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Wisconsin Physicians Service (WPS)

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1

LCD Title

Psychiatric Partial Hospitalization Program (PHP)

Contractor's Determination Number

PSYCH-016

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is *italicized* throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1833(e) of Title XVIII of the Social Security Act prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1835(a) of Title XVIII of the Social Security Act references physician certification.

Section 1861(s)(2)(B) of Title XVIII of the Social Security Act references partial hospitalization in a hospital outpatient setting.

Sections 1861(ff) and 1832 (a)of Title XVIII of the Social Security Act define the partial hospitalization benefit and provide for coverage of partial hospitalization in a hospital or CMHC setting. Section 1861 (ff) also provides coverage of partial hospitalization in a Critical Access Hospital (CAH) outpatient setting.

Section 1862(a)(1)(A) of Title XVIII of the Social Security Act excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(7) of Title XVIII of the Social Security Act excludes routine physical examination.

Code of Federal Regulations:

42 CFR, § 410.32 states that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

42 CFR § 410.43 describes conditions and exclusions from partial hospitalization services.

42 CFR § 424.24 lists requirements for certification of partial hospitalization services.

Federal Register:

Federal Register, Vol. 59, No. 29, February 11, 1994, pages. 6570-6579 is the Partial Hospitalization Services in Community Mental Health Centers Interim Final Rule.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 2:

20 Active Treatment in Psychiatric Hospitals

20.1 Definition of Active Treatment

20.1.1 Individualized Treatment or Diagnostic Plan

20.1.2 Services Expected to Improve the Condition or for Purpose of Diagnosis

30 Services Supervised and Evaluated by a Physician

30.1 Principles for Evaluating a Period of Active Treatment

40 Definition of Nonpsychiatric Care in Psychiatric Hospital

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6:

70 Outpatient Hospital Psychiatric Services

70.3 Partial Hospitalization Services

CMS Publication 100-03, *Medicare National Coverage Determinations Manual* (MNCDM), Chapter 1:

70.1 Consultations With a Beneficiary's Family and Associates

160.25 Multiple Electroconvulsive Therapy (MECT) (Transmittal 10, April 6, 2004)

170.1 Institutional and Home Care Patient Education Programs

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4:

260 Outpatient Partial Hospitalization Services

260.1 Hospital Outpatient Partial Hospitalization Services Billing Requirements

260.1.1 Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

260.2 Professional Services Related to Partial Hospitalization

260.3 Outpatient Mental Health Treatment Limitations for Partial Hospitalization Services

260.4 Reporting Service Units for Partial Hospitalization

260.5 Line Item Date of Service Reporting for Partial Hospitalization

260.6 Payment for Partial Hospitalization Services

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12:

150 Clinical Social Worker (CSW) Services
160 Independent Psychologist Services
160.1 Payment [for testing services performed by psychologists other than clinical psychologists]

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1, Transmittal No. 167, Change Request 3194, April 30, 2004, provides instructions for discontinued use of revenue code 0910 effective 10/01/2004.

CMS Publication 100-2, *Medicare Benefit Policy Manual* and CMS Publication 100-04, *Medicare Claims Processing Manual*, Change Request 6320, January 2009 Update of the Hospital Outpatient Prospective payment System (OPPS).

CMS [then HCFA] Ruling 97-1, February 1, 1997, defines Medicare policy for limitation of liability for PHP services for which Medicare payment is denied.

Primary Geographic Jurisdiction

Carrier: Wisconsin, Illinois, Michigan, Minnesota

MAC A/B: Iowa, Missouri, Nebraska, Kansas

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands

Secondary Geographic Jurisdiction

Oversight Region

Original Determination Effective Date

Revision Effective Date:

Indications and Limitations of Coverage and/or Medical Necessity

INTRODUCTION

Psychiatric partial hospitalization is a distinct and organized intensive psychiatric outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with an acute mental illness in order to avoid inpatient care through this type of ambulatory care.

The Medicare psychiatric partial hospitalization benefit was established and is intended to furnish services in lieu of inpatient psychiatric care. Partial Hospitalization requires admission and certification of

need by a psychiatrist or physician (MD/DO) trained in the diagnosis and treatment of psychiatric illness. Partial hospitalization programs (PHPs) differ from inpatient hospitalization in the lack of 24-hour observation, and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient's involvement.

