Inpatient Psychiatric Facility (IPF) Coverage & Documentation

Presented by
Palmetto GBA JM A/B MAC
Provider Outreach and Education
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Disclaimer

This information is current as of August 31, 2016.

Any changes or new information superseding this information is provided in articles with publication dates after August 31, 2016, posted on our website: www.PalmettoGBA.com/jma

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Objectives

Review Inpatient Psychiatric Facility (IPF) coverage & documentation guidelines.

Enable providers to utilize this information to positively affect billing practices.

Maximize program protection against inappropriate payments & protect the Medicare Trust Fund.
Agenda

- IPF Coverage & Benefits
- IPF Billing Requirements
- Documentation Requirements
- Medical Review & CERT Review
- Stay Connected
IPF Coverage Requirements
IPF Coverage

- Patient must be under the care of a physician
- Physician must certify/recertify the need for inpatient care
- Patient must require “active treatment”
  - When “active treatment” ends, program payment can no longer be made
Certification

- Physician must certify the medical necessity of psychiatric inpatient services
- Certification is based on a current psychiatric evaluation of the patient
- Evaluation must be done upon admission or as soon thereafter as is reasonable and practicable
Recertification

- First Recertification
  - No later than the 12th day of hospitalization

- Subsequent Recertification's
  - Intervals established by hospital’s utilization review committee on case-by-case basis
  - Intervals must be at least every 30 days
Admission Criteria

- Patients must require intensive, comprehensive, multimodal treatment
- Acute psychiatric condition must require “active treatment”
- Level and intensity of the services required during an inpatient stay must exceed those that may be rendered in an outpatient setting
Admission Criteria

• Combined with the requirement for intensive 24 hour care, the severity and awareness of the symptoms and the likelihood of responding to treatment are the significant determining factors for the necessity of inpatient psychiatric treatment
Active Treatment

• Payment for inpatient psychiatric hospital services is to be made only for “active treatment” that can reasonably be expected to improve patient’s condition
  ◦ Provided under individualized treatment or diagnostic plan
  ◦ Reasonable expectation of improving patient’s condition or form purpose of diagnosis, and
  ◦ Supervised and evaluated by a physician
Active Treatment

- Period of observation may be considered part of active treatment if essential to overall treatment plan
- Physically or mentally deteriorating conditions do not necessarily exclude a beneficiary from coverage if specific symptoms or comorbid conditions are being treated
Benefit Overview
Inpatient Benefits

- Inpatient Hospital Benefit Days
  - 90 benefit days (60 full – 30 coinsurance)
  - 60 lifetime reserve days (LRD)

- Inpatient Psychiatric Benefit Days
  - Lifetime limitation
  - 190 days utilized in free standing psychiatric facilities
  - Common Working File tracks days paid
Beneficiary Liability

- Part A deductible & coinsurance per benefit period, per day utilized
  - Deductible, days 1 - 60
  - Coinsurance, days 61 - 90
  - Lifetime Reserve Days, days 90-150
  - Non-covered services
  - Non-covered days
Pre-Entitlement Utilization

- Reduction Rule subtracts days from 150 potentially available days when beneficiary:
  - Was inpatient in Medicare participating IPF on first day of entitlement & for any of the 150 days prior to entitlement
  - Does not apply to psychiatric care in general hospital (prior to entitlement)
  - Reduction applies only to beneficiary’s first entitlement period
Pre-Entitlement Utilization

Example One - Patient admitted 20 days before Medicare entitlement
• 130 days of benefits available (90 Benefit days + 60 LTR – 20 days prior = 130)
• Payment for 60 full days + 30 coinsurance days + 40 LTR days
Pre-Entitlement Utilization

Example Two – Patient hospitalized for 60 days in general hospital & 90 days in IPF, ending with first day of entitlement; during first benefit period patient was in general hospital for 90 days receiving psychiatric care

- 60 days in general hospital prior to entitlement do not reduce available days
- 90 days of prior psychiatric stay reduces available days to 60
Pre-Entitlement Utilization

Example Three – Patient in general hospital 10 days for mental condition, transferred to IPF for 78 days prior to entitlement; remained for 130 days, then transferred to general hospital for treatment of medical condition for 20 days

