Riverside University HEALTH SYSTEM Behavioral Health

MEDICAL NECESSITY DOCUMENTATION AND GUIDELINES FOR INPATIENT PROVIDERS (ACUTE DAYS)

Medi-Cal will pay for (reimburse) acute psychiatric hospitalizations when *Medical Necessity* is documented in the hospital records. Certain criteria must be met to establish that Medical Necessity is present; these criteria are described in the section Title 9 of the *California Code of Regulations.*

In simplest terms, Medical Necessity is established when documentation in the hospital records shows that a particular patient could be reasonably, safely and effectively treated *only* in an acute psychiatric hospital setting and not at a lower level of care.

In order to establish Medical Necessity for **ADMISSION**, the following must be documented:

Diagnosis:
The patient has a mental health disorder or emotional disturbance, which is the cause of his/her impairments. Any valid psychiatric diagnosis found in ICD-10 is allowable for potential reimbursement. However, neurocognitive disorders are not reimbursable.

Impairment:
Documentation establishes the presence of symptoms or behaviors that:

a) Indicate a current danger to self (DTS), danger to others (DTO) or of significant property destruction -OR-
b) Prevent a patient from providing for, or utilizing, food, clothing or shelter; i.e., grave disability (GD) -OR-
c) Present a severe risk to the patient's physical health -OR-
d) Represent a significant deterioration in ability to function

--AND--

e) Cannot be safely treated at a lower level of care and requires further psychiatric evaluation, medication treatment or other treatment which can reasonably be provided only in a psychiatric hospital

Efficacy:
The treatment planned for and provided to the patient must have a reasonable likelihood of reducing the impairments. In other words, even if a patient is seriously impaired by a psychiatric

disorder, when there is little or no reason to think that continued treatment in an

acute hospital will result in further, significant improvement, Medical Necessity is no longer present. At that point, placement is usually indicated.

The criteria to establish Medical Necessity for **CONTINUED STAY** are very similar to those used for admission.

a) Continued presence of indications which meet the medical necessity criteria for psychiatric hospital services -OR-
b) Serious adverse reaction to medication, procedures or therapies requiring continued hospitalization -OR-
c) Presence of new indications which meet medical necessity criteria for psychiatric inpatient services -OR-
d) Need for continued medical evaluation or treatment that could only be provided if the patient remained in a psychiatric inpatient hospital

Additional documentation guidelines:
In general, documentation for each continued hospital day should reflect symptoms and behaviors *exhibited on that day* and not from previous days. In other words, ideally the documentation establishing medical necessity for each day should be able to *stand alone* and not depend on documentation from previous days. (Recent symptoms may sometimes need to be considered. For example, a patient who says he has S/I but has never harmed himself is at a much lower risk of self-harm than a patient who says he has S/I and who was admitted a couple of days earlier after a very serious suicide attempt).

The primary diagnosis documented in the hospital discharge summary must be a covered diagnosis. If the primary diagnosis is not a covered diagnosis, the entire hospitalization must be denied as an *Administrative Denial.*

A patient whose primary diagnosis is a substance use disorder, substance intoxication or substance withdrawal does not have a covered/reimbursable diagnosis for admission to an acute psychiatric hospital and the hospitalization will be denied. (However, this is scheduled to change in early 2026.) As long as there is another psychiatric disorder which is primary and which is the primary focus of treatment in the hospital, the substance abuse can (and should) also be addressed. If the patient is diagnosed with a primary mood or psychotic disorder, which appears to be secondary to substances, that diagnosis is covered/reimbursable.

Documentation that describes specific behaviors is much more likely to meet Medical Necessity than documentation that just describes impressions or conclusions. For example, it is better to write that a patient yelled, slammed his door and hit the wall with his closed fist rather than

just writing that the patient was agitated. Statements that a patient is a moderate suicide risk, can't contract for safety or can't formulate a plan for self-care are of little value. (See *Attachment B*)

In order to meet criteria for DTS or DTO based on S/I or H/I, ideally a specific plan or intent to harm oneself or others should be present. Just noting S/I or H/I without a plan or intent is not always sufficient by itself to establish Medical Necessity. Sometimes documenting a behavior in the hospital (e.g., attempting suicide or hitting a staff member) will also establish medical necessity for DTS or DTO.

