# Medicare Program Integrity Manual

**Department of Health and Human Services (DHHS)**
**Centers for Medicare and Medicaid Services (CMS)**

**Transmittal 15** **Date: OCTOBER 29, 2001**

**CHANGE REQUEST 1831**

| CHAPTERS | REVISED SECTIONS | NEW SECTIONS | DELETED SECTIONS |
|---|---|---|---|
| 6 | 15.1, 15.2, 15.4 | | 15.2A-15.2D, 15.3 |
| | | | |
| | | | |
| | | | |

**NEW/REVISED MATERIAL--EFFECTIVE DATE: August 2, 2001**
**IMPLEMENTATION DATE: December 13, 2001**

**CLARIFICATION/MANUALIZATION--EFFECTIVE/IMPLEMENTATION DATE: Not Applicable**

**Chapter 6, Section 15, MR of Partial Hospitalization Claims,** clarifies the circumstances under which contractors should issue "technical denials" and when they should issue 1862(a)(1)(A) denials. Removes language that could have been construed as a National Coverage Determination or coverage provision in an interpretive manual. Moves some examples from the benefit category list to the reasonable and necessary list.

**These instructions should be implemented within your current operating budget.**

# Medicare Program Integrity Manual

## Chapter 6 - Intermediary MR Guidelines for Specific Services

Table of Contents



### 15.1 – General – (Rev.)

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

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

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

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

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

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

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

## 15.2 - Bill Review Requirements - (Rev.)

*When contractors conduct medical* review of partial hospitalization bills*, they must do so* in accordance with applicable MIM sections. For partial hospitalization services provided by CMHCs see MIM §3651, §3604 (except §3651.C).

## 15.4 - Reasons for Denial - (Rev. )

For all selected claims, review medical documentation and determine whether the services provided were covered. The reviewer should apply the criteria in the following order (benefit category requirements, statutory exclusions, then reasonable and necessary) when making a payment determination. In order to be covered, a service must meet all three of the following criteria. *Contractors must be very careful in choosing which denial type to use since providers cannot appeal benefit category and statutory exclusion denials, since beneficiaries' liability varies based on denial type, and since certain types of denials cannot be billed to Medicaid and other secondary payors. Contractors should use the guidelines listed below in selecting the appropriate denial reason.*

### A - Make A Benefit Category Determination

*In order to meet the benefit category requirements described in the statute, regulations, and national coverage provisions of the MIM, a provider's medical record must contain two things at the time of initial certification:*

1. *A **statement** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services (referred to as an "in lieu of" statement) and the establishment of an initial plan. This statement/plan must be signed by a physician. Either this statement/plan must be dated or there must be evidence in the medical record that the statement/plan was made within the required timeframe (MIM 3194.2.A).*

   ***Example** 1: The beneficiary is admitted on January 24th. The progress notes reveal an entry by a nurse dated Jan 25th , followed by an undated "in lieu of" statement and initial plan signed by a physician, followed by an entry by a nurse dated Jan 26th. In this example, there is evidence that the statement was made and /initial plan was established at the time of admission and the contractor should **not** issue a benefit category denial.*

2. *A comprehensive treatment plan reviewed by a treating physician. Such a plan may be a) included in the treatment notes, progress notes, or group notes, etc. and/or b) written on a separate "careplan" document in the medical record. The treating physician may indicate that the comprehensive treatment plan has been reviewed by signing a separate "careplan" document or by indicating in a progress note that the treatment plan was reviewed. Either this comprehensive treatment plan must be dated or there must be evidence in the medical record that the comprehensive treatment plan was reviewed within the required timeframe (MIM 3194.2.C). There must be some evidence that the*

*plan is complete (e.g., contains goals, as well as amount/duration/frequency of most modalities).*

*Example 2: The contractor finds a progress note (which is dated or where the date can be inferred) written by a treating physician which reads: "Interviewed pt. Improving slightly with meds. Less frequent hallucinations. Have reviewed treatment and talked with staff. Pt is participating in program. Should continue. Will see pt in a few days." In this example, there is evidence that the comprehensive treatment plan was reviewed by a treating physician.*

*Example 3: The contractor finds in the progress notes an indication of the amount, duration, and frequency for 2 of the 6 modalities. In this example, there is some evidence that the comprehensive treatment plan is complete, and thus the contractor would not issue a benefit category denial.*

*In order to meet the benefit category requirements described in the statute, regulations, and national coverage provisions of the MIM, a provider's medical record must contain at the time of recertification:*

1. *A **statement (signed by a treating physician)** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization services. Either this statement must be dated or there must be evidence in the medical record that the statement was made within the required timeframe (MIM 3194.2.B)*

2. *Some evidence that a treating physician has periodically reviewed the comprehensive treatment plan within the required timeframe.*

   *Example 4: The contractor finds a progress note (which is dated or where the date can be inferred) written by a treating physician that which reads: "Pt is progressing. No hallucinations. Careplan reviewed. " In this example, there is evidence that the physician reviewed the treatment plan, and thus the contractor would not issue a benefit category denial.*

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

*At Initial Certification*

- *A **statement (signed by a physician)** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization service and initial plan is not present in the medical record or there is no evidence that the required timeframes were met;*

- *A comprehensive treatment plan is not present in the medical record or there is no evidence that the required timeframes were met;*

*At Recertification*

- *A **statement (signed by a treating physician)** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization service is not present in the medical record or there is no evidence that the required timeframes were met.*

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

**B - *Make A Statutory Exclusion Determination***

*In order for billed services to be considered statutorily excluded from coverage, the services must be* excluded from coverage under any provision in §1862(a) of the Act *other than 1862(a)(1) medical necessity and 1862(a)(9) custodial care.*

*Statutory Exclusion* denials are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1).

**C - *Make A* Reasonable and Necessary *Determination***

*In order to meet the reasonable and necessary requirements described in the statute, regulations, and national coverage provisions of the MIM, a provider's medical record must contain at the time of initial certification:*

- *Evidence supporting the physician's **statement** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization service;*

- *Evidence that is consistent with the comprehensive treatment plan and sufficient evidence demonstrating that the comprehensive treatment plan is complete (e.g., includes a description of the modalities being used -- including amount, duration, and frequency, goals, and all the other requirements listed in MIM 3194.2.C). If the treatment plan is incomplete, the reviewer should use clinical judgement to determine whether sufficient evidence exists that the services are reasonable and necessary.*

*In order to meet the reasonable and necessary requirements described in the statute, regulations, and national coverage provisions of the MIM, a provider's medical record must contain at the time of recertification:*

- *Evidence that the medical record addresses the patient's response to the therapeutic interventions provided by the PHP, the patient's psychiatric symptoms that continue to place the patient at risk of hospitalization, and treatment goals for coordination of services to facilitate discharge from the PHP.*

The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a partial hospitalization program;

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

- *The **statement** that the beneficiary would require inpatient psychiatric care in the absence of partial hospitalization service is present but is not supported by the medical record. For example:*

    - *Patients who are otherwise psychiatrically stable or require medication management only;*

- *There is no evidence that the physician has reviewed the **comprehensive treatment plan** within the required timeframes;*

- *A treatment plan is present but is not adequate (e.g., fails to includes a sufficient description of the modalities being used -- including amount, duration, and frequency, goals, and all the other requirements listed in MIM 3194.2.C). If the treatment plan is missing one or two of the required elements, the reviewer should use clinical judgement to determine whether the plan is adequate to support the reasonableness and necessity of the services.*

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