare & Medicaid Services; Medicare & your mental health benefits, Section 1: Outpatient mental healthcare & professional services
General outpatient hospital psychiatric services

Medicare requirements and Covered and non-covered services

The outpatient psychiatric hospital services and supplies must be

- Medically reasonable and necessary
- Furnished under an individualized written plan of care (POC)
- Supervised and periodically evaluated by a physician

<table>
<thead>
<tr>
<th>Covered outpatient services</th>
<th>Non-covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual and group therapy</td>
<td>Meals and transportation</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Activity therapies, group activities or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered</td>
</tr>
<tr>
<td>Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients</td>
<td>&quot;Geriatric day care&quot;</td>
</tr>
<tr>
<td>Drugs and biologics</td>
<td>Psychosocial programs</td>
</tr>
<tr>
<td>Activity therapies</td>
<td>Vocational training</td>
</tr>
<tr>
<td>Family counseling services</td>
<td></td>
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<tr>
<td>Patient education programs</td>
<td></td>
</tr>
<tr>
<td>Diagnostic services</td>
<td></td>
</tr>
</tbody>
</table>

Source: Medicare, Section 1861, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B

General principles of medical record documentation

- Medical records should be complete and legible
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history
  - Physical examination findings and prior diagnostic test results
  - Assessment, clinical impression, and diagnosis
  - Plan for care
  - Date and legible identity of observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible for treating and/or consulting physician
- Appropriate health risk factors should be identified
- Patient’s progress, response to changes in treatment, and revision of diagnosis should be documented
- CPT and ICD-9-CM codes reported on the health insurance claim should be supported by documentation in the medical record

Partial hospitalization programs

Medicare requirements

- Medicare may cover partial hospitalization:
  - If the services are provided as an alternative to inpatient psychiatric care
  - If the treatment is provided during the day and doesn’t require an overnight stay
  - Services provided through hospital outpatient department or community mental health center
- Services covered:
  - Occupational therapy that’s part of the mental health treatment
  - Individual patient training and education about their condition
- The following program and patient criteria must be met:
  - Individual plan of care
  - Multidisciplinary team approach
  - Treatment goals
  - Comprehensive, highly structured and scheduled multimodal treatment
  - Ability to cognitively and emotionally participate

Medicare requirements (cont’d)

Content requirements:
- The individual would require inpatient psychiatric care if the partial hospitalization services were not provided.
- The services are or were furnished while the individual was under the care of a physician.
- The services were furnished under a written plan of treatment.

Plan of treatment requirements:
- The plan is an individualized plan that is established and is periodically reviewed by a physician in consultation with appropriate staff participating in the program, and that sets forth—
  - The physician’s diagnosis
  - The type, amount, duration, and frequency of the services
  - The treatment goals under the plan
- The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient’s condition.

Sources: Centers for Medicare & Medicaid Services, Medicare & your mental health benefits, Section 1: Outpatient mental healthcare & professional services; Centers of Medicare & Medicaid Services, Medicare Learning Network, SE0816, Medicare Payments for Part B Mental Health Services
The recertification must indicate that:

- 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
- Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program

Timing and signature requirements:

- The first recertification is required as of the 18th day of partial hospitalization services. Subsequent re-certifications are required at intervals established by the provider, but no less frequently than every 30 days.

Common challenges and leading practices

<table>
<thead>
<tr>
<th>Coding concerns</th>
<th>Leading practices</th>
</tr>
</thead>
</table>
| Individual psychotherapy claims may lack documentation to justify the time billed:  
  - Individual psychotherapy can be billed as one of three time periods: 20 to 30 minutes, 45 to 50 minutes, or 75 to 80 minutes;  
  - When the documentation waived face-to-face time spent, the services are billed at lowest possible time period | Continuously review processes and workflow. Focus on ensuring the running of a high quality coding department.  
  - Analysis of internal data to identify trends and outliers.  
  - Benchmarking of internal data with external data to identify if internal trends are in line with national and state average.  
  - Based on internal and external benchmarking, focused chart review and detect root causes for any errors. Focused chart review of target CPTs and providers. |
| Medical history documentation | Medical history documentation is missing.  
  - Missing documentation around diagnosis, mental status examination, and psychiatric history. | |
Discussion/questions

