

American Hospital Association
American Psychiatric Association
Federation of American Hospitals
National Association of Psychiatric Health Systems

March 22, 2005

Rick Reeves
Mutual of Omaha
Medicare Division
P.O. Box 1602
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Dear Mr. Reeves:

Please accept this letter as a formal request for reconsideration of Mutual of Omaha's Local Coverage Determination (LCD) for Psychiatric Inpatient Hospitalization (2005-01) on behalf of our members who provide inpatient psychiatric care in regions where Mutual of Omaha serves as Medicare fiscal intermediary.

Since the level of evidence required for LCD reconsideration is the same as that required for new/revised LCD development (PIM 13.7.1) and since no "published authoritative evidence derived from definitive randomized clinical trials or other definitive studies" (PIM 13.7.1) dealing with the medical care covered by the LCD were cited in support of the current Mutual of Omaha LCD for Psychiatric Inpatient Hospitalization, we are basing our request for reconsideration primarily on "general acceptance by the medical community (standard of practice) as supported by sound medical evidence." (PIM 13.7.1)

Our request is based on the current standard of practice for psychiatric inpatient care as communicated to us by experts in the delivery of inpatient psychiatric care. The comments in the enclosed Reconsideration Request, which deal with some specific problems in the current LCD, arise from the direct experience of these members in providing inpatient care and from their interactions with other providers who participate in this care. The issues raised in this request for reconsideration do not comprise all of the issues that should be raised once the reconsideration process begins. It is our hope that the expert medical advisory panel that we hope will be created to work with Mutual of Omaha on the revision of the LCD will raise any other issues that need to be taken into account.

As currently written, the LCD is not consistent with expert medical opinion on the delivery of inpatient psychiatric care. Implementation of the LCD as written would likely inhibit the delivery of medically necessary care to Medicare beneficiaries.

Thank you for your attention to the details provided in the attached reconsideration request, which outline specific areas for reconsideration, based on standards of practice for inpatient psychiatric care. Please contact Mark Covall at NAPHS if you have questions (mark@naphs.org or 202-393-6700, ext. 100).

Sincerely,

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Attachments: Addendum A, Addendum B, Reconsideration Request

cc: Jackie Stanard, Kansas City Regional Office, Centers for Medicare and Medicaid Services

REVIEWERS: PLEASE COMMENT: DOES THIS CLARIFICATION ACCOMPLISH WHAT IT IS INTENDED TO DO: MAKE IT CLEAR THAT NOT ALL ELEMENTS MUST BE IN THE MEDICAL RECORD? IT DOES NOT FORCLOSE THE POSSIBILITY THAT THE FI COULD DEEM ANY ONE OF THE ELEMENTS ABSOLUTELY ESSENTIAL.

Addendum A

Proposed Statement Of Purpose / Preamble
to the Mutual Of Omaha LCD on Psychiatric Inpatient Hospitalization

Submitted by the American Hospital Association, American Psychiatric Association, Federation of American Hospitals, and National Association of Psychiatric Health Systems

March 2005

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.

Addendum B

Nominees for Expert Clinical Advisory Panel

Submitted by the American Hospital Association, American Psychiatric Association, Federation of American Hospitals, and National Association of Psychiatric Health Systems

March 2005

NEED NOMINEES FROM ALL ORGANIZATIONS

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RECONSIDERATION REQUEST

for the Mutual of Omaha LCD for Psychiatric Inpatient Hospitalization

*Quotations of passages from the Mutual of Omaha LCD are in boldface type
and recommended changes are in boldface italics.*

Submitted by the American Hospital Association, American Psychiatric Association, Federation of American Hospitals, and National Association of Psychiatric Health Systems

March 2005

1. Admission Criteria (Intensity of Service): **“There must be evidence of failure at, inability to benefit from, or unacceptable risk in an outpatient treatment setting.”**

Comment: Evidence of past failure in or inability to benefit from an outpatient setting, if known, can be presented as historic fact. It is our understanding that this admission criteria listing derives from § 13.5.4 of the Program Integrity Manual (PIM), which pertains to establishing prerequisites. It should be noted, however, that in this section of the PIM it states:

