

Medicare Benefit Policy Manual

Chapter 2 - Inpatient Psychiatric Hospital Services

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10 - Inpatient Psychiatric Facility Services

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

10.1 – Background

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

This section and its subsections provide instructions about the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). The IPF PPS *replaced* the reasonable cost/Tax Equity and Fiscal Responsibility Act (TEFRA) based payments subject to TEFRA limits under [§1886 \(b\)](#) of the Social Security Act (the Act) for discharges beginning on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at [42 CFR 412](#), Subpart N, provides payment for inpatient psychiatric treatment when provided to a patient in psychiatric hospitals, and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs). Psychiatric hospitals and psychiatric units that used to be paid reasonable-cost under TEFRA, §1886(b) of the Act, are now paid under the IPF PPS.

As described in 42 CFR 412.23(a), a psychiatric hospital must meet the following requirements to be excluded from the Inpatient Prospective Payment System (IPPS) and paid under the IPF PPS:

(1) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(2) Meet the conditions of participation for hospitals and special conditions of participation for psychiatric hospitals set forth in 42 CFR part 482.

As described in 42 CFR 412.27, a psychiatric unit must meet the following requirements to be excluded from the IPPS payment system, and paid under the IPF PPS:

(1) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.

(2) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.

(3) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the requirements given in section 30 of this chapter.

(4) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written,

individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as given in section 40 of this chapter.

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.

10.2 - Statutory Requirements

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary—(1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) *is permitted* to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), section 405(g) *authorized extending* the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

10.3 - Affected Medicare Providers

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means, an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and staffing requirements in [42 CFR 412.27](#).

The regulations at [42 CFR 412.402](#) define an IPF as a hospital that meets the requirements specified in [42 CFR 412.22](#) and [42 CFR 412.23\(a\)](#), [42 CFR 482.60](#), [42 CFR 482.61](#), and [42 CFR 482.62](#), and *a* unit that meets the requirements specified in [42 CFR 412.22](#), [42 CFR 412.25](#), and [42 CFR 412.27](#).

The IPF PPS does not change the basic criteria for a hospital or hospital unit to be classified as a psychiatric hospital or psychiatric unit that is excluded from the hospital prospective payment systems under [§1886\(d\)](#) and §1886(g) of the Act, nor does it revise the survey and certification procedures applicable to entities seeking this classification.

The provider number ranges (Online Survey and Certification and Reporting System (OSCAR) number) for IPFs are from xx-4000 through xx-4499, xx-Sxxx, and xx-Mxxx.

The following hospitals are not included in IPF PPS.

- Veterans Administration hospitals; see [42 CFR 412.22 \(c\)](#).
- Hospitals that are reimbursed under state cost control systems approved under [42 CFR Part 403](#); Psychiatric hospitals (provider numbers xx-4000 - xx-4499) in the State of Maryland are paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital in Maryland identified by 'S' in the third position of the OSCAR number are waived from the IPF PPS, as are the acute hospital in which they are located. Currently there are no CAHs in Maryland.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under [42 CFR 402\(a\)](#) of Pub.L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub.L. 92-603 (42 U. S. C. 1395b-1); IPFs in acute care hospitals that are paid in accordance with demonstration projects are paid in accordance with the demonstration project;
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. See [42 CFR 412.22\(c\)](#).

Payments to foreign hospitals are made in accordance with the provisions set forth in [42 CFR 413.74](#).

10.4 - Conditions for payment under the IPF Prospective Payment System (Rev. 253, Issued: 12-14-18, Effective: 01-16-19, Implementation: 01-16-19)

As required in 42 CFR 412.404, effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility (IPF), defined as an inpatient psychiatric hospital or distinct psychiatric unit of an acute care hospital or CAH, must meet the following conditions to receive payment under the IPF prospective payment system (PPS) for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

If an IPF fails to comply fully with these conditions, CMS may, as appropriate withhold (in full or in part) or reduce Medicare payment to the IPF until the facility provides adequate assurances of compliance, or CMS may classify the IPF as an inpatient hospital that is subject to the requirements for hospitals and paid under the hospital Inpatient Prospective Payment System.

