

**American Hospital Association**  
325 Seventh Street, NW, Washington, DC 20004  
Phone: 202/638-1100, Web: [www.aha.org](http://www.aha.org)

**American Psychiatric Association**  
1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901  
Phone: 703/907-7300, Web: [www.psych.org](http://www.psych.org)

**National Association of Psychiatric Health Systems**  
As of 8/16/04: 701 13<sup>th</sup> Street, NW, Suite 950, Washington, DC 20005-3903  
Phone: 202/393-6700, E-mail: [naphs@naphs.org](mailto:naphs@naphs.org); Web: [www.naphs.org](http://www.naphs.org)

---

August 12, 2004

Carol Richards, R.N., Medicare Policy Coordinator  
Mutual of Omaha  
P.O. Box 1602  
Omaha, NE 68101

**REFERENCING:**  
**COMMENTS ON DRAFT LCD—INPATIENT PSYCHIATRIC SERVICES**

Dear Ms. Richards:

As a follow-up to our June 30 letter, the National Association of Psychiatric Health Systems (NAPHS), the American Hospital Association (AHA), and the American Psychiatric Association (APA) submit these comments to Mutual of Omaha regarding its recent issuance of the Draft Local Coverage Decision (LCD) for Inpatient Psychiatric Services. Having had an opportunity to review the draft in greater detail, we find that this draft LCD parallels the inpatient psychiatric LCDs proposed by two other fiscal intermediaries (FIs), Associated Hospital Services and AdminaStar Federal, with whom we have also been working. In letters to those FIs and to CMS, we have outlined a variety of concerns about both clinical and procedural shortcomings with their proposals. Many of those same concerns are raised by language that appears in your draft.

We are pleased to share our thoughts on constructive changes that would improve the Mutual of Omaha draft and look forward to partnering with you to improve the process through which comments are sought for LCDs.

**LCDs Should Only Use “Reasonable And Necessary” Criteria To Determine Medical Necessity**

The proposed inpatient psychiatric services LCD far exceed minimal and reasonable standards to determine Medicare coverage for inpatient psychiatric services. No amount of provider education could result in consistent and uniform compliance with the requirements. In addition, no record would fully comply with the LCD if the LCD’s requirements were collectively and vigorously enforced. Providers’ inability to comply with every individual component of the LCD would place them at risk for massive retrospective denials of medically necessary care and possible False Claims Act liability. Enforcement of the LCD, as written, would force providers to choose whether they can continue to bill Medicare under these requirements, and, therefore, continue to provide needed care to Medicare beneficiaries.

The LCD documentation guidelines, as written, are overly prescriptive and have no basis in the law, regulations, or any CMS program memoranda. The LCD imposes new, binding, and substantive obligations not only for reimbursement determinations, but also on the provider rendering hospitalization services. Thus, such an LCD is neither an interpretive rule nor a general statement of agency policy, but rather a substantive rule. There is little doubt that the purpose of an LCD is to create binding norms and criteria to be used by the intermediaries in making payment determinations. In our view, the LCD would be a substantive rule subject to notice and comment rulemaking provisions of the Administrative Procedures Act.

We approach this LCD with the history of our experience with the partial hospitalization LMRP. Similar to the partial hospitalization LCD, the inpatient psychiatric services LCD is dependent on retrospective chart review and contains the same kind of highly prescriptive language that will result in technical denials that cannot be appealed. While our ability to deliver services was highly disrupted by the enforcement of the partial hospitalization LMRP and resulted in the closure of many partial programs, you can be assured that enforcement of the current LCD would potentially jeopardize the delivery of inpatient psychiatric services across all providers.

### **Incorporate a Clear Statement of Purpose and Proper Use of the LCD**

To ensure that the purpose of the LCD is clear to all parties, a statement of purpose/preamble must be part of the official LCD. Because the LCD will be used to determine if providers will be reimbursed for a specific episode of hospitalization, the language throughout must focus on what is reasonable and necessary and avoid overly prescriptive language. Specific language that we recommend is attached (see Attachment A – “Proposed Statement of Purpose/Preamble”).

