Regence Oregon and Utah | Regence Idaho and select counties of Washington

Medical Policy Manual Behavioral Health, Policy No. 29

Psychiatric Inpatient Hospitalization

Effective: November 1, 2022

Next Review: January 2023
Last Review: October 2022

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Inpatient Psychiatric Hospitalization is a 24-hour acute treatment setting occurring on a locked unit that is licensed as a hospital by the appropriate agency and under the direct supervision of an attending psychiatrist or psychiatric extender.

MEDICAL POLICY CRITERIA

Notes: Submission of a behavioral health intake form is required for initial intake, concurrent review, stepdown request to a lower level of care, and discharge confirmation.

I. An Inpatient Psychiatric Hospitalization (IP) admission provided under the supervision of an attending psychiatrist or psychiatric extender may be indicated when all of the following (A. – B.) are met:

   A. All of the following intensity of service criteria (1. – 11.) are met:

      1. The hospital or inpatient unit is licensed by the appropriate state agency.

      2. There is an expectation that the member's history and physical examination is completed within 24 hours of admission (unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care).

3. There is an expectation that drug screens and relevant lab tests are completed upon admission and as clinically indicated and are documented in the medical record.
4. The attending provider is a psychiatrist, a licensed psychiatric nurse practitioner, or physician assistant with formal practice agreement with a psychiatrist (when permitted by state laws) who is responsible for diagnostic evaluation within 24 hours of admission. After the initial diagnostic evaluation, there is an expectation that the physician, or physician extender provides and documents medical monitoring and evaluation daily. The attending provider must be available 24 hour a day, 7 days per week.
5. There is an expectation that within 24 hours of admission, following a multidisciplinary assessment that includes input from recent treating providers, an individualized treatment plan (ITP) is developed and documented in the medical record. The ITP should use evidence-based concepts, where applicable, and be amended as needed for changes in the individual's clinical condition. The ITP should include, but is not limited to, subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, need for services for comorbid medical or substance use conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care, and other issues that affect the likelihood of successful community tenure.
6. Treatment programing includes an expectation of at least one individual counseling session per week, or more as clinically indicated, which is documented in the medical record.
7. There is an expectation that evaluations of the member are performed daily by a licensed behavioral health provider and are documented in the medical record.
8. Treatment programing is multidisciplinary and includes clinical services provided daily that comprehensively address the needs identified in the member's treatment plan.
9. Mental health and medical services are available on-site (or off-site by arrangement) 24 hours per day, 7 days per week.
10. On-site registered nursing care is available 24 hours a day, 7 days a week with full capabilities for all appropriate interventions in medical and behavioral health and emergencies that occur on the unit.
11. On-site, licensed clinical staff is available 24 hours a day, 7 days a week adequate to supervise the member's medical and psychological needs.

B. All of the following severity of illness criteria (1. – 2.) are met:

1. All the following (a. – d.) are met:
    a. The member has been given a severe mental health diagnosis according to the most recent DSM criteria which will be the primary focus of daily active treatment.

b. There is reasonable expectation that treatment at this level of care will meaningfully impact the presenting symptoms/behaviors leading to the admission.

c. The treatment is not primarily for the convenience of the provider or member (e.g., primarily for lack of housing options, respite care, custodial needs or extended discharge planning).

d. Treatment could not be safely provided at a lower level of care or no safe lower level of care is available.

2. One or more of the following must be met:

a. There is significant evidence that member is an imminent risk of harm to self or to others due to one or more of the following reasons:

i. The member has made a recent and serious attempt to substantially harm self or someone else in a way that was intended to be deadly.

ii. The member is verbalizing intent and plan to harm self or someone else in a way that would either be deadly or cause serious bodily harm.

iii. Recent self-injurious behaviors that are substantial enough to require 24-hour observation and safety planning (example: Cutting self substantially enough to require sutures).

iv. Recent violent, impulsive, and/or agitated behavior that cannot safely be controlled outside of 24-hour monitoring and intervention to prevent serious harm to self or others.

b. The member is experiencing severe deterioration in their ability to care for themself due to the severity of their psychiatric condition. Examples of this level of deterioration are:

i. The member is not taking care of basic tasks such as eating, drinking, caring for hygiene or taking prescribed psychiatric medications which contributes to deterioration.

ii. The member is experiencing a recent onset or exacerbation of psychotic symptoms that are resulting in significant deterioration of functioning that can only be safely managed with 24-hour observation and treatment. (Examples include: delusional thinking with limited to no awareness of reality, auditory and/or visual hallucinations, severe paranoia).

c. Member has a comorbid medical condition in addition to active psychiatric symptoms and requires the resources of an inpatient hospital for safe and appropriate treatment.