- 10 prior general hospital days do not count toward reduction
Pre-Entitlement Utilization

- 78 previous psychiatric hospital days subtracted from 150 benefit days
  - 60 full days + 12 coinsurance days = 72 benefit days for psychiatric care
- 20 days for general hospital medical admission
  - 18 coinsurance days + 2 LTR days
IPF Billing Requirements
Billing

- Psychiatric Hospital PTANs
  - Free Standing = xx-4000 – xx-4499
- Acute care hospital distinct part unit (DPU) = xx-S001 – xx-S999
- CAHs = xx-Mxxx – xx-Mxxx
Billing

- Allowable type of bill (TOB) = 111, 112, 117, 118, or 110

- Claim Submission Timeframes
  - Use 111 TOB for claims that span less than 60 days from admit to discharge
    - One claim, unless benefits exhaust
    - Occurrence code A3 = benefits exhaust
    - Use 110 TOB for benefit exhaust claims
Interim Billing

- If claim spans more than 60 days from admit to discharge you may choose to interim bill with first claim submitted as:
  - 112 TOB with patient status code 30
  - 117 TOB for all sequential claims in 60 days increments with patient status code 30
    - When beneficiary discharges use the appropriate discharge patient status
    - Occurrence code A3 = benefits exhaust
Ancillary Billing - 12x TOB

• Claim Submission Timeframes
  ◦ For beneficiaries that are at benefits exhaust or at a non-skilled level of care, you may submit ancillary claims on a monthly basis
    • Wait until benefits 11x exhaust claim processes before submitting ancillary 12x
  ◦ Flu shots are also billed on 12x during a covered inpatient stay
    • Inpatient claim should be processed before flu shot claim is submitted
Billing Instructions

Claims must include:

- Patient information
  - Heath Insurance Claim Number (HICN)
  - Date of Birth
  - Gender

- Source of admission

- Patient discharge status
Billing Instructions

- Pre-Admission Services = 1 day window
  - Not subject to 3 day window

- Source of Admission
  - DPUs must use source of admission code “D” on incoming transfers from acute care area of same hospital
    - Prevents overpayment due to ED adjustment when acute area is billing for covered services
Interrupted Stays

- Discharged & readmitted to same or other IPF before midnight on 3rd consecutive day
  - Use occurrence Span Code 74 & dates to reflect when leave began & ended
    - From Date = Day of discharge for the IPF
    - Through Date = Last day patient was not present in IPF over the midnight hour
  - Use revenue code 0180 to reflect number of days during interrupted stay with $0.00 charges
Interrupted Stay Example

- Patient leaves IPF January 1, 2016; returns to same IPF January 3, 2016
  - Considered an interrupted stay
  - Non-Covered days = 2
  - Occurrence span code 74; dates 1/1/16 - 1/2/16
  - Revenue code 0180 = 2 units with $0.00 charges
ICD-10 Diagnosis Codes

- Code to the highest level of specificity
- Principal diagnosis
  - Code responsible for admission
  - Determines correct DRG assignment
- Secondary diagnosis
  - Conditions co-exist on admission or develop during length of stay
Electroconvulsive Therapy (ECT)

- Use Revenue Code 0901
- Appropriate units for ECT performed during inpatient stay
- Date of last ECT treatment received during inpatient stay
- ICD-10 diagnosis codes:
  - GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ
Same Day Transfer

- If patient was admitted to IPF & transferred to another hospital on same day
- IPF bills same day for admission & discharge
  - Bill day in non-covered; report condition code 40
  - Bill room & board revenue code units with charges as covered
  - Report discharge status code 02 (acute care hospital) or 65 psychiatric hospital or unit
- Receiving hospital bills claim as usual
Services by Other Facilities

- Services provided by other facilities during IPF stay are not separately reimbursable to other facility
  - Need to seek reimbursement from the IPF

- Same day discharge & readmission
  - Providers do not separate claims
  - Follow interrupted stay policy
Documentation Requirements
Assessment & Diagnostic Data

• Medical records must stress psychiatric components of the record, including history of findings & treatment provided for the psychiatric condition for which patient is hospitalized