INDICATIONS AND LIMITATIONS OF COVERAGE

Patients admitted to a partial hospitalization program must be under the care of a physician who is knowledgeable about the patient and certifies the need for partial hospitalization and require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patient or legal guardian must provide written informed consent for partial hospitalization treatment. The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction must be of an acute nature and not a chronic circumstance. PHP patients must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program.

Patients eligible for Medicare coverage of a partial hospitalization program comprise two groups:

- those patients who are discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment; or
- those patients who, in the absence of partial hospitalization, would require inpatient hospitalization.

There must be a reasonable expectation of improvement in the patient's disorder and level of functioning as a result of the active treatment provided by the partial hospitalization program.

Active treatment directly addresses the presenting problems requiring admission to the partial hospitalization program. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psycho-educational groups pertinent to the patient's illness. Medical and psychiatric diagnostic evaluation and medication management are also integral to active treatment. The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program. If a substance abuse disorder is also present, the program must be prepared to appropriately treat the co-morbid substance abuse disorder (dual diagnosis patients).

A program comprised primarily of activity, social, or recreational therapy does not constitute a partial hospitalization program. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services for Medicare coverage.

Admission Criteria (Intensity of Service):

In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness. Patients admitted to a partial hospitalization program:

1. Do not require the 24-hour-per-day level of care provided in an inpatient setting, and
2. Must have an adequate support system to sustain/maintain themselves outside the partial hospitalization program;
3. Must not be a danger to themselves or others;
4. Level of care must be necessary to prevent inpatient hospitalization, and
5. Must be evidence of failure at or inability to benefit from a less intensive outpatient program;

6. An acute onset or a decompensation of a covered Axis I mental disorder which severely interferes with multiple areas of daily life;
7. Must require active treatment, including a combination of services such as intensive nursing and medical intervention, psychotherapy, occupational and activity therapy;
8. Require PHP services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses; and
9. Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the PHP program.

Admission Criteria (Severity of Illness):

Patients admitted to a partial hospitalization program generally must:

1. Have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR™) published by the American Psychiatric Association (2000) (see the “ICD-9-CM Codes That Support Medical Necessity” section) which severely interferes with multiple areas of daily life.
 - a. The degree of impairment will be severe enough to require a multidisciplinary structured program, but not so severe that patients are incapable of participating in and benefiting from an active treatment program, and able to be maintained outside the program.
2. Have a level of functioning below 40, as measured using the Global Assessment of Functioning Scale found in the DSM-IV-TR®.
3. Not be in immediate/imminent danger to self, others, or property, but there may be a recent history of self-mutilation, serious risk taking, or other self-endangering behavior.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

Discharge Criteria (Intensity of Service):

Patients in partial hospitalization programs may be discharged by:

1. Stepping up to an inpatient level of care,
 - a. Inpatient admission would be required for patients needing 24-hour supervision because of probability for self-harm, harm to others, or inability to care for self outside the hospital.
2. Stepping down to a less intensive level of outpatient care.
 - a. Would be considered when patients no longer require a multidisciplinary and multimodal program as described above.
 - b. Would become outpatients and individual mental health services could then be billed by appropriate providers.

Patients admitted to a PHP program must require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. Although there may be occasions of unavoidable absences to a day of PHP participation, patient participation in the program four days per week, with a total of 20 hours per week of program services as specified in the plan of care. This is the minimum level of active treatment at which it would be reasonable and necessary for a patient to participate in a partial hospitalization program and their cause must be documented in the medical record

Discharge Criteria (Severity of Illness):

1. A patient whose clinical condition improves or stabilizes and/or who cannot benefit from or does not continue to require the intensive, multimodal treatment available in a partial hospitalization program should be stepped down to outpatient care.

2. A patient whose Global Assessment of Functioning is above 45 should be considered appropriate for discharge to a less intensive level of care.
3. A patient who is unwilling to participate in a partial hospitalization program would be considered appropriate for discharge.

Covered Services:

Items and services that can be included as part of the structured, multimodal active treatment program, are identified in section 1861(ff)(2) of the Act.

Medically necessary diagnostic services related to mental illness.

Individual or group Therapy

Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the state in which they practice (e.g. licensed clinical social worker, certified alcohol and drug counselor). Group therapy size should be limited to ten or fewer individuals participating.