- IPFs subject to the IPF PPS. Subject to the special payment provisions of §412.22(c), an IPF must meet the general criteria set forth in §412.22. In order to be excluded from the hospital inpatient prospective payment system as specified in §412.1(a)(1), a psychiatric hospital must meet the criteria set forth in §§412.23(a), 482.60, 482.61, and 482.62 and psychiatric units must meet the criteria set forth in §412.25 and §412.27.
- Limitations on charges to beneficiaries
 - Prohibited charges. Except as permitted below, an IPF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary is greater than the amount the facility is paid under the IPF PPS.
 - Permitted charges. An IPF receiving payment under the IPF PPS for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under 42 CFR §§409.82, 409.83, and 409.87 and for items or services as specified under 42 CFR §489.20(a).
- Furnishing of inpatient hospital services directly or under arrangement. Subject to the provisions of §412.422, the applicable payments made under the IPF PPS are payment in full for all inpatient hospital services, as specified in §409.10. Hospital inpatient services do not include the following:
 - (a) Physicians' services that meet the requirements of 42 CFR §415.102(a) for payment on a fee schedule basis.
 - (b) Physician assistant services, as specified in section 1861(s)(2)(K)(i) of the Act.
 - (c) Nurse practitioners and clinical nurse specialist services, as specified in section 1861(s)(2)(K)(ii) of the Act.
 - (d) Certified nurse midwife services, as specified in section 1861(gg) of the Act.
 - (e) Qualified psychologist services, as specified in section 1861(ii) of the Act.
 - (f) Services of a certified registered nurse anesthetist, as specified in section 1861(bb) of the Act and defined in 42 CFR §410.69.
 - CMS does not pay providers or suppliers, other than IPFs, for services furnished to a Medicare beneficiary who is an inpatient of the IPF, except for the professional services described in (a) through (f) above.

- *The IPF must furnish all necessary covered services to a Medicare beneficiary who is an inpatient of the IPF, either directly or under arrangements (as specified in 42 CFR §409.3).*
- *Reporting and recordkeeping requirements. All IPFs participating in the IPF PPS must meet the recordkeeping and cost reporting requirements as specified in 42 CFR §§412.27(c), 413.20, 413.24, and 482.61. Medical record requirements are detailed in section 30 of this chapter.*

An IPF may not file its cost reports as an “all-inclusive” provider unless that all-inclusive status has been previously approved by its Medicare Administrative Contractor, in accordance with the Provider Reimbursement Manual, Part 1, chapter 22, section 2208.

20 - Admission Requirements

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In *accordance with* 42 CFR 412.27(c), for all IPFs, a provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of comorbid *conditions* as well as the psychiatric diagnosis. *The reasons for admission must be clearly documented as stated by the patient or others significantly involved, or both.*

*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, according to 42 CFR 412.23(a). Distinct part psychiatric units of acute care hospitals and CAHs are required to admit only those patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the *International Classification of Diseases, Tenth Revision, Clinical Modification*.*

As a condition for Medicare payment, all admissions to IPFs must be certified and recertified by a physician, as detailed in section 30.2.1.

30 - Medical Records Requirements

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

The medical records maintained by an IPF must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

In addition, consistent with *the hospital conditions of participation*, all medical records, including progress notes and treatment plan, should be legible and complete, and should be promptly signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

30.1 - Development of Assessment/Diagnostic Data

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(c) and 42 CFR 482.61(a), medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data must include the patient's legal status. *According to the Interpretative Guidelines for 482.61(a)(1) given in the State Operations Manual (SOM; see IOM 100-07, Appendix AA), legal status is defined in the State statutes and dictates the circumstances under which the patient was admitted and/or is being treated - i.e., voluntary, involuntary, committed by court, evaluation and recertification are in accordance with State requirements.*

(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of comorbid *conditions* as well as the psychiatric diagnoses.