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Appendix
§424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities

### Physician certification

**As a condition of payment for hospital inpatient services under Medicare Part A, according to section 1814(a) of the Social Security Act, CMS is requiring, only for long-stay cases and outlier cases, separate physician certification of the medical necessity that such services be furnished.**

- **The reason for continued hospitalization** - The physician certifies the reason for either (i) continued hospitalization of the patient for inpatient medical treatment or medically required diagnostic study or (ii) special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. For example, documentation of an admitting diagnosis and/or FTEA: this part of the certification requirement.
- **The estimated time the patient will need to remain in the hospital** - For the purposes of meeting the requirement for certification, updated or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.
- **The plans for post hospital care, if appropriate**

Sources: Centers for Medicare & Medicaid Services, Medicare Learning Network, Mental health services, ICN 903195.

### Timing:

- The certification must be signed and documented no later than 30 days into the hospital stay.
- Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. For all other long stay cases, the certification must be signed and documented no later than 30 days into the inpatient portion of the hospital stay.

### Signature requirement:

Certifications must be signed by the physician (a doctor of medicine or osteopathy) responsible for the case, or by another physician knowledgeable of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

### Format:

- As specified in 42 CFR 414.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the responsible individual signs, or on a separate separate form or draft as part of the medical record. Certifications and recertifications must be a separate signed statement for each certification or recertification. If all certifications and recertifications are on the discharge summary, the provider must indicate the dates that the individual’s medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

### General outpatient hospital psychiatric services

#### Medicare requirements

- **The outpatient psychiatric hospital services and supplies must be**
  - Medically reasonable and necessary for the purpose of diagnostic study or be reasonably expected to improve the patient’s condition.
  - Furnished under an individualized written plan of care (POC) that states:
    - The type, amount, frequency, and duration of services to be furnished
    - The diagnosis
    - Anticipated goals (except when only a few brief services are furnished)
  - Supervised and periodically evaluated by a physician who
    - Prescribes the services
    - Determines the extent to which treatment goals have been reached and whether changes in direction or emphasis are needed
    - Provides supervision and direction to the therapists involved in the patient’s treatment
    - Documents his or her involvement in the patient’s medical record
    - For the purpose of diagnostic study or, at a minimum, designed to reduce or control the patient’s psychiatric symptoms to prevent a relapse or hospitalization and improve or maintain the patient’s level of functioning.
Partial hospitalization programs

Reasonable and necessary services:
Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient hospitalization. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable expectation of improvement for mental health services:
- Services furnished under partial hospitalization programs must be for the purpose of diagnostic study or be reasonably expected to improve the patient’s condition.
- The treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning.
- 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 prevent hospitalization.

Summary:
Medicare may cover partial hospitalization:
- If the services are provided to patients as an alternative to inpatient psychiatric care.
- If the treatment is provided during the day and doesn’t require an overnight stay.
- Services provided through hospital outpatient department or community mental health center.

Medicare requirements (cont’d)

In accordance with 42 CFR Parts 400 and 410, partial hospitalization services for Medicare purposes, means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and that furnishes services to patients who either:
- Have been discharged from inpatient hospital treatment, and the PHP is in lieu of continued inpatient treatment; or
- Would be at reasonable risk of requiring inpatient hospitalization in the absence of partial hospitalization.

A PHP, for Medicare purposes, is a program that is furnished by a hospital to its outpatients or by a CMHC that provides partial hospitalization services.

