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Medicare Advantage Policy Manual **Policy ID:** M-BH19

Behavioral Health (Psychiatric) Services

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member.

The Medicare Advantage Medical Policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and the Centers of Medicare and Medicaid Services (CMS) policies, when available. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and in some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services.

DESCRIPTION

Behavioral health services aid in the effective treatment of patients with various psychiatric disorders. Depending on the severity and type of disorder, services may range from inpatient facility stays to individual outpatient therapy sessions, family counseling, and medication management. Not all treatment programs or providers are eligible for coverage under the Medicare program or Medicare Advantage. See the policy below for further details.

MEDICARE ADVANTAGE POLICY CRITERIA

Procedure(s):	***CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:***

Medicare coverage guidelines are the primary resources for medical necessity decision-making. However, decisions regarding the medical reasonableness and necessity of treatment may also be made based on the advice of a medical director, consistent with accepted medical practice and industry standards. To aid with "accepted medical practice" decisions, additional criteria found in standardized clinical assessment tools or policies developed by the health plan may be used to supplement the Medicare references. The health plan's medical policies are developed in part using published clinical guidelines from national organizations such as the American Psychiatric Association (APA), Association for Ambulatory Behavioral Healthcare (AABH) and American Academy of Child and Adolescent Psychiatry (AACAP). Based on the services rendered and the condition being treated, possible alternate guidelines are included below.

Inpatient Services "The term 'inpatient psychiatric facility services' means inpatient hospital services furnished to a patient of an inpatient psychiatric facility. IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and CAHs." (*Medicare Benefit Policy Manual. Chapter 2 - Inpatient Psychiatric Hospital Services, §10.1 – Background*)	***Admission:*** "Psychiatric hospitals are required to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons." Therefore, all inpatient psychiatric facility (IPF) admissions ***must include ALL of the following***: • A provisional or admitting diagnosis for every patient; • The diagnosis of any comorbid diseases as well as the psychiatric diagnosis; • Documentation that the patient requires active treatment; • Documentation that the active treatment will be of an intensity that can be provided appropriately only in an inpatient setting; and, • Documentation that the active treatment will be rendered for a psychiatric principal diagnosis found in in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five of the International Classification of Diseases applicable to the service date. *(See Section 20 in the following link: Medicare Benefit Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Services, §20 - Admission Requirements)* ***Active Treatment:***

Procedure(s):	***CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:***

"Payment for IPF services is to be made only for 'active treatment' that can reasonably be expected to improve the patient's condition… For services in an IPF to be considered "active treatment," they must be:

- Provided under an individualized treatment or diagnostic plan. The written plan must include the following:
  - A substantiated diagnosis;
  - Short-term and long-range goals;
  - The specific treatment modalities utilized;
  - The responsibilities of each member of the treatment team; and
  - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.
  - *(§30.3 – Treatment Plan and 30.3.1 - Individualized Treatment or Diagnostic Plan) (See Section 20 in the link).*
- Reasonably expected to improve the patient's condition or for the purpose of diagnosis; however, it is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution. The treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms that necessitated hospitalization and improve the patient's level of functioning. *(§30.3.2 - Services Expected to Improve the Condition or for Purpose of Diagnosis);* and
- Supervised and evaluated by a physician *(see §30.2.3 – Services Supervised and Evaluated by a Physician for further details).*
- The administration of a drug or drugs does not necessarily constitute active treatment. The administration of antidepressant or tranquilizing drugs that are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment, assuming that the other elements of the definition of active treatment is met.

Discharge Planning

"The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from

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	appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge." *(See Section 30.5 in the following link: Medicare Benefit Policy Manual. Chapter 2 - Inpatient Psychiatric Hospital Services, §30.5 - Discharge Planning and Discharge Summary)* **Note:** Please read all applicable sections and subsections, in their entirety, for complete criteria details, including what may or may not be considered "active treatment" or a reasonable and necessary Medicare-covered IPH service.
Partial Hospitalization Program (PHP) "Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care." *(Medicare Benefit Policy Manual, Chapter 6, §70.1.B – Partial Hospitalization)* "Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in	***Admission:*** 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. Patients admitted to a PHP must: • Be under the care of a physician who certifies the need for partial hospitalization; • Require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care; • Require a 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); • Be able to cognitively and emotionally participate in the active treatment process; • Be capable of tolerating the intensity of a PHP program.