Occupational Therapy

Occupational therapy requiring the skills of a qualified occupational therapist; if required: must be a component of the physician's treatment plan for the individual. While occupational therapy may include prevocational and vocational assessment and training, when the services are related primarily to specific employment opportunities, work skills, or work settings, they are not covered.

Services of Other Staff

Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients. In addition, **individual, family and group psychotherapy must be performed by individuals authorized or licensed by the state in which they practice to provide these services.** With the exception of hospitals receiving payments under the Graduate Medical Education (GME) program, Medicare does not pay for the professional services of individuals who are in training and have not yet obtained licensure.

Drugs and Biologicals

Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes are subject to the limitations specified in 42 CFR 410.29. For example, oral medications that can be self-administered are not covered. Note: medication must be safe and effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under an investigational protocol.

Individualized Activity Therapies

Individualized activity therapies that are individualized to the patient's goals and not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each particular activity therapy modality utilized, and define its role in the treatment of the patient's illness and functional deficits. Providers should not bill activity therapies as individual or group psychotherapy services.

Family Counseling

Family counseling services for which the primary purpose is the treatment of the patient's condition. Such services include the need to observe the patient's interaction with the family for diagnostic purposes, or to assess the capability of and assist the family members in aiding in the management of the patient. Counseling the family to aid in the management of the patient may include attempts to modify the behavior of the family members. This may be covered if such services are related to the treatment of the

patient's condition (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 70.1).

Patient Training and Education

Patient training and education closely and clearly related to the individual's care and treatment of their diagnosed psychiatric condition, may be reimbursed under Medicare if the programs are appropriate and integral parts in the rendition of covered services which are reasonable and necessary for the treatment (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 170.1).

LIMITATIONS:

The following services do not represent reasonable and necessary partial hospitalization services and coverage is excluded under Section 1862 (a)(1)(A) of the Social Security Act:

- Day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- Programs attempting to maintain psychiatric wellness, e.g. day care programs for the chronically mentally ill;
- Treatment of chronic conditions without acute exacerbation which do not place the individual at risk for relapse or hospitalization;
- Services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
- Vocational training.

The following services are excluded from the scope of partial hospitalization services defined in Section 1861(ff) of the Social Security Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation;
- Professional physician services, physician assistant services, and clinical psychologist services.

It is not reasonable and necessary to provide partial hospitalization services to the following types of patients and coverage is excluded under Section 1862(a)(1)(A) of the Social Security Act:

- Patients who cannot or refuse to participate (due to their behavioral, cognitive, or emotional status, e.g. individuals with persistent substance abuse, moderate to severe mental retardation or organic brain syndrome) with active treatment of their mental disorder, or who cannot tolerate the intensity of a partial hospitalization program;
- Patients who require 24-hour supervision because of the severity of their mental disorder or their safety or security risk;
- Patients who require primarily social, custodial, recreational, or respite care;
- Patients with multiple absences or who are persistently non-compliant;
- Patients whose plan of care does not meet support the need for active treatment for a minimum of four days per week, with a total of 20 hours per week of program services;

- Patients who have met the criteria for discharge from the partial hospitalization program, or who require inpatient hospitalization.

OTHER COMMENTS

Sites of Service:

Partial hospitalization services may be covered under Medicare when they are provided in a hospital outpatient department or a Medicare-certified Community Mental Health Center (CMHC). Partial hospitalization services rendered within a hospital outpatient department are considered “incident to” a physician’s (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital).

If a hospital outpatient department operates a partial hospitalization program offsite, the services must be rendered under the direct supervision of a physician (MD/DO).

Partial hospitalization services provided in a CMHC require general supervision by a physician (MD/DO). This means that a physician must be at least available by telephone, but is not required to be on the premises of the CMHC at all times. CMHCs must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Sec. 1866(e)(2) of the Act. CMS’s definition of a CMHC is based on Sec. 1916(c)(4) of the Public Health Service (PHS) Act. The PHS definition of a CMHC is cross-referenced in Section 1861(ff) of the Act. If a CMHC operates a partial hospitalization program offsite, the services are unlikely to be considered medically necessary if not rendered under the direct personal supervision of a physician (MD/DO). Direct personal supervision means that the physician must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing services. Availability on another floor or somewhere else in the institution does not meet this requirement.

See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1.1[C] for billing requirements for CMHCs.

