Inpatient Psychiatric Facility (IPF)

Coverage & Documentation
Disclaimer

This information is current as of May 4, 2018. Any changes or new information superseding this information is provided in articles with publication dates after May 4, 2018 at:

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Objectives

- Review inpatient psychiatric facility (IPF) coverage & documentation guidelines
- Maximize program protection against inappropriate payments & protect the Medicare trust fund
- Enable providers to utilize this information to positively affect billing practices
Agenda

• IPF Coverage & Benefits
• IPF Billing Requirements
• Documentation Requirements
• Medical Review
• CERT Review
Coverage Requirements
IPF Coverage

- Patient must be under 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 as is reasonable & practicable
Recertification

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

- **Subsequent Recertification**
  - 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 & 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 & 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 & 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 (LTR)

- 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
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
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 exhaust claim processes before submitting ancillary claims
  - Flu shots are also billed on 12x during a covered inpatient stay
    - Inpatient claim should be processed before flu shot claim is submitted
Billing - Claims must include

- **Patient information**
  - Beneficiary ID #
  - Date of Birth
  - Gender

- **Preadmission services = 1 day window**
  - Not subject to 3 day window

- **Patient discharge status**

- **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 3\(^{rd}\) 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, 2018; returns to same IPF January 3, 2018
  - Considered an interrupted stay
  - Non-Covered days = 2
  - Occurrence span code 74; dates 1/1/18 - 1/2/18
  - 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 Must Be:

- Licensed or otherwise authorized by state in which they practice
- Performing duties within their scope of practice & training
- For services not state regulated, hospital credentialing applies
- 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
Targeted Probe & Educate
Diagnosis Related Group (DRG) 885 Psychosis
Medical Review

• Targeted Probe & Education (TPE) reviews ensure claims process correctly the first time
  ▪ Decreases later recovery of payment
• Provider education provided to prevent future inappropriate billing
• Providers are notified of selection by ADR
REVIEW FOCUS

Data Analysis

Improper Payment Reduction Strategy

CMS Directive: Determine the targeted items, services, devices and/or providers
Data Analysis =

- Billing Comparisons
- Trends
- Utilization Patterns
## TPE PROCESS

<table>
<thead>
<tr>
<th>Initial Probe</th>
<th>Round 2</th>
<th>Round 3</th>
<th>CMS Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider notification</td>
<td>• 45-56 days &gt; education - ADRs</td>
<td>• 45-56 days &gt; education - ADRs</td>
<td>• Extrapolation</td>
</tr>
<tr>
<td>• ADR</td>
<td>• Validation</td>
<td>• Validation</td>
<td>• Referral to ZPIC, UPIC or RAC</td>
</tr>
<tr>
<td>• Validation</td>
<td>• Calculation</td>
<td>• Calculation</td>
<td>• 100% prepay review</td>
</tr>
<tr>
<td>• Calculation</td>
<td>• Results letter</td>
<td>• Results letter</td>
<td></td>
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<tr>
<td>• Results letter</td>
<td>• 1:1 Education</td>
<td>• 1:1 Education</td>
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<tr>
<td>• Education</td>
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<td>*not all inclusive</td>
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DOCUMENTATION REQUEST - EACH PROBE ROUND

• ADR between 20-40 claims from the provider
  ▪ Provider notification letter will advise you of how many claims will be requested

• Respond with medical records within 45 days
  ▪ Highly recommend as an internal best practice of sending documentation within 30 days

• No response by 45 days counts as an error
TPE PROVIDER CONTACT

VIP when responding to TPE ADR

• Imperative that you include the name & number of your designated contact person

• Our medical reviewer will contact your designated person prior to the conclusion of each TPE round to discuss the review summary
## DIAGNOSIS RELATED GROUP (DRG) 885 - PSYCHOSIS

<table>
<thead>
<tr>
<th>Denial Codes</th>
<th>CMS Code</th>
<th>Description</th>
<th>Education Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>5D161/5H161</td>
<td>GAI05</td>
<td>No physician orders</td>
<td>IOM 100-8, Ch. 3, Sec. 3.3.2.4 &amp; 3.6.2.2, 100-2, Ch. 15, Sec. 80.6.1, SSA 1842(p)(4), CFR 410</td>
</tr>
<tr>
<td>5D650/5H650</td>
<td>GAM01</td>
<td>No valid certification present</td>
<td>IOM 100-2, Ch. 15, 220.1.3</td>
</tr>
<tr>
<td>5D800</td>
<td>GAJ01</td>
<td>No initial psychiatric evaluation</td>
<td>SSA1862(a)(1)(A), 100-8, Ch. 3, Sec. 3.6.2.1-2, &amp; 3.4.1.3</td>
</tr>
<tr>
<td>5D700</td>
<td>GAI03</td>
<td>No valid plan of treatment present</td>
<td>IOM 100-8, Ch. 3, Sec. 3.2.3.8C, 42 CFR424.5(a)(6), SSA 1833(e)</td>
</tr>
<tr>
<td>5C199</td>
<td>GAK09</td>
<td>Billing Error</td>
<td>IOM 100-4, Ch. 23, Sec. 3.6.2.5</td>
</tr>
</tbody>
</table>

Refer to Medical Review/General on our website!
CERT Review Errors
CERT Error Findings

• CERT data demonstrates vulnerability & improper payment

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

Specific CERT error finding for IPFs:

• 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
Use this checklist when your claim is selected for review by the CERT contractor. You will have 45 calendar days to submit the requested information from the date of the original request for medical records. After 75 days from the initial request, the money will be recouped from the paid claim if documentation is not received by the CERT contractor.

Please submit the documentation using the fax number, mailing address or other options listed on the CERT Request letter which includes a Barcoded Cover Sheet. The Barcoded Cover Sheet should be placed on top of the documentation when submitted. The documentation should include, but is not limited to:

- UB-04 Form
- Signed and dated physician’s orders for all services billed
- Physician’s certification/re-certification
- Plan of treatment
- Psychiatric evaluation
- Mental Status examination (attitudes and behavior, orientation, long and short term memory, estimate of intelligence)
- Discharge planning/summary
- Nurse’s notes
- Group therapy notes
- Progress notes
- Any other diagnostic reports
- Medication lists
- Documentation to support medical necessity

If applicable please submit:

- Psychiatric studies
- Documentation required by a Local Coverage Determination (LCD) or National Coverage Determination (NCD)

Psychotherapy Claims
Stay Connected!

Webinars, Videos, Interactive Tools & Website Education materials
Speaker Requests, Workshops and Partnership Events
Specialty Conferences and Ask the Contractor Teleconferences (ACT)

Provider Contact Center
JJA 877-567-7271
JMA 855-696-0705

Thank You!

#StayConnected
UPCOMING WEBCAST EDUCATION

• Quarterly Medicare Updates
  ▪ June 13, 2018

• Inpatient Rehabilitation Facility (IRF)
  ▪ June 27, 2018

Use the Event Registration Portal to Register!
Please Take the Survey!