ACUTE PSYCHIATRIC INPATIENT SERVICES
HS-277

APPLICATION STATEMENT
The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER
The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND
Acute inpatient psychiatric treatment is provided in a secure, locked setting which is staffed 24/7 with nursing personnel and psychiatric specialists. Care includes skilled psychiatric nursing care, daily medical evaluation and management, and a structured treatment milieu. The goal of acute inpatient psychiatric care is to stabilize individuals with a sudden onset of psychiatric symptoms that create an emergent need for care, or a notable exacerbation of psychiatric symptoms associated with a persistent, recurring disorder. These members pose a significant danger to self or others, or display severe psychosocial dysfunction to the extent that their health is at imminent risk. Special treatment may include physical and mechanical restraint, seclusion, and a locked unit.

Acute Psychiatric Inpatient Services
Policy Number: HS-277

Original Effective Date: 12/12/2014
Revised Date(s): 12/3/2015; 12/8/2016; 10/5/2017
Active family/significant other involvement is important unless contraindicated.

**POSITION STATEMENT**

**Applicable To:**
- Medicaid – All Markets
- Medicare – All Markets

**Exclusion Criteria**

1. Member’s clinical problem is primarily social, financial, and/or medical in nature and there is an absence of a primary psychiatric diagnosis.
2. The member can be safely maintained at a lower level of care.
3. The individual exhibits serious and persistent mental illness and is not in an acute exacerbation of the illness.

**Delivery**

WellCare expects acute psychiatric inpatient services to include an initial assessment with the attending psychiatrist within 24 hours of admission and a documented daily visit with a psychiatry/specialist prescribing provider 7 days a week. Member must be seen initially by a MD within the time frame required by state law, and then every day. Exceptions to this requirement may be granted based on geographic considerations and provider access/availability; however the minimum standard includes documented visits by a specialty prescriber at least 5 days a week and no more than 48 hours apart.

**Admission Service Criteria**

Member must meet the following criteria for admission:

1. Evaluation by a licensed behavioral health clinician indicates symptomatology consistent with a mental health diagnosis which requires and can reasonably be expected to respond to therapeutic interventions provided at this level of service.

AND at least ONE of the following (Items 2-11):

2. The member has made a suicide attempt which is serious by degree of lethality and/or intention, or has suicidal ideation with a plan and means that has potential lethality. Impulsive behavior and/or concurrent intoxication may increase the need for consideration of this level of care. However, 23-hour observation may be used initially to rule out the presence of acute psychiatric symptomatology and/or as a result of intoxication. Assessment should include an evaluation of:
   a. the circumstances of the suicide attempt or ideation;
   b. the method used or planned;
   c. statements made by the individual related to their intent;
   d. whether the member arranged for their own rescue;
   e. the presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses;
   f. the presence or availability of a support system; and
   g. history of prior suicide attempts

3. If using the Columbia-Suicide Severity Scale, there is a “yes” response to either question 1 or 2 on the Suicidal Ideation section, OR, a total score >10 on the Intensity of Ideation section.

4. Current homicidal or assaultive threats or behavior, resulting from a mental health disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means).

5. Command hallucinations directing harm to self or others.
6. Recent history (within 24 hours of admission) of significant self-mutilation (non-chronic) requiring medical attention beyond basic first aid, significant risk-taking that has the potential for lethality or significant risk of harm to others, or loss of impulse control resulting in danger to self or others.

7. Recent history (within 24 hours of admission) of violence resulting from a recognized DSM disorder.

8. Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the individual cannot function at a less intensive level of care, thus risking their health and well-being, or their life.

9. Disorientation or memory impairment which is due to a recognized DSM disorder and accompanied by severe agitation which endangers the welfare of the individual or others.

10. The individual manifests major disability in social, interpersonal, occupational, and/or educational functioning which is leading to dangerous or life-threatening functioning and that can only be addressed in an acute inpatient setting.

11. Inability to maintain adequate nutrition or self-care due to a psychiatric disorder and family/community support cannot be relied upon to provide essential care.

**Continued Stay Criteria**

Member must meet **ALL** of the following criteria for continued stay:

1. Member continues to meet the criteria defined in above Admission Criteria: acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate; **AND,**

2. The multi-disciplinary discharge planning process starts from the initial behavioral health assessment, and includes the patient and family/significant other as appropriate unless contraindicated; **AND,**

3. Treatment planning is individualized and appropriate to the individual’s changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems, social, occupational and interpersonal assessment with involvement unless contraindicated. Family sessions need to occur in a timely manner. Treatment planning goals should be realistic and attainable. Expected benefits from all relevant modalities, including family and group treatment are documented; **AND,**

4. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident; **AND,**

5. There is the need for significant ongoing psychiatric interventions, including medication adjustments for management of core symptoms/behaviors or side effects; **AND,**

6. Care is rendered in a clinically appropriate and evidence-based manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan; **AND,**

7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated and consistent with prescribing guidelines. Treatment plan will be updated to address non-compliance issues; **AND,**

8. Patient is actively participating in plan of care and treatment to the extent possible consistent with his/her condition; **AND,**

9. Coordination with relevant outpatient providers is implemented.
Discharge Criteria

Any of the following criteria are sufficient for discharge from this level of care:

1. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a lower level of care. Follow-up aftercare appointment is arranged for a timeframe consistent with the individual's condition and applicable standards.

2. The individual no longer meets admission criteria or meets criteria for a less intensive level of care.

3. The individual, family, legal guardian and/or custodian are competent but non-participatory in treatment or in following program rules and regulations.

4. The non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.

5. Either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment.

6. Consent for treatment is withdrawn and, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment.

7. Support systems that allow the patient to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured.

8. The individual is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care due to exhibiting baseline behavior/symptoms of a chronic condition.

REV Code 124 must be billed in accordance with the FL AHCA Hospital Handbook.

Covered CPT Codes

+ 90785 Interactive Complexity
90791-90899 Psychiatric Diagnostic Procedures

Covered ICD-10-CM Diagnosis Code

R45.851 Suicidal ideation
T14.91 Suicide attempt
X71.0XXA-X83.8XXS Intentional self-harm
Z91.5 Personal history of self-harm

Covered ICD-10-PCS Codes

GZ5ZZZ-GZ5ZZZ Individual psychotherapy

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. InterQual Behavioral Health Inpatient Initial Review criteria, 2015.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>10/6/2017, 12/8/2016</td>
<td>Approved by MPC. No changes.</td>
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<tr>
<td>12/3/2015</td>
<td>Approved by MPC. Updated coding.</td>
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<tr>
<td>12/12/2014</td>
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Clinical Coverage Guideline