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Comments and Responses Regarding Draft Local Coverage Determination: Psychiatric Partial Hospitalization Programs

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Psychiatric Partial Hospitalization Programs (PHP) LCD. The official notice period for the final LCD begins on February 14, 2008, and the final determination will become effective on April 1, 2008.

Comment: Several commenters said the draft LCD did not use the strongest scientific evidence available, yet they did not provide any additional scientific evidence or state where and for what policy parameters scientific evidence was lacking.

Response: The draft LCD does not attempt to recreate a practice guideline for any particular psychiatric condition. It is meant to define under what circumstances it is reasonable and necessary for patients to be admitted to a PHP under Medicare rules and regulations. If there are specific parameters for which additional available scientific research would be germane, providers may submit that at any time for a LCD reconsideration.

Comment: Several commenters wished to see the word “generally” added to the limitation that a PHP patient must have an acute Axis I psychiatric disorder, as defined by the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV). Specifically, the commenters did not want certain Axis II Personality Disorder diagnoses excluded from coverage.

Response: We will add the word “generally” to this section of the LCD and add Axis II diagnoses for which there is evidence to support a PHP level of service to treat the illness.

Comment: The same commenters asked that Borderline Personality Disorder, 301.83, be added to the list of ICD-9 codes that support medical necessity, citing the APA *Practice Guideline for the Treatment of Patients with Borderline Personality Disorder* which recommends PHP as one applicable treatment modality for these patients.

Response: We will add this diagnosis code to the final policy.

Comment: Several commenters pointed to language in the Social Security Act (SSA §1861 [ff]) that describes PHP services as “reasonably expected to improve or maintain the individual’s condition,” where the word “maintain” refers to when no improvement may be expected, a PHP is necessary to support a patient’s level of functioning so that if discharged, the patient would be unable to benefit from a lesser level of psychiatric treatment, decompensate, and require inpatient hospitalization. They asked for language that allows maintenance as a goal of PHP treatment.

Response: A major focus of the draft LCD for PHP is to emphasize the requirement for active treatment for PHP patients and to distinguish this from custodial or day treatment programs for psychiatric patients, which are not a Medicare benefit. While it is true that improvement or maintenance may characterize active treatment, it is rare that a patient must be maintained in a PHP level of care to prevent rapid decompensation and inpatient admission. What is important to keep in mind is that while improvement or maintenance may characterize active treatment, the patient must also fulfill the physician certification and recertification requirement found in 42 CFR Section 424.24 that says a PHP patient would require inpatient hospital admission if the PHP services were not provided. If at the time of certification or re-certification the patient would otherwise require inpatient hospitalization, the patient may be maintained in a PHP, as long as active treatment is being rendered.

Comment: Several commenters objected to the use of the APA Axis V Global Assessment of Functioning (GAF) score ranges to describe patients who may be appropriate for PHP admission or discharge, saying the GAF scores were not developed to determine if a patient required a particular level of care.

Response: The use of GAF scores in the LCD were intended to serve as educational guidelines for providers to estimate a range of severity of illness for admission to and discharge from PHP. The use of the GAF score was not intended as an absolute marker that defines patients eligible or not eligible for PHP services. It has been used for this diagnostic purpose by the APA for many years—as an overall description of a patient’s level of functioning. However, the use of the GAF score is not necessary for the purpose of the LCD, and we will delete it.

Comment: One commenter said the draft LCD did not contain all the pertinent Medicare Program References but did not specify which references were missing.

Response: We felt we had included all applicable Medicare program references. If applicable references are missing, we will add them as they are identified.

Comment: The same commenter objected to the draft LCD language that states, "Partial hospitalization services are furnished... to patients with acute mental illness in order to avoid inpatient care..." saying it was more restrictive than language in CMS' manuals.

Response: Taken out of context and in isolation, CMS language or language in the SSA seems to allow PHP services as a maintenance program for patients with chronic mental illness. Although this language describes the goals of active treatment, it does not define medical necessity criteria. The language in the draft LCD is intended to emphasize the medical necessity parameter found in the certification language in 42 CFR Section 424.24 that says PHP patients would otherwise require inpatient care, not only upon admission, but at each recertification. PHP patients form a subset of patients who have the severity of illness equal to those patients who require inpatient admission, but do not need 24 hours of care.

Comment: The same commenter suggested that a lower frequency of services be allowed in a PHP for patients transitioning out of a PHP.

Response: Medicare covers a range of levels of psychiatric care, and if needed, patients may transition down through a continuum of levels of care. However, the PHP benefit is not designed to provide those lower levels of care. Lower levels of psychiatric care may be provided in other settings.

Comment: The same commenter requested clarification of the use of the word "should" in the statement, "Group therapy should be limited to 10 or fewer individuals participating."

Response: The word "should" in this context means that while "10 or fewer" is not an absolute parameter. Groups larger than 10 patients may render a medically necessary therapy service, but groups that large, because of their unwieldy size, tend to ignore a number of patients and may not be medically necessary for some patients. In order to ensure medical necessity, groups should be of a manageable size that allows attention to all members of the group.

Comment: The same commenter suggested clarifying that “individualized” activity therapies are activity therapies that are individualized to the patient’s goals.

