Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1809 **Date: SEPTEMBER 15, 2000**

CHANGE REQUEST 882

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3005.3 - 3008.2	3-9 - 3-9.3 (4 pp.)	3-9 - 3-9.3 (4 pp.)
Table of Contents - Chapter II	3-26.3 (1 p.)	3-26.3 (1 p.)
3112.7 - 3112.8	3-38.7 - 3-38.10 (4 pp.)	3-38.7 - 3-38.10 (4 pp.)
3194.1 - 3194.2 (Cont.)	3-64.37 - 3-64.41 (5 pp.)	----------

This revision manualizes Program Memorandum A-99-39, Change Request 882, dated September 1999.

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

Section 3194, Partial Hospitalization Services, is a new section manualizing medical review instructions for coverage of partial hospitalization services.

NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 16 ,2000*
IMPLEMENTATION DATE: October 16, 2000

Section 3007, Under Arrangements, adds a paragraph applicable to Community Mental Health Centers (CMHC) that provide the Public Health Services required core services. This paragraph specifies the provider agreement requirements for providing these services under arrangement and makes the manual consistent with the language in the State Operations Manual.

Section 3112.7, Outpatient Hospital Psychiatric Services, makes editorial changes to sections C. and D.2.c., that distinguish partial hospitalization services from other Medicare covered outpatient psychiatric services.

Section 3194, Partial Hospitalization Services, includes new material at §3194.2 on physician recertification requirements as published in the Medicare Prospective Payment System for Hospital Outpatient PHP recertification requirements; 42 CFR 424.24(e).

These instructions should be implemented within your current operating budget.

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.

on or after the effective date of the agreement will require that the provider have a recordkeeping capability sufficient for determining the cost of services furnished Medicare beneficiaries.

The termination of participation (§3008) does not immediately abrogate all of the provider's responsibilities and in specific matters a responsibility may extend beyond the effective date of termination. For example, the provider continues to be responsible (as applicable) for those provisions of the law and regulations which provide for program coverage to remain in effect for specified periods of time beyond the effective termination date, for those beneficiaries who were accepted for care and treatment by the provider before such date. The provider also continues to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

3005.2 Term of Agreement With Providers Other than SNFs.--With the exception of agreements with skilled nursing facilities, an agreement with a provider of services (§3005) is not time-limited and has no fixed expiration date. These agreements remain in effect until such time as there is a voluntary termination (§3008.1), an involuntary termination (§3008.2), or an invalidation of the agreement by reason of change of ownership (§3009).

3005.3 Term of Agreement With SNFs.--All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. In appropriate situations, the agreement may also contain a cancellation clause. Therefore, when it is determined that a skilled nursing facility is eligible and that its agreement for participation in the Medicare program will be accepted for filing, the term of the agreement will be determined in the following manner:

A. No Deficiencies.--Where the facility is certified as being in full compliance with all standards contained in the conditions of participation for skilled nursing facilities, the term of the agreement will, as appropriate to the period of certification for which the facility has been approved, be for a term of up to 12 full calendar months.

B. Deficiencies.--Where the facility is certified as not being in full compliance with all standards contained in the conditions of participation for skilled nursing facilities, the term of the agreement will, as appropriate to the period of certification or conditional period of certification for which the facility has been approved:

1. Be for a term which expires no later than the close of the 60th day following the last day of the time period specified in the facility's written plan providing for the correction of deficiencies in meeting the conditions of participation, provided that such term will not exceed 12 full calendar months; or,

2. Provide a conditional term of up to 12 full calendar months, subject to a cancellation clause that the agreement may be cancelled on a predetermined date which shall be no later than the close of the 60th day following the last day of the time period specified in the facility's written plan providing for the correction of deficiencies in meeting the conditions of participation, provided that such date will occur within such 12-month term.

If the health and safety of Medicare patients will not be jeopardized thereby, the term of an agreement may be extended for 2 full calendar months where it is found necessary to prevent

irreparable harm to the facility; or to prevent hardship to Medicare beneficiaries being furnished care by the facility; or if it is found to be impracticable within the term of the agreement to determine whether the facility is complying with the provisions of the Act and regulations issued thereunder.

Intermediaries are advised of the term of each SNF agreement by the HCFA regional office.

3006. ADMISSION OF MEDICARE PATIENTS FOR CARE AND TREATMENT.

The participation of a provider of services which voluntarily files an agreement to participate in the health insurance program contemplates that such provider will admit Medicare beneficiaries for care and treatment, and upon admission, will provide them with such services as are ordinarily furnished by the provider to its patients generally. A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by HCFA as a basis for termination of the agreement for cause.

3007. UNDER ARRANGEMENTS.

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the provider must exercise professional responsibility over the arranged-for services.

The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress notes relating to all services received and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders. In the case of home health services and outpatient physical therapy or speech pathology services, the provider must ensure that the required plan of treatment is periodically reviewed by the physician and secure from the physician the required certifications and recertifications. Additionally, the provider (other than an SNF) must ensure that the medical necessity of such services is reviewed on a sample basis by the utilization review (UR) committee if one is in place, the facility's health professional staff or an outside UR group. (Effective October 1, 1990, an SNF is no longer required to have a plan for UR.) The provider, including an SNF that conducts optional UR services, is responsible for medical necessity decisions made under arrangement by an outside group.

In the case of Community Mental Health Centers (CMHCs), Medicare participation is conditioned upon the CMHC providing either directly or under arrangement the core services that are specified in §1913(c)(1) of the Public Health Service Act. A CMHC may provide one or more core services under arrangement with another individual, group, or entity only when the following criteria are met:

1. Service Authorized by State Law.--In no case may a CMHC provide a service under arrangement when the CMHC has not been given authority to provide the service itself directly under State statute, licensure, certification, or regulation.