“Prerequisites shall be based on medical appropriateness, not on cost effectiveness, in the case of psychiatric patients, an unacceptable risk in a future outpatient setting is a matter of medical judgment based on the patient’s clinical presentation and as much history as can be obtained, frequently in an urgent setting. Best practices do not require evidence for failure in or the inability to benefit from an outpatient treatment setting if such history is unobtainable at the time of emergency presentation for hospitalization. In addition, certain patients have no outpatient histories. In the absence of the ability to determine if such a history exists, obtaining evidence as opposed to making a medical judgment would require a trial of outpatient setting, frequently inadvisable precisely because of the unacceptable risk.

Recommended changes: ***There must be evidence of failure at or inability to benefit from outpatient treatment or documentation of a medical judgment that the patient would face an unacceptable risk in an outpatient setting.***

2. Admission Criteria (Severity of illness):

“ 1. Threat to self requiring 24 hour professional observation.

a. Recent suicidal ideation, gesture or attempts within 72 hours prior to admission.

b. Recent self mutilation (actual threat) within 72 hours prior to admission.”

Comment: Placing subparagraphs a. and b. under number 1, may imply that “threat to self” is defined by subparagraphs a. and b. (and also c. which is not a subject of discussion in this letter).

Threat to self, overt or implied, is the most common immediate reason for psychiatric hospitalization. However, it does not require suicidal ideation, gesture, attempts, or mutilation to conclude that the patient is such a threat. In a recent study examining suicidal ideation in patients who actually killed themselves in the hospital or shortly after discharge, close to 80% of such patients had no such ideation or denied suicide ideation as their most recent recorded clinical observation. (Reference 1).

Contemporary evaluation of suicidality requires a comprehensive assessment that includes ideation, gesture, or attempts when present, but also includes other factors such as patient’s

history of attempts (not restricted to recent history), associated symptoms such as those accompanying major depressive disorder, schizophrenia, or substance abuse, and changes in the patient's circumstances such as loss of a loved one or critical social support (Reference 2).

Further, the inclusion of the phrase "**within 72 hours prior to admission**" is clinically arbitrary. If a pattern of suicide attempts has established itself as connected with specific circumstances and symptoms, and those circumstances and symptoms have clearly repeated themselves, the physician should be alerted to the potential need for 24-hour professional observation whether or not verbal threats or actual attempts fell within a 72-hour period. Contemporary best practices require a multifactorial approach to suicide evaluation and the exercise of medical judgment about whether or not the recent history is relevant to the patient's risk rather than reliance on an arbitrary number of hours.

Recommended changes:

- 1. Threat to self requiring 24-hour professional observation.**
- 2. A history of suicidal ideation, gesture or attempts relevant to the current risk.**
- 3. A history of self mutilation (actual or threatened relevant to the current risk).**

(Renumber or re-letter the subsequent admission criteria.)

3. "A physical exam must be completed to rule out medical/neurological causes of psychiatric symptomatology. Several conditions should be first treated in a medical ward or even in an intensive care unit prior to the psychiatric hospitalization. Examples are drug overdose, anticholinergic delirium, and neuroleptic malignant syndrome, among many others. "

Comment: The latter two examples, anticholinergic delirium and neuroleptic malignant syndrome, may arise after psychiatric hospitalization and often cannot be "first treated" in a medical setting.

The phrase, "**A physical exam must be completed,**" implies a complete physical examination. This is frequently impossible in an emergency setting. Rather, best practices are to conduct as much of the physical examination as can be done reasonably, employing laboratory testing and imaging relevant to the suspicion of medical and neurological causes to the extent possible. Such suspicion does not necessarily require a complete physical examination but often arises from observation of the patient's mentation, state of consciousness and partial examination such as with vital signs.