The PHP program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program. A physician must provide supervision and evaluation of the patient’s treatment and the extent to which the therapeutic goals are being met.

Professional Services Related to Psychiatric Partial Hospitalization:

Providers of mental health services must be qualified to perform the specific mental health services that are billed to WPS Medicare. In order for services to be covered, mental health professionals must be working within their state Scope of Practice and licensed or certified to perform mental health services by the State in which the services are performed.

The following billing requirements also apply to CMHC providers. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1 [B].)

The professional services listed below when provided in all hospital outpatient departments are

separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and not paid as partial hospitalization services.

- *Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;*
- *Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;*
- *Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and*
- *Clinical psychologist services as defined in §1861(ii) of the Act.*

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the services of the PA. (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1[B]).

GENERAL COMMENTS:

Medicare Part B coverage is available for hospital outpatient partial hospitalization services that are medical reasonable and necessary.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

Limitation of liability and refund requirements apply when denials are based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be considered medically necessary by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes. In these instances it is recommended, although not required, that the provider notify the beneficiary in writing with a Notice of Exclusion of Medicare Benefits (NEMB).

Notice to beneficiaries related to discharge and coverage notification as described in CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 2, Sections 80-80.2, applies.

If the facility portion of partial hospitalization programs is denied as not medically necessary this does not mean that the physician service is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in a partial hospitalization facility is not

medically necessary.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for Psychiatric Partial Hospitalization Program services as authorized by State law. (See Sections 1861(s)(2) and 1862(a)(14) of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Please refer to the documentation requirements section for documentation requirements and the coding and billing guideline article pertinent to Psychiatric Partial Hospitalization Programs for billing requirements.

Coverage Topic

Mental Health Care (Partial Hospitalization)

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 13x Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment -- eff. 7/00)
- 76x Clinic-CMHC (eff 4/97)
- 85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

CMS Medicare does not recognize codes 0912 and 0913 services under its partial hospitalization program regulations.

In accordance with CPT/HCPCS 2009 update with effective date of 01/01/2009: revenue code 0915 Psychiatric/psychological services-group therapy will be reported with CPT/HCPCS codes G0410 or G0411 and revenue code 0916 Psychiatric/psychological services-family therapy with CPT/HCPCS codes 90846 or 90847.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier or MAC Part B or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI or MAC Part A using revenue codes 096X, 097X or 098X.

0250	Pharmacy-general classification
043X	Occupational therapy-general classification
0900	Psychiatric/psychological treatments-general classification
0904	Psychiatric/psychological treatments-activity therapy (eff 4/94)
0914	Psychiatric/psychological services-individual therapy
0915	Psychiatric/psychological services-group therapy
0916	Psychiatric/psychological services-family therapy
0918	Psychiatric/psychological services-testing
0942	Other therapeutic services-education/training (include diabetes diet training)
0961 - 0969	Professional fees-psychiatric - Professional fees-other
0971 - 0979	Professional fees-laboratory - Professional fees-speech pathology
0981 - 0989	Professional fees-emergency room - Professional fees-private duty nurse

CPT/HCPCS Codes

Codes G0129, G0176, and G0177 are only used for partial hospitalization programs.

90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION
90802	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION
90816	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;
90817	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES
90818	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR

RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;

90819 INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES

90821 INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;

90822 INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES

90823 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;

90824 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES

90826 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;

90827 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES

90828 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;

90829 INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT,

	PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)
96101 - 96103	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI, RORSCHACH, WAIS), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT - PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI), ADMINISTERED BY A COMPUTER, WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT
96116	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT
96118 - 96120	NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY, WECHSLER MEMORY SCALES AND WISCONSIN CARD SORTING TEST), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT - NEUROPSYCHOLOGICAL TESTING (EG, WISCONSIN CARD SORTING TEST), ADMINISTERED BY A COMPUTER, WITH QUALIFIED HEALTH CARE PROFESSIONAL INTERPRETATION AND REPORT
G0129	OCCUPATIONAL THERAPY SERVICES REQUIRING THE SKILLS OF A QUALIFIED OCCUPATIONAL THERAPIST, FURNISHED AS A COMPONENT OF A PARTIAL HOSPITALIZATION TREATMENT PROGRAM, PER SESSION (45 MINUTES OR MORE)
G0176	ACTIVITY THERAPY, SUCH AS MUSIC, DANCE, ART OR PLAY THERAPIES NOT FOR RECREATION, RELATED TO THE CARE AND TREATMENT OF PATIENT'S DISABLING MENTAL HEALTH PROBLEMS, PER SESSION (45 MINUTES OR MORE)
G0177	TRAINING AND EDUCATIONAL SERVICES RELATED TO THE CARE AND TREATMENT OF PATIENT'S DISABLING MENTAL HEALTH PROBLEMS PER SESSION (45 MINUTES OR MORE)
G0410	GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE-FAMILY GROUP, IN A

PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES

G0411 INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES

Effective for dates of service on or after 01/01/2009: HCPCS G0410 and G0411 replace CPT codes 90853 and 90857 for PHP services, CPT codes 90849 and 90899 are no longer accepted as billable PHP codes.

Effective for dates of service on or after 01/01/2009: revenue code 0915 Psychiatric/psychological services-group therapy will be reported with HCPCS codes G0410 or G0411.

Revenue code 0916 Psychiatric/psychological services-family therapy with CPT codes 90846 or 90847; 90849 is no longer accepted for PHP services.



ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Codes not listed below as “ICD-9 CM Codes That Support Medical Necessity” will be denied. Non-covered diagnosis codes may be covered upon appeal on an individual consideration basis with supporting evidence of medical necessity. (Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The codes selected are those codes which appear in the ICD-9-CM and that are defined in *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR™)*.

Note: Every effort has been made to attempt to reflect the psychiatric diagnostic coding conventions of DSM-IV-TR™ in the psychiatric diagnoses section. Cases that fall outside DSM-IV-TR™ coding may be considered for coverage on a case-by-case basis.

291.3 ALCOHOL-INDUCED PSYCHOTIC DISORDER WITH HALLUCINATIONS

291.89 OTHER SPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS

292.11 DRUG-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS

292.12 DRUG-INDUCED PSYCHOTIC DISORDER WITH HALLUCINATIONS

292.84 DRUG-INDUCED MOOD DISORDER

292.89 OTHER SPECIFIED DRUG-INDUCED MENTAL DISORDERS

[293.81](#) - PSYCHOTIC DISORDER WITH DELUSIONS IN CONDITIONS CLASSIFIED
[293.84](#) ELSEWHERE - ANXIETY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE

295.10- DISORGANIZED TYPE SCHIZOPHRENIA UNSPECIFIED STATE-
295.14 DISORGANIZED TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE
EXACERBATION

295.30- 295.40	PARANOID TYPE SCHIZOPHRENIA UNSPECIFIED STATE- SCHIZOPHRENIFORM DISORDER, UNSPECIFIED
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
295.90	UNSPECIFIED TYPE SCHIZOPHRENIA UNSPECIFIED STATE
296.01 - 296.05	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MILD - BIPOLAR I DISORDER, SINGLE MANIC EPISODE, IN PARTIAL OR UNSPECIFIED REMISSION
296.11 - 296.15	MANIC AFFECTIVE DISORDER RECURRENT EPISODE MILD DEGREE - MANIC AFFECTIVE DISORDER RECURRENT EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.21 - 296.25	MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE MILD DEGREE - MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.31 - 296.35	MAJOR DEPRESSIVE AFFECTIVE DISORDER RECURRENT EPISODE MILD DEGREE - MAJOR DEPRESSIVE AFFECTIVE DISORDER RECURRENT EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.41 - 296.45	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, IN PARTIAL OR UNSPECIFIED REMISSION
296.51 - 296.55	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, IN PARTIAL OR UNSPECIFIED REMISSION
296.61 - 296.65	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, IN PARTIAL OR UNSPECIFIED REMISSION
296.7	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) UNSPECIFIED
296.80 - 296.82	BIPOLAR DISORDER, UNSPECIFIED - ATYPICAL DEPRESSIVE DISORDER
296.89	OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER
297.1	DELUSIONAL DISORDER
297.3	SHARED PSYCHOTIC DISORDER
298.8	OTHER AND UNSPECIFIED REACTIVE PSYCHOSIS
298.9	UNSPECIFIED PSYCHOSIS
300.21	AGORAPHOBIA WITH PANIC DISORDER
300.3	OBSESSIVE-COMPULSIVE DISORDERS
301.83	BORDERLINE PERSONALITY DISORDER
303.91 - 303.92	OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE CONTINUOUS DRINKING BEHAVIOR - OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE EPISODIC DRINKING BEHAVIOR

