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# Medicare Hospital Manual

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Department of Health and  
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HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

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Section 230.5, Outpatient Hospital Psychiatric Services, is edited for consistency with PM-A-99-39.

Section 230.7, Outpatient Partial Hospitalization Programs (PHP), is created to include medical review instructions from PM-A-99-39

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

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## CHAPTER II

### Section

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Additional examples of covered items are surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations; prosthetic devices; and leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes. (See §§228.3-228.5 for details on coverage of these items.)

### 230.5 Outpatient Hospital Psychiatric Services.--

A. General.--There is a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs and from intensive treatment programs to those that provide primarily supportive, protective, or social activities. Because of this diversity, it must be ensured that payment is made only for covered services that meet the requirements of the outpatient hospital benefit.

In general, to be covered the services must be: (1) incident to a physician's service (see §230.4.A), and (2) reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonable be expected to improve the patient's condition.

B. Coverage Criteria.--The services must meet the following criteria:

1. Individualized 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 services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)

2. Physician Supervision and Evaluation.--Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

3. Reasonable Expectation of Improvement.--Services must be for the purpose of diagnostic study or reasonably be 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 the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

C. Partial Hospitalization--Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. See section 230.7 for specific program requirements.

D. Application of Criteria--The following discussion illustrates the application of the above guidelines to the more common modalities and procedures used in the treatment of psychiatric patients and some factors that are considered in determining whether the coverage criteria are met.

1. Covered Services--Services generally covered for the treatment of psychiatric patients are:

- o Individual and group therapy with physicians, psychologists, or other mental health professionals authorized by the State.

- o Occupational therapy services are covered if they meet the criteria in §210.9. The services must require the skills of a qualified occupational therapist and be performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.

- o Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.

- o Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered. (See §230.4B.)

- o Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

- o Family counseling services. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition. (See Coverage Issues Manual, §35-14.)

- o Patient education programs, but only where the educational activities are closely related to the care and treatment of the patient. (See Coverage Issues Manual §80-1.)

- o Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan.

2. Noncovered Services--The following are generally not covered except as indicated:

- o Meals and transportation.

- o 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.

"Geriatric day care" programs are available in both medical and nonmedical settings. They provide social and recreational activities to older individuals who need some supervision during the day while other family members are away from home. Such programs are not covered since they are not considered reasonable and necessary for a diagnosed psychiatric disorder, nor do such programs routinely have physician involvement.

o Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. **Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they are covered.** However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.

o Vocational training. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered. (See §210.9B.)

3. Frequency and Duration of Services.--There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria discussed in §230.5B.3 to determine whether with continued treatment there is a reasonable expectation of improvement.

#### 230.6 Outpatient Observation Services.--

A. Outpatient Observation Services Defined.--Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed 1 day. Some patients, however, may require a second day of outpatient observation services. In only rare and exceptional cases do outpatient observation services span more than two calendar days.

B. Coverage of Outpatient Observation Services.--Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. (See §210 regarding coverage of inpatient admissions.) When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient. If a patient is retained on observation status for 48 hours without being admitted as an inpatient, further observation services will be denied as not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A maximum of 48 hours of observation may be reimbursed. Count as the first hour the time of admission to an observation bed.

C. Notification of Beneficiary.--If you intend to place or retain a beneficiary in observation for a noncovered service, you must give the beneficiary proper written advance notice of noncoverage under limitation on liability procedures. Noncovered, in this context, refers to such services as those listed in §230.6E.

D. Exception to Denial of Services After 48 Hours.--A hospital that believes exceptional circumstances in a particular case justify approval of additional time in outpatient observation status may request an exception to the denial of services from their fiscal intermediary. HCFA expects such cases to be rare, and is currently unable to envision any scenario in which a hospital's retaining

a patient in outpatient observation status for more than 48 hours without admitting him or her as an outpatient would be appropriate. However, because unforeseeable circumstances could arise, HCFA is providing for the possibility of exceptions.

1. Timing of Exception Request--There is no preauthorization of exception requests. A hospital that believes exceptional circumstances in a particular case justify approval of additional time in outpatient observation status may request an exception to the denial of further observation services at the time of billing.

2. Content of Exception Request--Request an exception by billing for additional hours on the same claim form. The intermediary will suspend the claim and ask for complete medical documentation for review of the medical necessity of all observation services billed.

3. Intermediary Review of Exceptions--HCFA expects approvable exception requests to be rare. HCFA asks the fiscal intermediary to use careful judgment in evaluation of the medical documentation submitted by a hospital with its bill.

E. Services Which Are Not Covered as Outpatient Observation--The following types of services are not covered as outpatient observation room services:

o Observation services which exceed 48 hours, unless the fiscal intermediary grants an exception based on the particular facts of the case. (See §230.6C.)

o Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, his or her family, or a physician (e.g., following an uncomplicated treatment or a procedure; physician busy when patient is physically ready for discharge; patient awaiting placement in a long-term care facility).

o Services which are covered under Part A, such as a medically-appropriate inpatient admission, or as part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those diagnostic services. Observation should not be billed concurrently with therapeutic services such as chemotherapy.

o Standing orders for observation following outpatient surgery. Note that the availability of outpatient observation does not mean that procedures such as cardiac catheterization, angioplasty, stent placement, or administration of tissue plasminogen activator, for which an overnight stay is anticipated, may be performed on an outpatient basis. See §210 regarding coverage of inpatient admissions.

o Services which were ordered as inpatient services by the admitting physician, but billed as outpatient by the billing office.

o Outpatient claims for inpatient care, such as complex surgery clearly requiring an overnight stay.