If a patient says that he is not currently suicidal in the hospital but he would be suicidal if he were discharged that day, it is helpful to document if the patient would feel safe if he were discharged to a lower level of care such as a CRT or B&C. If the patient says he would feel safe at a CRT or B&C or if this option is not discussed, Medical Necessity may not be established.

In order for command auditory hallucinations (CAH) to meet the impairment criteria of DTS or DTO, documentation should also note the patient's ability or inability to resist the commands.

In order to meet the criteria for GD, documentation *must* indicate that the patient is unable to *utilize* food, clothing or shelter even when it is provided to him. If a patient could be safely and reasonably discharged to a lower level of care (e.g., B&C, CRT, IMD, SNF) where essentials are provided, then a patient is not considered to be gravely disabled.

Simply stating that a patient is unable to formulate a plan for self-care does not, by itself, establish Medical Necessity based on GD. It is necessary to document the behaviors resulting in grave disability. Examples of behaviors establishing Medical Necessity based on GD include: refusing food or liquids to the point it jeopardizes a patient's health, refusing to remain clothed, engaging in sexual behavior in public areas, and behaving in other ways that are so grossly disorganized he could not be managed at a lower level of care.

When a patient is admitted from ETS or another emergency department, admission criteria are based on the patient's clinical condition just prior to admission. This is particularly relevant when a patient has stayed in ETS/ED for several days awaiting a hospital bed. Sometimes the patient will have improved significantly during this waiting period and then could be reasonably and safely discharged from ETS/ED rather than be admitted to an acute psychiatric hospital. This might occur when a patient initially presents with psychosis from a drug intoxication or when a patient suddenly develops S/I because of a recent stressor but the symptoms quickly resolve.

Psychiatrist and nursing notes will not always be consistent. Occasional days of inconsistencies would not likely result in denials. However, when the same inconsistencies occur multiple days in a row, the credibility of the entire medical record suffers.

Documentation by a psychiatrist, nurse or other professional which consists of only check boxes is inadequate; some narrative is required. The more narrative, the better.

If a patient is hospitalized for three **business** days or more, an *Interdisciplinary Treatment Plan* must be present in the records. It must be signed by a treating psychiatrist. If this MD-signed treatment plan is not present, the entire hospitalization must be denied as an *Administrative Denial.* If a patient is hospitalized for less than three **business** days, an *Interdisciplinary Treatment Plan* is not required. (Weekends and major holidays are not counted.) For additional information on the elements required in an ITP, see *Attachment C*.

The reimbursable date and time of admission begins when the patient is physically brought onto the inpatient unit and begins to receive care and/or evaluation, which usually is documented in a nursing progress note or assessment. The reimbursable date and time of admission is *not* when the admission orders are written by the physician.

By themselves, changes in medications or doses of medication are not a justification for continued hospital stay. They are part of a typical treatment plan. However, if an MD does not prescribe medications to a patient with chronic or severe symptoms, it brings into question the *efficacy* of the hospitalization and, at some point, Medical Necessity may not be evident and days may be denied. The *efficacy* will also be questionable if a patient, who clearly needs medications, is allowed to refuse medications for many days and a petition for a Riese Hearing is not submitted by the psychiatrist.

IM medication for *agitation* is strong justification for Medical Necessity. IM medication for extrapyramidal symptoms (EPS), by itself, does not usually support Medical Necessity. Receiving an IM of a long-acting antipsychotic, by itself, does not justify Medical Necessity. Sometimes the day following the administration of IM medication for agitation meets Medical Necessity as a stabilization day.

