Clinical Policy: Acute Psychiatric Intensive Care (PIC)

Reference Number: IA.CP.BH.500 Coding Implications
Date of Last Revision: 06/26 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This clinical policy describes the medical necessity criteria for acute psychiatric intensive care services for Iowa Total Care as outlined by the Iowa Administrative Code and the State of Iowa Department of Health and Human Services.

Acute psychiatric intensive care is defined as care provided for a condition with rapid onset that is accompanied by severe symptoms and is generally of brief duration, requiring emergency treatment and intensive psychiatric care. While these services may be delivered in any inpatient setting, the level of care provided is beyond the capacity of general psychiatric inpatient care to assure the safety of the member, other patients, and staff. The goal of these specialized services is acute stabilization and treatment of the member's presenting condition, including dangerous behavior, so that the member can transition to a general inpatient psychiatric unit or another less-intensive level of care.[1]

Policy/Criteria

I. It is the policy of Iowa Total Care that *acute psychiatric intensive care services* are **medically necessary** when all the following are met:

A. Member/enrollee meets all the following:
   1. Is between 18 and 64 years of age;
   2. Has serious mental illness meeting both of the following:
      a. Persistent or chronic mental health, behavioral, or emotional disorder that is specified within the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or its most recent International Classification of Diseases;
      b. Causes serious functional impairment and substantially interferes with or limits one or more major life activities, including functioning in the family, school, employment or community;
   3. Presents a current, severe, imminent risk of serious harm to self or others;
   4. Displays additional complexity of need related to at least one of the following:
      a. Complex comorbidities, including intellectual or developmental disability, autism spectrum disorder, substance use disorders, or traumatic brain injuries;
      b. History of violence or current aggression that is secondary to mental illness;
      c. Request for member transfer that has been rejected for a different inpatient level of care by one or more hospitals due to severity of symptoms;
      d. Lack of responsiveness to typical interventions or a condition that is treatment-refractory;
      e. Disorganized psychotic state or manic thought process that impairs the ability to function, or risks the safety of the member or others;
      f. Behavior that causes significant disruption to the general milieu of the unit (i.e., instigating others in negative ways);

g. High elopement risk;
h. Any other atypical reason that the treating mental health provider feels that additional resources are needed to keep the member/enrollee and others safe;

B. Documented need for services that require increased or specialized staffing, equipment, or facilities based on at least two of the following:
1. Fall precaution protocol in place;
2. Restraints or seclusion room are required;
3. Assistance is required with activities of daily living;
4. Complex nursing care required;
5. Acutely impaired cognitive functioning from baseline as measured by a validated cognitive assessment scale such as, but not limited to, the Mini Mental State Examination (MMSE) or the Montreal Cognitive Assessment (MOCA);
6. Documentation of interventions to address acute, complex mental illness and comorbidities;
7. Safety protocols in place to address the physical risk posed to staff, other patients, and infrastructure;
8. Elopement risk precaution protocol in place;

C. None of the following exclusionary criteria apply:
1. The member/enrollee can be safely maintained and effectively treated in a less-intensive level of care;
2. The member/enrollee exhibits serious and persistent mental illness but is not in an acute exacerbation of the illness;
3. The primary problem is not psychiatric but is a social, legal, or medical problem without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration, the justice system, or for respite or housing;
4. Behavioral dyscontrol in the context of traumatic brain injury, intellectual disability, pervasive developmental disorder, dementia, or other medical condition without indication of acute crisis related to a diagnosis listed in the most current version of the DSM.

II. It is the policy of Iowa Total Care that *discharge* from acute psychiatric intensive care services is **medically necessary** when meeting any of the following:

A. Criteria for acute psychiatric intensive care services requiring specialized milieu and increased observation and staffing levels are no longer met but admission criteria are met for general inpatient mental health services or another level of care, either more- or less-intensive, where the member/enrollee can be safely treated;
B. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care;
C. Progress toward treatment goals is not being made and there is no reasonable expectation of progress at this level of care;
D. The need for high-intensity services is the result of a chronic condition, and the member requires transfer to a long-term care setting for ongoing treatment.

Background

Psychiatric intensive care settings provide 24-hour skilled nursing care, daily medical care, structured treatment milieu, multidisciplinary assessments, and multimodal interventions, enhanced staffing, and increased capacity for observation and intervention by staff specifically trained to treat and contain atypical aggressive, assaultive, and dangerous behavior occurring in the context of an acute psychiatric presentation.[1]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
90899	Unlisted psychiatric service or procedure. (Revenue Code 0204)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date	03/24	
Annual review. Policy title updated to include "Acute." Description updated with no impact to criteria. All policy statements updated to include "Iowa Total Care and Centene Advanced Behavioral Health." Minor rewording throughout policy for clarity. Moved definition of SMI from a note to criteria in I.A.2. Specified in I.B.5. that the impaired cognitive functioning is measured by a validated cognitive assessment scale and moved examples from a note into the criteria. Background added. References reviewed and updated.	03/25	
Annual review. Removed all instances of Centene Advanced Behavioral Health. References reviewed and updated.	06/26	

References

1. Acute Inpatient Psychiatric Intensive Care Services Clinical Guidelines. State of Iowa Department of Health and Human Services. https://hhs.iowa.gov/media/239/download?inline=. Accessed June 22, 2026.
2. Iowa Administrative Code. Human Services 441.Chapter 78.3(8). https://www.legis.iowa.gov/docs/ACO/chapter/441.78.pdf. Published October 15, 2025. Accessed June 22, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted

standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take

precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.