<u>304.01 -</u>	OPIOID TYPE DEPENDENCE CONTINUOUS USE - OPIOID TYPE DEPENDENCE
<u>304.02</u>	EPISODIC USE
<u>304.11 -</u>	SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, CONTINUOUS -
<u>304.12</u>	SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, EPISODIC
<u>304.21 -</u>	COCAINE DEPENDENCE CONTINUOUS USE - COCAINE DEPENDENCE
<u>304.22</u>	EPISODIC USE
<u>304.41 -</u>	AMPHETAMINE AND OTHER PSYCHOSTIMULANT DEPENDENCE
<u>304.42</u>	CONTINUOUS USE - AMPHETAMINE AND OTHER PSYCHOSTIMULANT DEPENDENCE EPISODIC USE
<u>304.61 -</u>	OTHER SPECIFIED DRUG DEPENDENCE CONTINUOUS USE - OTHER
<u>304.62</u>	SPECIFIED DRUG DEPENDENCE EPISODIC USE
<u>304.71 -</u>	COMBINATIONS OF OPIOID TYPE DRUG WITH ANY OTHER DRUG
<u>304.72</u>	DEPENDENCE CONTINUOUS USE - COMBINATIONS OF OPIOID TYPE DRUG WITH ANY OTHER DRUG DEPENDENCE EPISODIC USE
307.1	ANOREXIA NERVOSA
307.51	BULIMIA NERVOSA
308.3	OTHER ACUTE REACTIONS TO STRESS
311	DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED
312.81	CONDUCT DISORDER CHILDHOOD ONSET TYPE
312.82	CONDUCT DISORDER ADOLESCENT ONSET TYPE
312.9	UNSPECIFIED DISTURBANCE OF CONDUCT
313.23	SELECTIVE MUTISM
313.81	OPPOSITIONAL DEFIANT DISORDER
313.82	IDENTITY DISORDER OF CHILDHOOD OR ADOLESCENCE
313.83	ACADEMIC UNDERACHIEVEMENT DISORDER OF CHILDHOOD OR ADOLESCENCE
313.89	OTHER EMOTIONAL DISTURBANCES OF CHILDHOOD OR ADOLESCENCE
V62.84	SUICIDAL IDEATION

Diagnoses that Support Medical Necessity

Not applicable.

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable.

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Required documentation for claim submission:

1. Physician certification for admission to PHP
2. Diagnosis according to the DSM IV and any comorbidity diagnoses
3. Progress notes from all providers of services
4. Recertification documentation
5. Initial psychiatric evaluation (see detailed requirements under Initial Psychiatric Evaluation)
6. Physician orders
7. Plan of treatment including discharge planning

Certification/Recertification:

Upon admission, a **certification** by the physician (MD/DO) must be made that the patient admitted to the partial hospitalization program would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in section 1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

Recertification *must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. The first recertification is required as of the 18th day of partial hospitalization services. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days [i.e., no less frequently than every 30 days following the first recertification which must be made as of the 18th day of partial hospitalization services]. The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:*

- *The patient's response to the therapeutic interventions provided by the partial hospitalization program.*
- *The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and*
- *Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program (42 CFR 424.24).*

Initial Psychiatric Evaluation:

The **initial psychiatric evaluation** with medical history and physical examination must be performed and placed in the chart within 48 hours of admission in order to establish medical necessity for partial hospitalization services. If the patient is being discharged from an inpatient psychiatric admission to a partial hospitalization program, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

In order to support the medical necessity of admission to the partial hospitalization program, the documentation in the initial psychiatric evaluation should include the following items:

- Patient's chief complaint;
- Description of acute illness or exacerbation of chronic illness requiring admission;
- Current medical history, including medications and evidence of failure at or inability to benefit from a less intensive outpatient program;
- Past psychiatric and medical history;
- History of substance abuse;
- Family, vocational and social history, including documentation of an adequate support system to sustain/maintain the patient outside the partial hospitalization program;
- Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgment, capacity for activities of daily living (ADLs);
- Physical examination (if not done within the past 30 days and available for inclusion in the medical record);
- Formulation of the patient's status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms as a result of the partial hospitalization program;
- ICD-9-CM/DSM-IV-TR™ diagnoses, including all five axes of the multi-axial assessment as described in the DSM-IV-TR™;
- Treatment plan, including long and short term goals related to the active treatment of the reason for admission, and types, amount, duration, and frequency of therapy services, including activity therapy, are required to address the goals.