### **Additional Technical Corrections Are Necessary**

We agree with Mutual of Omaha that an LCD should “consist only of reasonable and necessary information” to determine medical necessity. However, we are concerned that the Mutual of Omaha draft as written goes beyond this principle in a number of areas. We further suggest that these sections go far beyond the intent of the Medicare statute and regulations. The overly prescriptive language in the following sections will lead to unwarranted denials of Medicare coverage:

- Admission Criteria
- Initial Evaluation
- Plan of Treatment
- Documentation Guidelines/Progress Notes
- Qualified Providers
- Other Providers Licensed or Otherwise Authorized by the State
- ICD-9-CM Codes that Support Medical Necessity

There are technical corrections needed in a number of areas. Attachment B details the problematic sections of the LCD and provides suggested technical modifications to resolve some of the LCD’s issues.

### **Consider Procedural Changes**

We appreciate and commend Mutual of Omaha in its response to the many providers and associations that requested additional time to comment. Providers need the opportunity to

provide thoughtful feedback to the clinical, administrative and legal issues that are raised whenever an LCD is proposed. It is also essential that providers understand the goals and rationale behind the LCD policy.

To ensure that providers can deliver constructive comments prior to implementation, there must be ample time for review and comment, as well as a clearly understood mechanism for notifying affected hospitals of the proposed LCD. Our associations have been dismayed to learn that many of our members were unaware of the draft policy on your Web site. We learned of it only a few days before your comment deadline. This confusion in the field is evidence that the current system of notification is not clearly understood and that many providers are not aware of mechanisms for distributing information for review. We would welcome the chance to work with you, as well as other fiscal intermediaries and CMS, to develop an effective notification process.

LCDs are often long (this draft is 32 pages) and cover complex concepts that require more than a passing glance. Something as simple as having page numbers on your Web-based draft could facilitate comments.

We would be happy to provide further clarification on any of these issues. If you have any questions, please contact Mark Covall at 202/393-6700, ext. 100, or [mark@naphs.org](mailto:mark@naphs.org), or Andrew Whitman at 703/907-7842, or [awhitman@psych.org](mailto:awhitman@psych.org).

Sincerely,

Mark Covall  
Executive Director  
National Association of Psychiatric Health Systems

James H. Scully Jr., M.D.  
Medical Director  
American Psychiatric Association

Rick Pollack  
Executive Vice President  
American Hospital Association

cc: Mark McClellan, Administrator, Centers for Medicare & Medicaid Services  
Thomas R. Barker, Esq., Acting Deputy General Counsel, Department of Health & Human Services  
Kimberly Brandt, Acting Director for Program Integrity, Office of Financial Management, Centers for Medicare & Medicaid Services

ATTACHMENT A

PROPOSED STATEMENT OF PURPOSE / PREAMBLE  
TO THE MUTUAL OF OMAHA LCD ON INPATIENT PSYCHIATRIC SERVICES

---

**The purpose of a Local Coverage Determination (LCD) is to establish criteria for payment of services that are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (Social Security Act, Title XVIII, Section 1862(a)(1)(A).”** The Psychiatric Inpatient Services LCD contains an extensive outline of the kinds of information that providers **may wish to consider** in order to document the requirement for provision of reasonable and necessary care. It is guidance to the field and does not represent an inclusive list of required elements.

**Not all elements listed in each section of this LCD need to be documented in the medical record in order to provide sufficient information to establish medical necessity.**

**It is not the purpose of an LCD to set standards for quality of care, or to ensure completeness of medical record documentation, or to act as a quality monitor. It is not intended to prescribe medical practice.**

As outlined in the *CMS Medicare Benefit Policy Manual*, payment for inpatient psychiatric hospital services is to be made only for “active treatment.” To assure that payment is made only under such circumstances, the law includes certain requirements that must be met before the services furnished in a psychiatric hospital can be reimbursed. They include the following:

- Payment for inpatient psychiatric hospital services is to be made only for “active treatment” that can reasonably be expected to improve the patient’s condition. For services in a psychiatric hospital 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;
  - Supervised and evaluated by a physician.
- A physician must certify and recertify to the medical necessity for the services at designated intervals of the inpatient stay. The certification and recertification statement must contain the following information:
  - An adequate written record of the reason for hospitalization or continued hospitalization;
  - An estimated period of time the patient will need to remain in the hospital;
  - Any plans for post-hospital care.

