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Form to Help Ensure Physicians Certify, Recertify Inpatient Psychiatric Hospitalization

By Nina Youngstrom

WellSpan Health in York, Pennsylvania, developed this tool to ensure physicians certify and recertify the medical necessity of inpatient psychiatric stays. Although Medicare doesn't require forms, auditors may deny claims for inpatient psych stays if they aren't convinced the medical records support the physician's certification and recertification. The form has all the critical pieces of certification and recertification in one place, says Jon Noll, performance improvement and compliance coordinator at WellSpan Philhaven, an inpatient facility in Mount Gretna, who was instrumental in developing the form. According to the conditions of Medicare payment for inpatient psych services (42 CFR Section 424.14, Parts A – D), physicians must certify the need for services on admission and on day 12 of the patient's hospitalization, then recertify no more than 30 days later and again 30 days after that. "No specific procedures or forms are required," according to the *Medicare Benefit Policy Manual.* But with reviews of inpatient psychiatric services underway by recovery audit contractors and Targeted Probe and Educate (*RMC 10/29/18, p. 1; 10/30/17, p. 1*), hospitals may want to use forms to avoid denials. "We said, 'Let's make it easier for reviewers to find the certifications," Noll explained. For now, WellSpan uses paper forms, but they will be transitioned into the electronic health records. Contact Noll at jnoll4@wellspan.org.

CERTIFICATION: On DAY 1 **Required for hospitalization** **Date Due**_____	I certify that inpatient hospitalization is necessary for the following reason(s): _____ I believe that inpatient services are required for treatment, and can reasonably be expected to improve the patient's condition, or are required for diagnostic study. I estimate that the period of hospitalization will be ____ days (or ___ weeks). Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ *(Attending Physician or Medical staff member) (Date) (Time)*

RECERTIFICATION: **On or before 12th dayof hospitalization** **Date Due**_____	I certify that continued hospitalization is necessary for the following reason(s): _____ I estimate that the additional period of hospitalization will be _____days (or_____ weeks) I certify that inpatient services furnished since the previous certification were, and continue to be, required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study. I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel. Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ *(Attending Physician or Medical staff member) (Date) (Time)*
2ND RECERTIFICATION: **On or before 30th day following previous certification** **Date Due**_____	I certify that continued hospitalization is necessary for the following reason(s): _____ I estimate that the additional period of hospitalization will be _____days (or_____ weeks) I certify that inpatient services furnished since the previous certification were, and continue to be, required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study. I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel. Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ *(Attending Physician or Medical staff member) (Date) (Time)*
3RD RECERTIFICATION: **On or before 30th day following 2nd recertification** **Date Due**_____	I certify that continued hospitalization is necessary for the following reason(s): _____ I estimate that the additional period of hospitalization will be _____days (or_____ weeks) I certify that inpatient services furnished since the previous certification were, and continue to be, required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study. I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel. Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ *(Attending Physician or Medical staff member) (Date) (Time)*

4TH RECERTIFICATION: **On or before 30th day following 3rd recertification** **Date Due**_____	I certify that continued hospitalization is necessary for the following reason(s): _____ I estimate that the additional period of hospitalization will be _____days (or_____ weeks) I certify that inpatient services furnished since the previous certification were, and continue to be, required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study. I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel. Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ (Attending Physician or Medical staff member) (Date) (Time)
5TH RECERTIFICATION: **On or before 30th day following 4th recertification** **Date Due**_____	I certify that continued hospitalization is necessary for the following reason(s): _____ I estimate that the additional period of hospitalization will be _____days (or_____ weeks) I certify that inpatient services furnished since the previous certification were, and continue to be, required for treatment that could reasonably be expected to improve the patient's condition or for diagnostic study. I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of IPF personnel. Plans for post-hospital care are: Extended Care Facility Home Health Care Office Care Other (specify)_____ _____ _____ _____ (Attending Physician or Medical staff member) (Date) (Time)