Recommended changes: ***A physical examination and other necessary diagnostic evaluations should be completed to the extent possible and as indicated by the patient's clinical presentation to rule out medical/neurological causes of psychiatric symptomatology. Several conditions should be treated in a medical setting as opposed to a psychiatric setting. Examples include: potentially life threatening drug overdose, anticholinergic delirium, neuroleptic malignant syndrome, among many others.***

Finally, in this section, nurse practitioners often perform physical examinations as capably as psychiatric physicians. A request is made to add to this sentence to the section:

An advanced practice nurse licensed to perform physical examinations may conduct such examinations upon admission, provided that a physician review the record of such examination and document his or her review by signature within 24 hours of admission.

4. Active Treatment: **“In accordance with the above definition of ‘improvement’, the administration of certain medications such as tranquilizing drugs which are expected to significantly alleviate a patient’s psychotic or neurotic symptoms would be termed active treatment (assuming the other elements of the definition are met). However, the administration of a drug or drugs does not itself necessarily constitute active treatment. Thus the use of mild tranquilizers for the purpose of relieving anxiety or insomnia would not constitute active treatment.....”**

Comment: The terms “**tranquilizer**” or “**tranquilizing**” and the term “**neurotic**”, while still used in the lay press, are now generally not favored for medical records or medical literature. Substitute terminology is recommended.

The last sentence which refers to the use of “mild tranquilizers” for the treatment of anxiety raises a specific problem. The term “**mild tranquilizer**” is undefined in the medical literature. Benzodiazepines have in the past sometimes been categorized as “minor tranquilizers” to distinguish them from “neuroleptic” or “antipsychotic” medication. Certain benzodiazepines, for example lorazepam, have an anxiolytic use well documented in the medical literature. Furthermore the use of such medication may be an important part in improving the severe anxiety or agitation accompanying manic psychosis or the intense subjective anxiety which serves as a prelude for suicidal behavior. .

The last sentence in the current LCD paragraph appears to intend to convey that, by itself, the use of psychiatric medication to relieve “mild” symptoms not otherwise requiring hospital level of care would not be considered “active treatment” sufficient for inpatient reimbursement. If that is the intent, substitute language is recommended below.

Recommended changes: ***“In accordance with the above definition of ‘improvement’, the administration of certain psychoactive medications which are expected to significantly alleviate a patient’s symptoms would be termed active treatment (assuming the other elements of the definition are met). However, the administration of a medication or medications, by itself, does not necessarily constitute active treatment. For example, the use of psychoactive medications would not, by itself, constitute active treatment for the purposes of reimbursement if they were used for the purpose of relieving symptoms which are sufficiently mild as to not require hospital level of care”***

5. Discharge Criteria (Intensity of Service): **“Patients in inpatient psychiatric care should be discharged by stepping down to a less intensive level of outpatient care.patients would become outpatients, receiving either psychiatric partial hospitalization or individual outpatient mental health services.....”**

Comment: Certain patients benefit more from group or family outpatient mental health services than “individual” outpatient mental health services.

Recommended changes: ***“.... patients would become outpatients, receiving either outpatient psychiatric partial hospitalization or outpatient mental health services....”***

6. Discharge Criteria: **“Patients whose clinical condition improves or stabilizes, who no longer pose an impending threat to self or others, and who do not still require 24 hour observation available in an inpatient psychiatric unit should be stepped down in treatment. Patients whose Global Assessment of Functioning score is in the range of 30-45 would usually be appropriate for discharge to a less intense level of care.”**

Comment: The first sentence in the above, if read literally, requires discharge if three somewhat overlapping criteria are met. These criteria are not exhaustive. Medical judgment must also take into account whether the patient will likely relapse to a point requiring re-hospitalization immediately after discharge even with the supports of stepped-down treatment. Although a patient may be stable for the moment, when such an immediate threat of relapse is present, the physician is required to take this into account with further active treatment and, if necessary, on a continuing inpatient basis.

There is near universal agreement among psychiatrists that a patient with a Global Assessment of Functioning (GAF) score beginning in the range of 30 is unlikely to be **“appropriate for discharge to a less intense level of care.”** A GAF of 30 includes psychotic symptomatology and symptoms of suicidality, two factors, especially when taken together, which usually indicate the need for hospitalization rather than for discharge. Finally, and perhaps most important, the GAF score is not used in contemporary practice for admission or discharge decisions.