Procedure(s):	*CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:*
§1861(ff) of the Social Security Act (the 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." *(Medicare Benefit Policy Manual, Chapter 6,* §70.3 - Partial Hospitalization Services*)*	• 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. ***Active Treatment*** "Partial hospitalization services that 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 in or of §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)." • Since the patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, they 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 or listed in Chapter 5 of the most current edition of the International Classification of Diseases (ICD), 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. ***Continued Active Treatment***

Procedure(s):	***CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:***

- This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition and is reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization.
- The overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms.
- Is expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care.
- 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.
- 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.

Discharge Planning

"Discharge planning from a PHP may reflect the types of best practices recognized by professional and advocacy organizations that 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."

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,

Procedure(s):	***CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:***
	• 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. *(See Section 70.3.B in the following link: Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B, §70.3.B - Patient Eligibility Criteria)* **Note:** Please review all of Section 70.3, in its entirety, for complete PHP information, including what may or may not be considered Medicare-covered PHP services and PHP program criteria.
Outpatient Services	***Vagal Nerve Stimulation for Depression:*** This policy does not address vagal nerve stimulation as a treatment of depression, which is addressed in a separate Medicare Advantage medical policy (see Cross References). ***Applied Behavior Analysis (ABA) for Autism:*** • While autism is a condition generally diagnosed during childhood or adolescence, adults with autism may have access to ABA services when indicated: o Prior to reviewing medical necessity criteria in the referenced policies below, providers rendering ABA services **must be** Medicare-eligible providers. In addition to the non-covered provider types listed in the above "Ineligible Providers" section, Licensed Behavioral Analysts are **not** Medicare-eligible providers. However, Medicare-approved providers for ABA treatment may include a Licensed Clinical Social Worker (LCSW) and a Licensed Clinical Psychologist (PhD or PsyD). If the provider is a Medicare-approved provider type, then the following health plan policies may be used for Medicare members over the age of 18. o Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder, Behavioral Health, Policy No. 18 ***General Criteria for Other Outpatient Services:***

Procedure(s):	***CMS Coverage Manuals, National Coverage Determinations (NCDs), Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs), Medical Policy Manual and Other References:***
	Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B, §70 - Outpatient Hospital Psychiatric Services See Chapter 6, Sections 70.1, 70.1.A, and 70.1.C.1 in the following links: • §70.1 – General • §70.1.A – Coverage Criteria • §70.1. C. Application of Criteria, Covered Services **Note**: Please review all of Section 70.1, in its entirety, for complete criteria details, including what may or may not be considered Medicare-covered outpatient hospital psychiatric services.
Additional resources for clinical determinations and placement decisions:	• The Level of Care Utilization System (LOCUS) • Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) • Early Childhood Service Intensity Instrument (ECSII) **Note: "ACAP" and "American Academy of Child and Adolescent Psychiatry" are registered trademarks of AACAP, and are used with permission. Use of these terms is prohibited without permission of AACAP. Use of these trademarks does not constitute certification or endorsement of this product, practice, or action by AACAP.** **The American Academy of Child and Adolescent Psychiatry does not accept liability for clinical judgment and/or clinical decisions made through use of this instrument, as intended or for any other use, and shall not be liable for any special, incidental, consequential, punitive, exemplary, or other indirect damages, howsoever caused, whether arising in contract, tort or otherwise, in connection with its use or implementation.**

NOTE: Please review the member's benefit handbook for covered services and providers.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Current clinical presentation and symptoms.
- Description of requested treatment plan, and if will be rendered on an inpatient or outpatient basis;
- If inpatient, type of facility services will be rendered in;
- Admitting diagnosis, as well as the diagnosis of any comorbid disease(s); and,
- Short-term and long-term goals;
- *See the applicable specific criteria reference for any additional documentation that may be required depending on the type of treatment requested.*

CROSS REFERENCES

Chemical Dependency and Substance Abuse Services, Behavioral Health, Policy No. M-20
Vagus Nerve Stimulation (VNS), Surgery, Policy No. M-74

REFERENCES

1. Noridian Medicare Mental Health web page
2. Outpatient Psychiatric Hospital Services
3. Partial Hospitalization Program (PHP)
4. Inpatient Psychiatric Hospital Services
5. Medicare Program Integrity Manual, Chapter 10 – Medicare Enrollment, §10.2.8 - Providers/Suppliers Not Eligible to Participate
6. Medicare Benefit Policy Manual, Chapter 3 - Duration of Covered Inpatient Services, §30 - Inpatient Days Counting Toward Benefit Maximums, C. Lifetime Inpatient Psychiatric Hospital Limitation
7. Medicare Benefit Policy Manual, Chapter 2 - Inpatient Psychiatric Hospital Services, §30 - Medical Records Requirements (Sections §30.1 and §30.2 provide further documentation guidance)

CODING

Codes	Number	Description
CPT	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who

Codes	Number	Description
		exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
	97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*