• Identification data must include patient’s legal status
Assessment/Data Gathering

- Provisional or admitting diagnosis must be made on every patient at time of admission & include Psychiatric diagnoses and comorbid diseases diagnoses
- Reasons for admission must be clearly documented as stated by the patient and/or others significantly involved
Assessment/Data Gathering

- Social service records, including reports of interviews with patient, family members, & others; must provide;
  - Assessment of home plans, family attitudes, community resource contacts & social history

- Complete neurological examination must be recorded at time of admission physical examination, when indicated
Psychiatric Evaluation

- Patient must receive psychiatric evaluation completed within 60 hours of admission
  - Include medical history & record of mental status
  - Note onset of illness & admission circumstances
  - Describe attitudes & behaviors
  - Estimate intellectual functioning, memory functioning & orientation; and
  - Include a descriptive inventory of patient’s assets
Documentation

- Physician’s Orders
- Treatment Plan
  - Must have an individual comprehensive treatment plan based on an inventory of patient’s strength & disabilities
  - Treatment received by patient must be documented in such a way to assure that all active therapeutic efforts are included
Treatment Plan Documentation

• Written plan must include
  ◦ Substantiated diagnosis
  ◦ Short-term & long-range goals
  ◦ Specific treatment modalities utilized
  ◦ Each treatment team member’s responsibilities
  ◦ Adequate documentation to justify diagnosis & treatment/rehabilitation activities carried out
General Documentation

- Separate progress notes for each service
  - Dated, legible signature by person providing service, with credentials
- Notes should include description of service, patient’s response & correlation to treatment plan goals
- Documentation of progress or lack of
Physician Documentation

- Progress notes should:
- Collectively describe course of inpatient stay
- Be recorded with each patient encounter
- Contain pertinent history, mental status, & detailed plans for continued therapy or discharge
Group/Individual Documentation

- Description of service provided
- For groups, specific content and purpose
- Summary of patient’s communications
- Description of therapeutic intervention
- Patient’s response to intervention
- Discharge planning
Discharge Criteria

- No longer requires 24 hour observation
- No longer meets severity of illness criteria
- Patient persistently unable or unwilling to participate in active treatment
Discharge

- Record of each discharged patient must have a discharge summary which includes:
  - Review of the patient’s hospitalization
  - Recommendations from appropriate services concerning follow-up care
  - Brief summary of patient’s condition on discharge
Qualified Providers

- All providers of service must be:
  - Licensed or otherwise authorized by the state in which they practice
  - Performing duties within their scope of practice and training
  - For services not state regulated, hospital credentialing shall apply
Qualified Providers

- Limits of local, state & federal scope of practice acts & licensure regulations apply to all practitioners

- Where more than one regulation is applicable, most restrictive limit shall apply
Medical Review & CERT Review
Medical Review

• Pre-payment probe reviews ensure claims process correctly the first time
  ◦ Decreases later recovery of payment
• Targeted reviews based on error findings
• Provider education provided to prevent future inappropriate billing
• Providers are notified of selection by ADR
CERT Review Errors

- CERT error findings = data demonstrates vulnerability & improper payment

- All Medicare Review Contractors follow:
  - IOM 100-08, Chapter 3, Section 3.3.2.6
  - Psychotherapy notes are defined CFR§164.501
IPF CERT Errors

- Medically unnecessary service or treatment
  - Received enough documentation to make a determination; services or treatment not related to improving patient condition

- Insufficient documentation
  - Received inconclusive documentation to support billed charges
IPF CERT Errors

- Provide necessary certification & recertification to support coverage
  - Signed document & dated
    - Include professional credentials & consistent e-signature documentation
  - Show that patient received active treatment during billing period
  - Provide individualized treatment plan
  - Support psychotherapy with type, amount, frequency, duration, diagnosis & anticipated goals
Keeping in Touch
#StayConnected

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- Sign up for our Listserv
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- View our Mobile Apps

Social Networking

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Have a Medicare question? Message us below or post it to our wall. For your privacy, please do not message any PHI or ESI information on social media platforms. For information on how to submit PII/ESI, contact us at (800) 555-1212.
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