Response: This was the intent of our use of the word “individualized” and we will incorporate the clarifying language.

Comment: The same commenter noted a section that required direct supervision in Community Mental Health Centers (CMHCs) for off-site PHPs.

Response: This requirement will be deleted. The physician supervision requirement for CMHCs should be general supervision, regardless of site.

Comment: The same commenter wanted the LCD to specify which services, specifically occupational therapy (OT) may be billed once per day.

Response: The required types and number of services for PHPs is specified in CMS’ program manuals. This information does not represent a medical necessity parameter and therefore will not be added to the LCD.

Comment: The same commenter wanted the language from 42 CFR 410.43 (a)(2) added to the LCD.

Response: While the cited language is pertinent to PHP services and describes the goal of active treatment, it does not sufficiently describe the patient population appropriate for PHP services. The parameters in 42 CFR 410.43 (a)(2) must be taken together with the certification requirements found in 42 CFR 424.24. Therefore, while the goal of active treatment may be “the control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization,” during each period of physician certification, the PHP patient must also otherwise require inpatient hospitalization if the PHP services were not provided. PHP services are medically necessary only as an alternative to inpatient psychiatric care.

Comment: The same commenter objected to putting a 24hour, or any, time frame for physical examination documentation to be placed in the chart.

Response: Since the population of patients that are eligible for PHP services is a subset of patients who are appropriate for inpatient admission, and the common standard of care for the medical history and physical examination for hospital inpatients is 24 hours, we used that time frame in the draft LCD. The Medicare Conditions of Participation for hospitals requires that the physical examination documentation be placed in the medical record within 48 hours after admission. We will adopt this 48hour parameter in the final LCD for PHP services. This parameter is intended to ensure that PHP patients receive an adequate and timely diagnostic evaluation.

Comment: The same commenter requested the list of medications not be a part of the treatment plan.

Response: The format for the documentation of the treatment plan is up to the provider. It is not necessary that the list of the patient's medications be in the treatment plan document, but it is necessary that the patient's psychotropic medications be a part of the active treatment rendered in the PHP. Therefore, the pertinent medications need to be referenced in the treatment plan as a part of the overall plan of care for the PHP patient. We will clarify this language.

Comment: The same provider requested the information in the Supplemental Instructions Article be made a part of the LCD.

Response: CMS' instructions to the carriers and fiscal intermediaries do not allow the merging of these documents.

Comment: Several commenters requested a number of ICD-9-CM codes be added to the list of codes that support medical necessity, but did not submit any scientific literature to support why individuals with these disorders that are usually treated as outpatients should be eligible for PHP services.

Response: We have found three additional diagnoses that are supported in the literature to occasionally require a PHP level of care: borderline personality disorder (ICD-9-CM code 300.6), agoraphobia with panic disorder (code 300.21), and obsessive compulsive disorder (code 300.3), although with the last two, the reason for admission may come from common co-morbid conditions. We will add these diagnoses to the LCD. The other requested conditions do not require the intensity of service found in a PHP, or are otherwise inappropriate (i.e., are not in the *DSM-IV* manual or do not describe patients who cannot participate in PHP services [e.g., catatonia]). If a patient with one of these other conditions is temporarily suicidal, the ICD-9-CM code for suicidal ideation (V62.84) should be added to the claim to support medical necessity for PHP services.

Comment: One commenter requested that language be clarified to say that acute illness and “exacerbations of chronic illness” are eligible for PHP.

Response: The commenter was concerned that the draft’s emphasis on the patient’s need to have acute symptoms implied that patients with chronic psychiatric illness were not appropriate for PHP. We see no distinction between an acute illness and an acute exacerbation. Throughout the LCD we have tried to emphasize that PHP is appropriate for patients with an acute condition, whether that condition is an initial episode of a new illness, or an exacerbation of an existing, chronic illness, and not for patients with chronic mental illness whose condition is stable and who are appropriate for a lower level of outpatient care, including day treatment. The language in the LCD should not be read to exclude chronic psychiatric illness in acute exacerbation.

Comment: The same commenter wanted language included in the LCD that allowed coverage for PHP patients where there is a “reasonable expectation that dysfunction requiring readmission to either inpatient status or partial hospitalization would recur in the absence of continuing partial hospitalization services.”

Response: The issue of providing PHP services to prevent relapse and rehospitalization is an important use of PHP services, but it does not mitigate the requirement that all PHP patients, at the time of certification or re-certification, must otherwise require inpatient hospitalization, at the time of the certification, and not at some indefinite time in the future. A number of levels of psychiatric care prevent relapse or rehospitalization, including PHP, but that is not a sufficient condition to support medical necessity for PHP services. Again, the primary purpose of the LCD is to describe those patients for whom PHP services are appropriate under Medicare rules and regulations, not simply describe the goals of PHP services.

Comment: The same commenter wanted the phrase “failure at or” removed from the sentence: “...there must be evidence of failure at or inability to benefit from a less intensive outpatient program.”

Response: We will accept either documentation of “failure at” a lower level of care, or a rationale why the patient “cannot benefit from” a lower level of care. Either method of supporting the need for PHP level of care is sufficient.

As a continuing part of the LCD development process, we welcome additional comments, supported by scientific literature, to request further reconsideration of this LCD.