II. Continued stay in an Inpatient Psychiatric Hospitalization (IP) provided under the supervision of an attending psychiatrist or psychiatric extender may be indicated when all of the following (A. – D.) are met:

A. The individual continues to meet admission criteria (I.A. – B.).

B. There is evidence of active discharge planning.

C. Family participation (see Policy Guidelines):

1. For Adults: Family treatment is encouraged when clinically appropriate. Family treatment is available to be provided at an appropriate frequency when clinically warranted.
2. For children/adolescents: Family treatment will be provided as part of the treatment plan. If family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy. The family/support system assessment will be completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.

D. One or more of the following criteria must be met:

1. The active treatment being provided to the member is demonstrating meaningful improvements in the member's clinical status and appears to be helping the member reach a level of stability that step-down to a lower level of care will be possible.
2. If the active treatment being provided to member does not appear to result in clinical improvements (or the member's condition has deteriorated further), the treatment team is actively re-evaluating the treatment plan and adjusting as needed to produce positive outcomes.
3. Member is experiencing complications arising from medications or other treatments (such as Electroconvulsive Therapy) with such severity that require further stabilization and 24-hour observation.
4. The member has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

POLICY GUIDELINES

FAMILY PARTICIPATION

Family participation may be conducted via telephonic sessions when there is a significant geographic or other limitation.

LIST OF INFORMATION NEEDED FOR REVIEW

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.

Initial Request:

- o Pre-Authorization Request Form
- o Supporting clinical documentation, including:
  - Initial Psychiatric Evaluation/Intake Assessment
  - Nursing Assessment/ History & Physical (if available)

- Any additional supporting clinical evidence, if available (example: letters from outpatient providers supporting this level of care)

o Preliminary Individualized Treatment Plan

Request for Extension/Concurrent Review:

o Supporting clinical documentation, including:
- Recent psychiatric evaluation
- MD Notes
- Treatment Plan/Progress Reports
- Any other supporting clinical evidence

CROSS REFERENCES

1. Eating Disorder Inpatient Treatment, Behavioral Health, Policy No. 25
2. Eating Disorder Intensive Outpatient, Behavioral Health, Policy No. 26
3. Eating Disorder Partial Hospitalization, Behavioral Health, Policy No. 27
4. Eating Disorder Residential Treatment, Behavioral Health, Policy No. 28
5. Psychiatric Intensive Outpatient, Behavioral Health, Policy No. 30
6. Psychiatric Partial Hospitalization, Behavioral Health, Policy No. 31
7. Psychiatric Residential Treatment, Behavioral Health, Policy No. 32
8. Intensive In-Home Family Intervention, Behavioral Health, Policy No. 34

REFERENCES

1. American Academy of Child and Adolescent Psychiatry. Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers. 2010. [cited 9/26/2022]. 'Available from:' https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf.
2. American Academy of Child and Adolescent Psychiatry, Practice Parameters, Washington, DC. [cited 9/26/2022]. 'Available from:' https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx.
3. American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2018. [cited 9/26/2022]. 'Available from:' http://psychiatryonline.org/guidelines.aspx.
4. *American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May 2013*, pp.
5. Association for Ambulatory Behavioral Healthcare: Partial hospitalization programs [cited 9/26/2022]. 'Available from:' https://aabh.org/standards-guidelines/.
6. Association for Ambulatory Behavioral Healthcare: Intensive Outpatient Program. [cited 9/26/2022]. 'Available from:' https://aabh.org/standards-guidelines/.
7. *Medicare Benefit Policy, Outpatient Hospital Psychiatric Services, Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)*, pp.
8. Mental Health America, Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions, June 2015.

[cited 9/26/2022]. 'Available from:' https://www.mhanational.org/issues/position-statement-44-residential-treatment-children-and-adolescents-serious-mental-health.
9. Harrington BC, Jimerson M, Haxton C, et al. Initial evaluation, diagnosis, and treatment of anorexia nervosa and bulimia nervosa. *Am Fam Physician.* 2015;91(1):46-52. PMID: 25591200
10. Mee-Lee D SG, Fishman MJ, Gasfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Shange Companies*®, 2013, pp.

CODES

Codes	Number	Description
CPT	None	
HCPCS	None	
Revenue Code	0114	R&B Private, Psychiatric
	0124	R&B Semi-Private, Psychiatric
	0134	R&B Multi-Bed, Psychiatric
	0144	R&B Deluxe Private, Psychiatric
	0154	R&B Ward, Psychiatric
	0204	ICU, Psychiatric

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