Claims for the preceding services will be denied as not reasonable and necessary, under §1862(a)(1)(A) of the Social Security Act. This will include denying claims for services which are not medically necessary, which duplicate other services, or which are provided in inappropriate settings.

**NOTE:** An inpatient is not considered to have been discharged if the patient is placed in outpatient observation status after an inpatient hospital admission. Any such services will not be recognized for payment outside the DRG payment for the admission.

The following examples illustrate the application of this policy, including example 4, when a decision to admit the patient is clearly justified.

**EXAMPLE 1:** A patient comes to the emergency room complaining of difficulty in breathing. The patient is seen by the physician on duty, who orders laboratory tests, including a blood gas analysis, and an injection to help the patient breathe more easily. The physician then has the patient placed in an outpatient observation unit to determine whether this intervention produces normal breathing. Six hours later the patient is again seen by the physician, who determines from the patient's chart and his or her own observation that the patient's vital signs are normal and the patient has resumed normal breathing. The patient is released. Under these circumstances, the outpatient observation services are covered, and the bill submitted by the hospital may include charges for those services.

**EXAMPLE 2:** A patient comes to a hospital's outpatient department to undergo a scheduled surgical procedure. After surgery, the patient is taken to the recovery room, where the patient exhibits difficulty in awakening from anesthesia and an elevated blood pressure. These conditions persist throughout the usual recovery period, and the patient is seen by a physician, who has the patient placed on observation. The physician leaves orders for the nursing staff to monitor the patient's condition and note any continued abnormalities that could indicate a drug reaction or other post-surgical complications. After a few hours in observation, the patient no longer is lethargic, has a normal blood pressure and shows no other signs of post-surgical complications. The physician, upon being advised of these conditions, orders the patient released from the hospital. Under these circumstances, coverage of outpatient observation services begins when the patient was placed in the observation bed. Services received in the hospital's outpatient surgical suite and recovery room cannot be covered as observation services, since they are otherwise covered.

**EXAMPLE 3:** A patient is scheduled to have an uncomplicated cataract extraction on an outpatient basis. The patient expresses a preference for spending the night following the procedure at the hospital despite the fact that the procedure does not require an overnight stay. The hospital may register and treat the patient on an outpatient basis and permit the patient to remain at the hospital overnight. The overnight stay cannot be covered as observation services because it is not medically necessary. (When this is the case, the patient must be notified in advance that the overnight stay is not medically necessary and that he or she can be charged for the additional services. If unforeseen complications necessitate inpatient admission, the patient is admitted and a Part A claim is submitted.)

**EXAMPLE 4:** A patient comes to the emergency room in the evening with complaints of sudden severe flank pain which radiates to the inner thigh, nausea, vomiting, and urinary frequency and urgency. Examination reveals soreness over the kidney area, spasm of the abdominal muscles and microscopic hematuria. Additionally, an x-ray reveals the presence of a stone in the ureter. The patient is admitted to the hospital as an inpatient at 11:00 p.m. The patient is treated with I.V. fluids, IM Morphine and an antispasmodic every 4 hours. Further diagnostic studies are scheduled for



the following morning. During the night, the patient passes a stone through the urethra without complications. The patient is then comfortable without nausea or urinary symptoms. Therefore, the patient is discharged at 9:00 a.m. and scheduled for follow-up in the physician's office. Although the patient was able to be discharged in less than 24 hours, the admission was appropriate, because it was reasonable to expect at the time of admission that the problem presented required more than 24 hours to resolve.

**230.7 Outpatient Partial Hospitalization Programs (PHP).**--Outpatient PHPs are structured to provide intensive psychiatric care by providing active treatment which utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act. The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

**A. Program Criteria.**--PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified CMHR.

Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

**B. Patient Eligibility Criteria.**--

**1. Benefit Category.**--Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature.

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patient's psychiatric condition requiring active treatment in a PHP.

Discharge planning from PHP may reflect the types of best practices recognized by professional and advocacy organizations which ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.

2. Covered Services.--Items and services that can be included as part of the structured, multimodal active treatment program, identified in §1861(ff)(2) include:

- o Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);

- o Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual;

- o Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;

- o Drugs and biologicals that cannot be self administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);

- o Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;

- o Family counseling services for which the primary purpose is the treatment of the patient's condition;

- o Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition; and

- o Medically necessary diagnostic services related to mental health treatment.

Partial hospitalization services which make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

3. Reasonable and Necessary Services.--This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. 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 to prevent hospitalization.

Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the PHP. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Patients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

#### 4. Reasons for Denial.--

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

- o Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;

- o Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or

- o Patients who are otherwise psychiatrically stable or require medication management only.

b. Coverage denials made under §1861(ff) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Social Security Act:

- o Services to hospital inpatients;

- o Meals, self-administered medications, transportation; and

- o Vocational training.

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

- o 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 PHP; or

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

5. Documentation Requirements and Physician Supervision--The following components will be used to help determine whether the services provided were accurate and appropriate.

a. Initial Psychiatric Evaluation/Certification--Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

b. Physician Certification Requirements--

o Signature – The physician certification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

o Timing – The first certification is required as of the 18 calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

o Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

-- 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.

c. Treatment Plan--Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the patient's response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

d. Progress Notes.--Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