(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

30.2 - Psychiatric Evaluation

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(c) and 42 CFR 482.61(b), each patient must receive a psychiatric evaluation that must—

- (1) Be completed within 60 hours of admission;
- (2) Include a medical history;
- (3) Contain a record of mental status;
- (4) Note the onset of illness and the circumstances leading to admission;
- (5) Describe attitudes and behavior;
- (6) Estimate intellectual functioning, memory functioning, and orientation; and

- (7) Include an inventory of the patient's assets in descriptive, not interpretative fashion.

30.2.1 - Certification and Recertification Requirements

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

Medicare Part A pays for inpatient services in an inpatient psychiatric facility only if a physician certifies and recertifies the need for services consistent with the requirements given in Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, chapter 4, §10.9, for certification requirements.

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required. The provider may adopt any method that permits verification of all the IPF's requirements to continue treatment. For example, the recertification may be entered on provider generated forms, in progress notes, or in the records (relating to the stay in question) and must be signed by a physician.

Claim denials may not be made for failure to use a certification or recertification form or failure to use particular language or format, provided that the medical record demonstrates the content requirements given at §30.2.1 are met.

30.2.1.1 - Certification

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

The certification period begins with the order for inpatient admission. The content requirements of the certification differ from those for other hospitals because the care furnished in inpatient psychiatric facilities is often purely custodial and thus not covered under Medicare. The purpose of the statements, therefore, is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage.

The certification that a physician must provide, with respect to IPF services, is documentation that the services furnished can reasonably be expected to improve the patient's condition or for diagnostic study. The certification is required at the time of admission or as soon thereafter that is reasonable and practicable.

30.2.1.2 - Recertification

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

If the patient continues to require active inpatient psychiatric treatment, then a physician must recertify as of the 12th day of hospitalization (with subsequent recertifications required at intervals established by the IPF's Utilization Review committee on a case-by-case basis, but no less frequently than every 30 days) that the services were and continue to be required for treatment that could reasonably be expected to improve the patient's

condition, or for diagnostic study, and that the patient continues to need, on a daily basis, active treatment furnished directly by, or requiring the supervision of, inpatient psychiatric facility personnel. In addition, the hospital records should show that services furnished were intensive treatment services, admission or related services *necessary for diagnostic study*, or equivalent services. See Pub.100-01, Medicare General Information, Eligibility and Entitlement Manual, chapter 4, §10.9, for recertification requirements.

30.2.1.3 - Delayed/Lapsed Certification and Recertification

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

IPFs are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications will be honored where, for instance, there *has* been an oversight or lapse, and a legitimate reason for the delay as noted in Pub. 100-01, *chapter 4, §10.9.1 and §20.1*. Denial of payment for lack of the required certification and recertification is considered a technical denial, which means a statutory requirement has not been met. Consequently, if an appropriate certification is later produced, the denial shall be overturned. Reopenings of technical denial decisions may be initiated by the contractor or the provider.

In addition to compliance with the appropriate certification and recertification content requirements, delayed certification and recertification must include an explanation for the delay and any medical or other evidence which the IPF considers relevant for purposes of explaining the delay. The IPF will determine the format of the delayed certifications and recertifications, and the method by which they are obtained. A delayed certification may be included with one or more recertifications on a single signed document. Separate signed documents for each delayed certification and recertification are not required as they would be if timely certification and recertification had been completed. For all IPF services, a delayed certification may not extend past discharge. IPF certification or recertification documentation may only be signed by a physician.

30.2.2 - Active Treatment

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

Payment for IPF services is to be made only for "active treatment" that can reasonably be expected to improve the patient's condition. To assure that payment is made only under such circumstances, the law includes certain requirements that must be met before the services furnished in an IPF can be covered, including medical necessity and certification.