THE LANGUAGE WE USE

- Here are a few examples of behaviorally non-specific words/phrases and their behaviorally specific counterparts:

DON'T WRITE THIS	THIS WOULD BE BETTER
Impulsive	Acts without anticipating consequences as exhibited by grabbing items from other patients' hands.
Aggressive	Shoved other patients out of the cafeteria line so thathe could be served first.
Postured Aggressively	Shook a closed fist in the therapist's face.
Threatening	She said, "If you ask me another question I will slap you."
Hostile	He shouted, "Go to Hell" when he was asked to join the therapy group.
+HI	Describe the ideation. Is it active or passive? Is it directed at a particular person? Is it directed at an identifiable group of people? Is it accompanied by homicidal intent? Is there a specific plan? Opportunity? Means? Timing?

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DON'T WRITE THIS	THIS WOULD BE BETTER
+DTO	What specific behaviors constitute "+DTO"?
Labile	Describe the different mood states, how quickly they alternate, whether there are triggers for the alternations, etc.
Sullen	"When greeted the patient stared intently back at me. When asked how he felt, he said, 'I hate it here.'"
Sexually Inappropriate	The patient began masturbating in the dayroom.
Disruptive	She frequently interrupted the group leader and other participants, shouting her thoughts and reactions.
Suicidal or +SI	Ideation? Passive or Active? Intent? Specific Plan? Means? Opportunity? Timing?
+DTS	What specific behaviors constitute "+DTS"?
+SIB	Describe the specific types of self-injurious behavior. What were the medical consequences?

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Despondent	The patient said, "I feel there is no hope for me. There is nothing I can do to change my life."
Psychotic	Appears preoccupied with listening to voices. Frequently shouts in response to what she hears.
Disorganized	In what specific ways is the patient being "disorganized"? Example: "Patient smeared feces on the walls of his bathroom."
+CAH	What are the voices commanding him to do? Is he able to resist obeying the commands?
Poor ADLs	Refuses to brush teeth. Has not showered X 2 days. Describe reasons for behaviors. E.g., are poor ADLS secondary to skill deficits, delusional beliefs, social phobia?
Paranoid	Describe the specific behaviors/statements which cause the writer to describe the patient as "paranoid."
Regressed	"Patient refused to put on clothing, and continued to sit, rocking back and forth, in the corner of his room."

THE LANGUAGE WE USE

DON'T SAY THIS	THIS WOULD BE BETTER
Unpredictable	In what specific ways has the patient exhibited "unpredictable" behavior? E.g., "The patient walked up to the counter at the nursing station, and shoved the computer onto the floor."
+Poor Coping Skills	Describe both the specific behaviors which lead to the inference that there are "poor coping skills," as well as the circumstances in which these deficits have been observed.
+GD	What observable behaviors constitute "+GD"? Simply being unable to formulate and/or execute a plan for self-care does not constitute being gravely disabled.
Blowing Up	What exactly did the patient do? For example, "He overturned the medication cart and punched a mental health worker in the mouth with a closed fist."

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Attachment C

INTERDISCIPLINARY TREATMENT PLAN REQUIREMENTS

If a patient is hospitalized for three **business** days or more, an *Interdisciplinary Treatment Plan (ITP)* must be present in the records. This must be a stand-alone document and not just part of the psychiatrist Initial eval document or a part of nursing assessment. The ITP must be signed by a treating psychiatrist prior to discharge. If this MD-signed ITP is not present, the entire hospitalization must be denied as an Administrative Denial. If a patient is hospitalized for less than three **business** days, an ITP is not required. (Weekends and major holidays are not counted.)

For review purposes, the plan of care is considered to consist of the ITP plus the physician's admitting order sheet. The plan of care should include the following elements:

a. Diagnoses, symptoms, complaints and complications indicating the need for admission
b. A description of the functional level of the patient
c. Specific observable and/or specific quantifiable goals/treatment objectives related to the patient's mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses
d. Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided (which are consistent with the qualifying diagnosis and includes the frequency and duration for each intervention)
e. Any orders for:
    1) Medications
    2) Treatments
    3) Restorative and rehabilitative services
    4) Activities
    5) Therapies
    6) Social services
    7) Diet
    8) Special procedures recommended for the health and safety of the patient
f. Plans for continuing care, including review and modification to the plan or care
g. Plans for discharge
h. Documentation of the patient's degree of participation in and agreement with the plan
i. Documentation of the physician's establishment of the plan (i.e., signature)