The following program and patient criteria must be met:
- Active treatment is furnished that incorporates an individualized POC with a coordination of services designed for the needs of the patient.
- Treatment includes a multidisciplinary team approach to care under the direction of a physician who certifies the patient’s need for partial hospitalization and for a minimum of 20 hours per week of therapeutic services, as evidenced by the POC.
- Treatment goals should be measurable, functional, time-framed, medically necessary and directly related to reason of admission.
- The patient requires comprehensive, highly structured and scheduled multimodal treatment that incorporates multiple disciplines and coordination within or individualized PHP because of a mental disorder that severely interferes with multiple areas of daily life (social, vocational, ADLs/IADLs, instrumental ADLs, and/or educational functioning).
- The patient is able to cognitively and emotionally participate in the active treatment process and is capable of tolerating the intensity of a PHP.

State-specific requirements
Local coverage determination
Massachusetts

In addition to Federal requirements, there may be state-specific regulations or guidelines that are covered by Local Coverage Determinations (LCD) for a given MAC jurisdiction. National Government Services, Inc. (NGS) has

General documentation requirements:
- Documentation to support medical necessity and active treatment
- Certification of the inpatient psychiatric facility

Initial psychiatric evaluation:
The initial psychiatric evaluation with medical history and psychological assessment is required at the time of admission. Inpatient facilities must have an individualized, comprehensive, outcome-oriented plan of care and treatment.

Frequency and duration of services: Reasonable expectation of improvement:
- Improvement in this context is measured by a reasonable expectation of improvement. This includes improvement in symptoms, and results of any diagnostic testing, plans for continued treatment or discharge.
- Frequency and duration of services may be covered. As long as the symptoms, and results of any diagnostic testing, plans for continued treatment or discharge.
- Reasonable expectation of improvement:
- Improvement in this context is measured by a reasonable expectation of improvement. This includes improvement in symptoms, and results of any diagnostic testing, plans for continued treatment or discharge.
- Services must be received or furnished directly by the patient's attending physician or the treating facility. The services may be furnished in an inpatient or outpatient setting.

Certification of the inpatient psychiatric facility:
To certify that the inpatient psychiatric facility admission was medically necessary for treatment which could reasonably be expected to achieve improvement in the patient's condition, or diagnostic study.

Restrain can be authorized by:
- A licensed independent clinical social worker or a qualified psychologist or a licensed professional clinical social worker.
- A qualified nurse practitioner or a qualified physician assistant.
- A consulting psychiatrist.
- A patient's legal representative.
- A person who has attained the age of sixteen years (section 10 & 12).

Voluntary and involuntary forms
Massachusetts

Voluntary and involuntary examination and commitment forms are also usually governed by state rules and regulations in Massachusetts, M.G.L. Sections 11 and 12 govern voluntary and involuntary admission.

Voluntary examination (section 11)
- The superintendent may require and retain on a voluntary basis any person providing the superintendent with a written request for such examination and the attending facility is suitable for such care and treatment.
- The examination may be made:
  - By a licensed independent clinical social worker or psychologist or a qualified nurse practitioner or a medical health specialist.
  - By a qualified psychologist or licensed professional clinical social worker.
- The superintendent may discharge any person admitted at any time he deems such care and treatment unnecessary or inappropriate.
- Permission to leave the facility shall be given by the person examined or in the case of a person under guardianship, by the guardian of the person.
- The superintendent may discharge any person at any time he deems such care and treatment unnecessary or inappropriate.
- Permission to leave the facility shall be given by the person examined or in the case of a person under guardianship, by the guardian of the person.

Involuntary examination (section 12)
- The superintendent may require and retain on a voluntary basis any person providing the superintendent with a written request for such examination and the attending facility is suitable for such care and treatment.
- The examination may be made:
  - By a licensed independent clinical social worker or psychologist or a qualified nurse practitioner or a medical health specialist.
  - By a qualified psychologist or a licensed professional clinical social worker.
  - By the guardian of the person on behalf of a person under his guardianship.
  - By a person who has attained the age of sixteen years.
- The superintendent may discharge any person admitted at any time he deems such care and treatment unnecessary or inappropriate.
- Permission to leave the facility shall be given by the person examined or in the case of a person under guardianship, by the guardian of the person.
- The superintendent may discharge any person at any time he deems such care and treatment unnecessary or inappropriate.
- Permission to leave the facility shall be given by the person examined or in the case of a person under guardianship, by the guardian of the person.

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