30.2.2.1 - Principles for Evaluating a Period of Active Treatment

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

In the context of IPF services, emphasis is placed on the presence of active treatment and, therefore, this determination is the crucial one. Simply applying the skilled care definition for general hospitals is not sufficient for determining whether payment may be

made since that definition does not take into account the patient's potential for improvement nor was it designed to permit the more sophisticated judgments required by the concept of active treatment. For services in an IPF to be designated as active treatment, they must be:

- Provided under an individualized treatment or diagnostic plan;
- Reasonably expected to improve the patient's condition or for the purpose of diagnosis; and
- Supervised and evaluated by a physician.

Such factors as diagnosis, length of hospitalization, and the degree of functional limitation, while useful as general indicators of the kind of care most likely being furnished in a given situation, are not controlling in deciding whether the care was active treatment. Refer to 42 CFR 482.61, Conditions of Participation for Hospitals, for a full description of what constitutes active treatment.

The period of time covered by the physician's certification is referred to as a period of active treatment. This period should include all days on which inpatient psychiatric facility services were provided because of the individual's need for active treatment (not just the days on which specific therapeutic or diagnostic services are rendered). For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time or it may include a period of observation, either in preparation for or as a follow-up to therapy, while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean the patient is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his/her condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The program's definition of active treatment does not automatically exclude from coverage services rendered to patients who have conditions that ordinarily result in progressive physical and/or mental deterioration. Although patients with such diagnosis will most commonly be receiving custodial care, they may also receive services that meet the program's definition of active treatment (e.g., where a patient with Alzheimer's disease or Pick's disease received services designed to alleviate the effects of paralysis, epileptic seizures, or some other neurological symptom, or where a patient in the terminal stages of any disease received life-supportive care). A period of hospitalization during which services of this kind were furnished would be regarded as a period of active treatment.

30.2.3 - Services Supervised and Evaluated by a Physician

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The types of services which meet the above requirements would include not only psychotherapy, drug therapy, and electroconvulsive therapy, but also such therapeutic activities as occupational therapy, recreational therapy, and milieu therapy, provided the therapeutic activities are expected to result in improvement in the patient's condition. If the only activities prescribed for the patient are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the patient), it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy, (or one of the other therapeutic activities is involved), it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy.

In addition, 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 definitions are met). However, the administration of a drug or drugs does not necessarily constitute active treatment.

Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews, at least once per week.

When the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed (based on consultations and conferences with therapists, review of the patient's progress as recorded on the medical record and the physician's periodic conversations with the patient), active treatment would be indicated. A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Medicare Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient, such services would be reimbursable under the medical insurance program.

30.3 - Treatment Plan

(Rev. 253, Issued: 12-14-18, Effective: 01-16-19, Implementation: 01-16-19)

The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate

other disciplines on the basis of a thorough evaluation of the patient's *-strengths* and *disabilities*. The plan of treatment must be recorded in the patient's medical record in accordance with *42 CFR 412.27(c)(3) and the Conditions of Participation for Hospitals in 42 CFR 482.61*.

30.3.1 - Individualized Treatment or Diagnostic Plan

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(c)(3) and 42 CFR 482.61(c), each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include—

- (1) A substantiated diagnosis;
- (2) Short-term and long-range goals;
- (3) The specific treatment modalities utilized;
- (4) The responsibilities of each member of the treatment team; and
- (5) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

The treatment furnished to the patient should be documented in the medical record in such a manner and with such frequency as to assure that all active therapeutic efforts are included. *The documentation should* provide a full picture of the therapy administered *and* an assessment of the patient's reaction to it.

30.3.2 - Services Expected to Improve the Condition or for Purpose of Diagnosis

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 424.14(b)(1) and 42 CFR 424.14(c)(1), the physician must include in all certifications and recertifications that the services provided could reasonably be expected to improve the patient's condition or are for the purpose of diagnostic study. 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 although 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.

