Psychiatric Inpatient Coverage Guidelines

Medicare Advantage Medical Policy #077
Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services Are Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider Inpatient Psychiatric care to be **eligible for coverage.****

Preauthorization by the Health Plan is required.

Patient Selection Criteria
Coverage eligibility will be met:

- Services are medically necessary for treatment which could reasonably be expected to improve the patient's condition: or, diagnostic study.******
- Services must meet the definition of "active treatment" as defined in the Medicare Benefit Policy Manual, Chapter 2, "Inpatient Psychiatric Hospital Services," §20.
- Patients must require Psychiatric Hospital admission for active treatment of a mental health condition that can only be provided appropriately in an inpatient hospital setting.

Policy Guidelines

- Providers will meet all documentation requirements identified in 42 CFR, Chapter IV, Subchapter G, Part 482, Subpart E, §482.61 and the Medicare Benefits Policy Manual, Chapter 2.
- Requirements for service delivery and documentation for admitted patients include but are not limited to the following:
    - Assessment and diagnostic data to include provisional diagnosis upon admission.
    - Psychiatric evaluation completed within 60 hours of admission.
    - Treatment plan based on the patient's strengths and disabilities which includes a substantiated diagnosis, short- and long-term goals, treatment modalities used, responsibilities of treatment team members, and adequate documentation to justify the activities carried out.
    - Hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services

- Physicians will also be required to recertify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.
- Progress notes that are legible and in accordance with applicable laws and hospital policies by qualified practitioners.
- Discharge plans and summary should be submitted upon discharge.

Background/Overview

Inpatient Psychiatric Hospital Services for inpatient levels of care are covered when criteria for admission are met. All inpatient services must be reasonable and necessary to be covered by the MA plan. Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they relate to the member's clinical circumstances.

In accordance with 42 CFR 412.27(c), for all IPFs, a provisional or admitting diagnosis must be made on every patient at the time of admission and must include the diagnosis of comorbid conditions as well as the psychiatric diagnosis. The reasons for admission must be clearly documented as stated by the patient or others significantly involved, or both. Psychiatric hospitals are required to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons, according to 42 CFR 412.23(a). Distinct part psychiatric units of acute care hospitals and CAHs are required to admit only those patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References

1. Medicare Benefit Policy Manual, Chapter 2, Inpatient Psychiatric Hospital Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c02.pdf

2. Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A. Https://www.cms.gov/Regulations-And-Guidance/Guidance/Manuals/Downloads/Bp102c01.pdf.
3. InterQual Solution. https://www.changehealthcare.com/clinical-decision-support
4. Code of Federal Regulations, 42 CFR, Chapter IV, Subchapter G, Part 482, Subpart E, §482.61
5. Code of Federal Regulations, 42 CFR, Chapter IV, Subchapter B, Part 412, Subpart B, §412.27
6. Medicare General Information, Eligibility, and Entitlement Manual, Pub #100-01, Chapter 4, §10.9 - 10.9 - Inpatient Psychiatric Facility Services Certification and Recertification https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf

Policy History

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Current Effective Date: 03/01/2025
11/19/2024 Utilization Management Committee review/approval. New policy
Next Scheduled Review Date: 02/2026

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®

Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.