Recommended changes: ***Patients whose clinical condition improves or stabilizes, who no longer pose an impending threat to self or others, who do not constitute a significant risk of symptom relapse if discharged that would likely require rehospitalization, and who do not still require 24-hour observation available in an inpatient psychiatric unit, should be stepped down in treatment.***

7. Initial Psychiatric Evaluation.

Comment: A requirement that each of the factors listed be included for all patients **“within 24 hours of admission”** would, in our opinion, be unrealistic and outside of actual practice. In situations of psychiatric emergency, certain of the specific factors required may not be available. Furthermore, the reasonable expectation that the patient **“will make timely and significant practical improvement in the presenting acute symptoms as a result of the psychiatric inpatient hospitalization services”** can often not be reliably made in that time period.

Best practices require that the physician take into account the patient’s need for safety and emergency treatment even in the absence of full information and then be guided by information gathered at a later time, by the patient’s response to treatment and by diagnostic tests subsequent to admission. None of these may be available within 24 hours of admission.

Recommended changes: Include in this paragraph a modification that: ***“requirements for elements of the initial psychiatric evaluation may be waived if they could not be obtained at the time, provided that there is documentation that after the initial psychiatric evaluation, reasonable attempts persisted to obtain further historical and physical examination data necessary for the patient’s treatment”.***

Add the words “medical judgment of likely” to the following sentence: ***“...current medical history, including medications, and evidence of failure at or documentation of medical judgment of likely inability to benefit from a less intensive outpatient program.”***

Add to the paragraph on physical examination as follows: ***“...neuroleptic malignant syndrome, among many others. If a full physical examination cannot be completed because of the patient’s condition, including the patient’s refusal to grant permission for such examination, observations relevant to medical/neurological causes of emotional symptomatology and partial physical examination relevant to those causes should be carried out to the extent possible. Such partial physical examination should be followed***

by a complete examination as the patient's clinical condition and permission for such examination allows.

Finally, again, many nurse clinicians may perform physical examinations as capably as psychiatric physicians themselves. **A request is made to permit a nurse licensed in advanced practice (or physician assistant) to do physical examinations, be permitted to conduct the physical examination upon admission with the results of the examination reviewed by a physician whose review is documented by his or her signature.**

8. Plan of Treatment:

Comment: Elements described here have been in existence for approximately 30 years as general criteria for hospital participation in the Medicare program (as opposed to review criteria for individual records for the purpose of determining medical necessity). These elements have not changed substantially. Practice, however, has changed greatly. Lengths of stay of one to two months, which were not uncommon when these criteria first originated, permitted tedious attention to the details of these plans without significantly compromising patient care. With present short lengths of stay and with an inpatient population ever more acutely ill, the requirement for each of these elements does not fit every patient and the attempt to include and record them all for each patient detracts from patient care by virtue of the inordinate time required. This comment is applicable both to the plan of treatment and to progress notes.

The current LCD document includes the statement **"the treatment plan must include."** If the LCD document on plan of treatment and progress notes were used according to the literal language of this section, then the exclusion of a single element of the LCD could be used to justify non-payment for services. The provider community perceives this as inappropriate and not contributing to patient care.

As an example of the issues involved, a requirement **"including the type, amount, frequency, and duration of the services to be furnished"** fits patient orders in which the type of medication, its milligram strength, the number of times per day, and the number of days it should be continued can be readily written. However, the application of the requirement, **"amount"** to individual or family psychotherapy and distinguishing this from **"frequency"** and **"duration"** is difficult or without significance.

Furthermore, treatment is adapted to that which the patient can use. Thus, while the need for psychotherapy might be predicted within the first three days after admission, the duration of that psychotherapy predicted at day three may be clinically meaningless.