Documentation to support medical necessity and “active treatment” that is required for Medicare reimbursement can take many forms. The LCD provides guidance in a number of areas related to documentation and may provide useful information to providers as they develop their documentation policies and procedures. However, the guidance should not be used by reviewers as a list of elements that **must** be found in records.

## ATTACHMENT B

### **SPECIFIC EXAMPLES OF PROBLEMATIC LANGUAGE AND RECOMMENDATIONS TO CORRECT THE DRAFT MUTUAL OF OMAHA INPATIENT PSYCHIATRIC SERVICES LCD**

---

In reviewing the draft LCD, there are a number of specific areas in which we recommend changes.

#### **Admission Criteria**

**DRAFT:** The draft states that “patients must require inpatient psychiatric hospitalization services at levels of intensity and frequency exceeding what may be rendered in an outpatient setting, including psychiatric partial hospitalization. There must be evidence of failure at, or inability to benefit from, or unacceptable risk in an outpatient treatment setting. **Claims for care delivered at an inappropriate level of intensity will be denied.**”

**CONCERNS:** **The admission criteria required by the LCD for Medicare coverage are inconsistent with both the statute and the regulations.** The criteria set specified in the LCD (as well as the consequences for perceived noncompliance—denial of claims) is fraught with ambiguity, particularly when information will be reviewed retrospectively. Certain patients present with a clear need to be in the hospital (e.g., a person having just made a serious suicide attempt with continuing suicidal impulses) even though they have never previously presented for services. Arduous documentation about failed outpatient treatment or inability to benefit from such treatment is not required by statute or regulation. This clearly adds an unnecessary, and heretofore unrequired, level of documentation and places the entire stay at risk for denial of reimbursement based solely on retrospective review of documentation.

In addition, the list of admission criteria used in the LCD to assess severity of illness is not supported by statutory or regulatory language. Specific descriptors for admission which are described under the section entitled “Severity of Illness” would not usually be found in a Medicare beneficiary’s medical records because the reasons for admission are required to be in highly individualized language (often in the patient’s own words) by 42 C.F.R. § 482.60. This section of the LCD also requires that in order to qualify for admission and subsequent Medicare coverage, suicidal thoughts, suicidal attempts, or threatening behavior must occur “within a 72-hour period.” This time frame is an artificially determined time limitation not found in 42 C.F.R. § 482.61, and has no support in the medical literature. The American Psychiatric Association recently issued a practice guideline entitled “Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors” (Nov. 2003). We have attached this paper for your reference. The APA practice guideline does not mention timeframes as a factor influencing decisions to hospitalize patients who have suicidal behaviors, and there is no evidence to support the usage of a time period to determine the risk of self-harm.

If the language and specific descriptions contained in the LCD admission criteria are not evident in the medical record, a reviewer could easily be led to deny the claim based on a perception of inadequate documentation. Facilities may use other statements of criteria for admission that clearly support the statutory requirement for documentation of the medical necessity for inpatient treatment but do not necessarily conform to the language in this list. We would welcome the

opportunity to work with you to include clinically accurate and more flexible criteria for hospital admissions.

RECOMMENDATION:

**Eliminate overly prescriptive references. Clarify the intent of the LCD in the preamble.**

**Discharge Criteria**

DRAFT: The proposed discharge criteria states that patients with a GAF score in the range of 30-45 usually are appropriate for discharge.

RECOMMENDATIONS:

**Delete specific GAF score references.** The GAF was never designed as a measure of readiness for discharge and has never been included in statute or regulation. Patients may be actively suicidal or homicidal yet have a GAF score in the 30-45 range.