2. Full Legal Responsibility.--A CMHC that provides a core service under arrangement remains the legally responsible authority through which comprehensive mental health services are provided. It is not sufficient for the arrangement to be a referral process where the CMHC does not assume overall management responsibility for the provision of core services by a separate individual, group, or entity. The CMHC must retain complete accountability for the service(s) provided under arrangement. The CMHC must retain legal, professional, and administrative responsibility to coordinate care, supervise, and evaluate the services, and ensure the delivery of high quality mental health treatment.

3. Written Agreement.--Arrangements must be in writing and accessible to HCFA and its agents.

If a CMHC provides services under arrangement, there must be a written agreement or contract between the two parties that specifies the services to be rendered and the manner in which the CMHC exercises its professional and administrative responsibility. Furthermore, for the agreement to serve as the vehicle through which the CMHC meets the requirement to provide all of the core services, the terms of the agreement must be adhered to in practice. In order to verify the nature of the relationship between the CMHC and the other party, the agreement must be accessible to HCFA or its agents, and the documentation for all services rendered, whether directly or under arrangement, must be maintained by the CMHC at the site identified in the provider agreement.

3008. TERMINATION OF PROVIDER PARTICIPATION

A provider may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

3008.1 Voluntary Termination.--A provider may terminate its agreement (and in the case of a SNF, it may terminate its agreement prior to the close of the specified term of its agreement) by filing with the Secretary a written notice of its intention to terminate the agreement. The Secretary may accept the termination date stated in the notice (the date must be the first day of a month and, in the case of a SNF, must occur within the specified term of such facility's agreement) or set a different date. However, the termination date set by the Secretary may not be more than 6 months from the date the provider's notice is filed. (See Medicare Intermediary Manual, Part 2, §2800.1 for additional information on voluntary termination and the intermediary's role.)

3008.2 Involuntary Termination, Including SNF Agreement Cancellations.--

The Secretary may terminate an agreement (and in the case of a SNF, he/she may terminate its agreement prior to the close of the specified term of the agreement) with a provider if it is determined that the provider:

- Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations;
- No longer meets the appropriate conditions of participation;
- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or

- o Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of an SNF agreement at the close of the predetermined date stated in the cancellation clause contained in such agreement (see §3005.3B) is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable conditions of participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals procedures contained in 42 CFR Part 498. There is no reconsideration step before the opportunity for a hearing.

For the intermediary's role in processing involuntary terminations, see Medicare Intermediary Manual, Part 2, §§2800.3 and 2801-2805.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services, i.e., to be a swing bed facility, (see §3130.1) does not automatically result in the involuntary termination of the hospital's agreement relating to the provision of hospital services.

3008.3 Expiration and Renewal-Nonrenewal of SNF Term Agreements.--All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. When the term of an agreement is extended (see §3005.3), the close of the last day of its specified term is the close of the day of the extension of the agreement. Thus, when the term of an agreement is extended, the provider's participation in the program continues, and the agreement does not expire until the close of the last day to which it has been extended.

Since an agreement with an SNF is not automatically renewable from term to term, each term agreement with an SNF requires that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement form previously accepted for filing provided the SNF continues to qualify for participation and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met, there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

CHAPTER II
COVERAGE OF SERVICES

Facilities who physicians are paid by the initial method may be reimbursed for its five sessions per week, 8 hours per session, intermittent peritoneal self-dialysis training program on the basis of a rate which does not exceed $120 per session, or a total of $600 per week, for each patient for the duration of that patient's training period. Facilities whose physicians are reimbursed under the alternative monthly method may be reimbursed for such a training program based on a rate which does not exceed $112 per session, or a total of $560 per week, for each patient for the duration of that patient's training period. This rate reflects a reduction by a prorated amount of the usual $12 per session reduction in facility reimbursement when its physicians are paid under the alternative method. If the facility does not provide laboratory services, then the screen is reduced by $5, i.e., $115 per session under the initial method or $107 per session under the alternative method.

3112.7 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; from intensive treatment programs to those that provide primarily supportive, protective or social activities. Because of this diversity, ensure 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 §3112.4A), 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 reasonably 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 will be 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 would be 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. Do not deny claims automatically because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, evaluate each case in terms of the criteria discussed above, and deny 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 §3194 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 to consider in determining whether the coverage criteria are met.

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

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

b. Occupational therapy services are covered if they meet the criteria in §3101.9. 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.

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

d. Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered. (See §3112.4B.)

e. 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.

f. 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.)

g. 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.)

h. 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:

a. Meals and transportation.

b. 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.

c. 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 would be covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it would not be covered.

d. 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 §3109.9B.)

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 should 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 §3112.7B.3 to determine whether with continued treatment there is a reasonable expectation of improvement.

3112.8 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 §3101 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, you should deny further observation services 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. The first hour of observation is the time of admission to an observation bed.

3194. PARTIAL HOSPITALIZATION SERVICES

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through 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.

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.

3194.1 Patient Eligibility Criteria.--

A. 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.

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

1. 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).

2. 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.

3. Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients.

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

5. 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.

6. Family counseling services for which the primary purpose is the treatment of the patient's condition.

7. 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.

8. 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 of §1835(a)(2)(F) of the Act unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff) of the Act. 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).

C. 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.

D. Reasons for Denial.--

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

2. 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.

3. 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;

3194.2 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 Recertification Requirements.--

o Signature - The physician recertification 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 recertification is required as of the 18th 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.