Outcomes of psychotherapy intervention, critical to a patient's improvement, may be easily described but not easily put into **"measurable"** terms. For example, a patient's admission of illness, and an apology to a family member may represent an emotional breakthrough that permits a productive pathway for development and prevention of future relapse. Attempts to put this in "measurable terms" stretch actual practice to fit a documentation requirement unsuitable for the specific purpose. For instance, the physician writing that "the patient shall state three times that he recognizes that he has had a manic illness and is sorry for the problems caused to his family" is not contributing to patient care by adding a "measurable term". Rather, he or she is performing an exercise designed to avoid penalty.

"Measurable terms" are, of course, well suited to other outcomes such as the gaining of weight to a safe level in anorexic patients. Medical judgment should be permitted to distinguish how best to describe outcomes in clinically meaningful terms.

Recommended changes: ***“...The treatment plan should include those elements necessary to document active treatment of the cause of the patient’s admission and other psychiatric and medical illnesses requiring treatment during the inpatient hospitalization. To the extent relevant to the patient’s condition, this plan should include: specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished and expected outcomes for treatment that are directly related to the cause of the patient’s admission and to other psychiatric or medical illnesses requiring treatment during the course of hospitalization.*”**

9. Progress Notes: ***“....a separate progress note is required for each service rendered.”***

Recommended change: ***“.... a separate progress note is required for each service rendered if such services are to be presented for separate payment or if such progress note is required to document active treatment”***.

10. Physician Progress Notes. ***“Physician progress notes should be recorded at each patient encounter and contain...”***.

Comment: The LCD prescribes the same format for each physician progress note. In practice this is inappropriate. The physician may see patients for a new psychiatric problem or for medical problems. The physician may be following the patient after a treatment intervention (such as intramuscular medication) four or five times during the day. A progress note is written after each patient visit. The current LCD requirement containing a list of details, all of which must be included, is not appropriate for all circumstances.

Recommended changes: ***Physician Progress Notes: A separate progress note should be written for each significant diagnostic and therapeutic service rendered and should be written by the team member rendering the service. Progress notes should include, to the extent clinically relevant, a description of the nature of the diagnostic or therapeutic service rendered, the patient’s response to the therapeutic intervention, and the relationship of the diagnostic or therapeutic services rendered to the goals of the treatment plan or to a new clinical problem. The relationship of the diagnostic or therapeutic services rendered to the goals of the treatment plan or to a new clinical problem should be reasonably apparent either because of the contents of the progress note itself or by the context of a specific progress note in juxtaposition to other notes in the record.***

11. Individual and Group Psychotherapy and Patient Education and Training Progress Notes.

Comment: The requirement here implies that a specified detailed progress note must be written after each **“education and training”** session, either **“individual”** or **“group”**. While such detail may be usefully written in progress notes regarding selected individual or group psychotherapies, it does not fit current practice regarding many important educational efforts. For example, in dual diagnosis units, group educational lectures or films on addiction and substance abuse are commonly used.

The impact of a group educational experience on a specific patient, however, is usually not best judged by interviewing each patient after each film or lecture and recording a progress note, a process that would seem to be dictated by the current documentation requirement. Instead, the impact of educational or training efforts is usually assessed by the physician or other clinician by noting changes in attitude, knowledge, and skills after a series of group and individual efforts,

both psychotherapeutic and educational, and documenting those changes (or lack of them) at clinically meaningful intervals. To apply the same requirements to group educational and training sessions as to individual or group psychotherapy would be burdensome and generally without clinical benefit to the patient.

Finally, the word *must* should be changed to the word *should* in this section to avoid being overly prescriptive.

Recommended changes: ***“Individual and group psychotherapy notes and education and training notes should follow the same guidelines as stated above under physician progress notes.”***

Thank you for your attention to this request, which is intended to initiate the LCD reconsideration process. It is our hope that by working together we will produce an LCD that reflects current best practices.

References:

1. K.A. Bush, J. Fawcett, D.G. Jacobs, Clinical Correlates of Inpatient Suicide, *J.Clin. Psychiatry*, 2003:64
2. G. Jacobson, The Inpatient Management of Suicidality, in *The Harvard Medical School Guide to Suicide Assessment and Intervention* (D.Jacobs, Ed.), 1998.