Eliminate reference to the sentence within “Discharge Criteria” that further states; “Patients unwilling or unable to participate in active treatment of their psychiatric condition would also be appropriate for discharge.” A very ill patient, who is actively hallucinating, very regressed, and unable to leave his room may appear to be unable to participate in active treatment as described in the LCD, yet is very much in need of hospitalization and is receiving and responding to appropriate active treatment through many modalities such as individual interactions, medication, close observation, etc. Discharge of this patient would be inappropriate. Psychiatric patients may state that they are not willing to participate in active treatment. If the nature of their condition places them at risk to themselves or others, they cannot be discharged. We are concerned that a reviewer in the course of a retrospective review using the draft language and criteria, could deny payment of claims.

**Qualified Providers**

DRAFT: The draft LCD includes the list of persons designated as qualified mental health providers but identifies them under language that says “providers of **inpatient** psychiatric services may include...” The list presented in the LCD is of persons typically able to provide and bill for services independently. The draft LCD requires that “an appropriate licensed supervisor must observe and provide one-on-one, in-person, supervision for at least one hour per week for non-licensed/certified MSWs, MFT interns, and psychological assistants.” The draft goes on to say, “A claim that does not fulfill the coverage requirements described above may be given individual consideration based on review of all pertinent medical information” (implying that claims will be denied if this supervision requirement is not met).

RECOMMENDATION:

**The requirements for one-on-one staff supervision are not appropriately applied to the inpatient environment.** The *Medicare Hospital Manual*, Section 212.1, states, “The services of qualified individuals other than physicians (e.g. social workers, occupational therapists, group therapists, attendants) must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual.” Staff work under job descriptions and do only the things for which they have documented competencies. They perform activities that are outlined in the treatment plan that has been developed under the supervision of the physician. There has never

been a requirement for face-to-face supervision of inpatient psychiatric staff. In addition, this supervision would not be documented in the medical record and, therefore, would be unavailable for retrospective review. **This wording should be eliminated.**

### **Other Providers Licensed or Otherwise Authorized by the State**

*RECOMMENDATION:* Many providers such as marriage and family therapists would be excluded from Medicare coverage under Section 1862(a)(1)(A) of the Social Security Act. Consequently, we recommend that these categories of practitioners be eliminated from the LCD.

### **ICD-9-CM Codes that Support Medical Necessity**

*DRAFT:* The LCD has two distinct lists, including ICD-9-Codes that Support Medical Necessity and ICD-9-Codes That DO NOT Support Medical Necessity.

#### *RECOMMENDATION:*

**Change language so that *all* ICD-9 codes are available. Nothing in the statute, regulations, or the *Medicare Manual* distinguishes between those covered and non-covered diagnoses.**

There are a whole group of diagnoses not contained on the list in the draft LCD, including several anxiety disorders, personality disorders, and somatoform disorders that "may be denied." During a medical review by the fiscal intermediary, if a medical reviewer reviewing a chart does not find one of the diagnoses listed in the LCD, the service most likely will be denied. Neither the Social Security Act nor the regulations determine the medical necessity criteria by which a given hospital stay should be covered by Medicare. Consequently, the Medicare coverage criteria for inpatient care should be the standard by which an inpatient psychiatric stay should be covered by Medicare.

### **Initial Psychiatric Evaluation**

*DRAFT:* The LCD describes an extensive list of elements that may be appropriate for inclusion in a psychiatric evaluation.

*CONCERNS:* Given the realities of acute psychiatric treatment, it is not always possible to obtain the information required for documentation of each area outlined. Patients may be too acutely ill to be able to provide a medical history or information about past treatment. In addition, patients may not have a representative who could provide family, vocational or social history. A patient may, because of his or her illness, refuse to have a physical exam at the point of admission. However, in such a case, it should be very clear from the limited information that can be obtained and documented that the patient meets medical necessity criteria for inpatient care (i.e., through a description of the current illness and mental status exam). Reviewers should use the information available to determine that the patient needs to be in a 24-hour structured, intensive and secure setting with medically directed active treatment.

#### *RECOMMENDATIONS:*

**Delete prescriptive references and clarify that detailed lists are intended only as a reference for reviewers. Include specific language that emphasizes that the presence of adequate documentation of medical necessity is required, which may be indicated by the presence of some (but not necessarily all) of the criteria listed.**

## **Plan of Treatment**

*DRAFT:* The draft LCD states that the plan of treatment must include the specific treatments ordered, including type, amount, frequency and duration of the services.