30.4 - Recording Progress

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(c)(4) and 42 CFR 482.61(d), progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as

specified in 482.12(c), by a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

As outlined above in §30 of this chapter, consistent with sound clinical practice (*and the hospital conditions of participation at 482.24(c)(1)*), all medical records, including progress notes, should be legible and complete, and should be promptly signed and dated by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

30.5 - Discharge Planning and Discharge Summary

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(c)(5) and 482.61(e), 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 appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

40 - Personnel Requirements

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs must have adequate numbers of qualified professional and supportive staff, according to 42 CFR 412.27 and 42 CFR 482.62.

IPFs must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

- (1) Evaluate patients;
- (2) Formulate written individualized, comprehensive treatment plans;
- (3) Provide active treatment measures; and
- (4) Engage in discharge planning.

Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

40.1 - Director of Inpatient Psychiatric Services; Medical Staff *(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)*

In accordance with 42 CFR 412.27(d)(2) and 42 CFR 482.62(b), inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

40.2 - Nursing Services

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with 42 CFR 412.27(d)(3) and 42 CFR 482.62(d), IPFs must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.

(1) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(2) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.

50 - Psychological Services

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF must provide or have available psychological services to meet the needs of the patients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures, according to 42 CFR 412.27 and 42 CFR 482.62.

60 - Social Services

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

In accordance with [42 CFR 412.27](#) and [42 CFR 482.62](#), there must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures..

1. The director of the social work department or service must have a Master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a Master's degree in social work, at least one staff member must have this qualification.
2. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

70 - Therapeutic Activities

(Rev. 59, Issued: 11-09-06, Effective: 01-01-05, Implementation: 12-04-06)

According to [42 CFR 412.27](#) and [42 CFR 482.62](#) IPFs must provide a therapeutic activities program.

(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.

80 - Benefit *Limits in Psychiatric Hospitals*

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per [42 CFR 409.62](#). The 190-lifetime limitation does not apply to certified psychiatric distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

90 - Benefits Exhaust

(Rev. 253, Issued: 12- 14-18, Effective: 01-16-19, Implementation: 01- 16-19)

Effective December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust, and the benefits exhaust date will substitute for the discharge date. The claim will be paid either on the discharge date if the benefits are available or on benefit exhaust date if the discharge is after the benefits exhaust date. When the services actually are provided, the PRICER version used to price claims for the time will be used. No pay/110 TOBs are allowed instead of continually adjusting the claims (117 TOB) until actual discharge occurs once benefits exhaust.

Under the Tax Equity and Fiscal Responsibility Act (TEFRA), the Provider Statistical and Reimbursement (PS&R) report used the benefits exhaust date as the discharge date. This changed when the IPF PPS was implemented, and the 'actual' discharge date was used. The days stay with the year they occurred, making it easier for the PS&R report (especially during the blend period) to settle the cost report. This means that:

1. Claims will be settled on the appropriate cost report;
2. The appropriate PPS-TEFRA blend percentage will be paid;
3. Patients with long lengths of stay will be counted on the correct PS&R report;
and
4. The PRICER version used will be the one in effect at the time the services were provided.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R253BP</u>	12/14/2018	Updates to the Inpatient Psychiatric Facility Benefit Policy Manual	01/16/2019	11062
<u>R223BP</u>	05/13/2016	Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification	08/15/2016	9522
<u>R194BP</u>	09/03/2014	Pub. 100-02 Language-Only Update for ICD-10	Upon Implementation of ICD-10	8605
<u>R181BP</u>	03/14/2014	Pub. 100-02 Language-Only Update for ICD-10 – Rescinded and replaced by Transmittal 194	10/01/2014	8605
<u>R69BP</u>	04/27/2007	Change to the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Discharge Bill	12/03/2007	5474
<u>R59BP</u>	11/09/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
<u>R56BP</u>	11/03/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
<u>R1BP</u>	10/01/2003	Initial Publication of Manual	NA	NA

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