*CONCERNS:* The plan of treatment is the outline of what the hospital has committed itself to do for the patient, based on an assessment of the patient's needs. There must be periodic review of the patient's response and progress toward meeting planned goals, according to 42 C.F.R. § 482.61(c)(1). The LCD describes a treatment planning process that **could** be used as a guide for organizations in their documentation of a patient's individualized treatment plan and the subsequent updating of the plan. If the treatment plan reviewed in a given record does not contain this level of specificity in all aspects (e.g., that the type, amount, frequency and duration of each specific treatment is not specified), it should not be assumed that the statutory requirement for an individualized treatment plan has not been met. An overall evaluation of the plan to determine how it reflects a plan for active treatment is appropriate.

### *RECOMMENDATION:*

**Delete prescriptive references and clarify** that lists are intended only as a guideline.

## **Progress Notes**

*DRAFT:* The statutory requirement for documentation (Section 1833(e) of the Social Security Act) states, "**No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period**" (emphasis added). The Conditions of Participation for Hospitals, 42 C.F.R. §§ 405.1037(a)(9) and (10), further state that "the treatment furnished the patient should be documented in the medical record in such a manner and with such frequency as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it."

The LCD uses these citations as the basis for making the interpretation that "**therefore a separate progress note is required for each service rendered**. The progress note should be written by the team member rendering the service and should include a description of the nature of the treatment service, the patient's status (behavior, verbalization, mental status) during the course of the service, the patient's response to the therapeutic intervention and its relation to the long or short term goals in the treatment plan. It should be clear from the progress note how the particular service relates to the overall plan of care." **It further requires that** "individual and group psychotherapy and patient education and training progress notes must describe the service being rendered (i.e., name of group, group type, brief description of the content of the individual session or group), the patient's communications, and response or lack of response to the intervention. Each progress note should reflect the particular characteristics of the therapeutic/educational encounter to distinguish it from other similar interventions."

*CONCERNS:* The specificity of documentation required by the LCD ventures far beyond the applicable statutory and regulatory requirements. It may be appropriate to document each individual or group session in a setting where patients are receiving discrete services that are

being billed individually, such as an outpatient group or individual session. However, payment for inpatient psychiatric care is based on a day of service, not (with the exception of services billed by individual providers such as physicians) on each service rendered. There is no statutory requirement for a separate progress note for each service in a setting where those services are not being billed separately. The content of physician progress notes must continue to support the need for medically necessary inpatient care, but are not required to contain specific elements. Likewise, individual and group psychotherapy and patient education and training notes, while very important tools in supporting the requirement to document a patient's response to the active treatment program, are not required to contain specific elements or be of a prescribed frequency as delineated in the LCD.

Staff employed by the facility and not billing for individual services provide group and individual interventions as specified in the patient's individualized treatment plan, which is under the direction of a physician. These staff members are typically nurses, psychiatric technicians, social workers and activity therapists. The time required to document each intervention at the level described in the LCD would detract significantly from the ability of staff to provide care and does not capture the patient's clinical response in an integrated way throughout the treatment day.

The LCD states an extensive list of elements that "should" and "must" be included in initial psychiatric evaluations, physician orders and treatment plans. With few exceptions, Medicare regulations are not prescriptive of medical practice and defer to the policies and procedures developed by the medical staff within an organization. Developing and prescribing such lists exceeds the reasonable function of an LCD.

We are concerned about any language that can be subjectively interpreted. For example, the broad statement that "Medical record documentation must be legible, and meet the criteria contained in this policy" could be broadly interpreted to deny a claim that one reviewer could not read, but that reasonable others could. We fear that inappropriate or inconsistent interpretation could lead to automatic denial of claims, leaving providers with no redress or potential for review of specific claims. As we suggested at the start of our letter, a preamble or clear statement of purpose can help to clarify the role of the LCD.

*RECOMMENDATION:*

**Delete documentation requirements that exceed the scope of the regulations.**