A team approach may be used in developing the initial psychiatric evaluation, but the physician (MD/DO) must document the mental status examination, physical examination, formulation, diagnosis, treatment plan, and certification.

Treatment Plan:

Partial hospitalization is active treatment that incorporates an individualized **treatment plan**, which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment plan is established by the physician, in consultation with appropriate staff members, and should be reviewed according to the changing needs of the patient's acute psychiatric illness, but never less than every 31 days. The treatment plan should be reviewed more frequently if the severity of the clinical condition or changes in the clinical condition of the patient (e.g., change of medication) make it reasonable to do so. The long and short-term treatment goals described in the treatment plan are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the response to treatment, for this relationship will be used in determining whether services are medically necessary. The treatment goals should be measurable, functional, time-framed, and directly related to the reason for admission. The treatment plan must include the specific treatments ordered, including reference to psychotropic medication management, the expected timeframes and outcomes for each treatment, and the discharge plan. The plan should document

ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

Progress Notes:

*Section 1833(e) of the Social Security Act requires services to be documented in order for payment to be made. Therefore, a **separate progress note** is required for each service rendered (e.g., HCPCS or revenue code billed). The progress note should be written by the team member rendering the service and should include a description of the nature of the treatment service, the patient's status (behavior, verbalizations, mental status) during the course of the service, the patient's response to the therapeutic intervention and its relation to the long or short term goals in the treatment plan. Each progress note should be legible, dated and signed, and include the credentials of the rendering provider. Documentation of group therapy sessions must indicate the name of the group, group type, an indication of the material under discussion, and the patient's response to the treatment encounter (Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 70.3).*

Appendices

Please refer to Medicare Part B publications, regulations, billing, and/or applicable LCDs for services that apply to Part B Medicare services for Psychiatric Partial Hospitalization Programs.

Determinations for medical necessity by the carrier or MAC Part B for individual professional services furnished to partial hospitalization patients are separate and independent from the Fiscal Intermediaries determinations regarding medical necessity coverage of the partial hospitalization program services. All of these professional services are potentially subject to the outpatient mental health treatment limitation.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Patient progress may be small or not be measurable at each session, however a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity. Code 90821-Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient; should only be used in exceptional instances. Additional documentation must be maintained in the patient's record to show medical necessity for this length of therapy in the acute setting.

Sources of Information and Basis for Decision

This bibliography represents those sources that were obtained during the development of this policy.

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the Fiscal Intermediary/MAC contractor this policy was developed in cooperation with advisory groups which include representatives from various specialties.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Block BM, Lefkowitz PM. Standards and Guidelines for Partial Hospitalization. Alexandria, VA: American Association for Partial Hospitalization, Inc; [no date].

Block BM, Lefkowitz PM. Standards and Guidelines for Partial Hospitalization: Adult Programs, 2nd ed.

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Block BM, Lefkovitz PM. Standards and Guidelines for Partial Hospitalization: Chemical Dependency Programs. Alexandria, VA: Association for Ambulatory Behavioral Healthcare; 1996.

Gartner L, Mee-Lee D. The role and current status of patient placement criteria in the treatment of substance abuse disorders. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center For Substance Abuse Treatment. Rockville, MD. [no date]

Green Spring Health Services. Utilization review criteria. Green Spring Health Services, Inc; 1992.

Kiser LJ, Barksdale SH. Overview of the partial hospitalization industry: an analysis of the data from the 1994 National Program Survey. Alexandria, VA: Association for Ambulatory Behavioral Healthcare, Inc; 1996.

National Quality Monitoring Program. Mental health quality monitoring screens and utilization review criteria. Science Applications International Corporation; November, 1995.

Schmidt CW, Yowell RK, Jaffe E. CPT® Handbook for Psychiatrists, Third Edition, Text Revision. Washington, DC, Copyright ©2004 American Psychiatric Publishing, Inc.

Wagner BD, Plotkin D, Lefkovitz PM, Block BM. Standards and Guidelines for Partial Hospitalization: Geriatric Partial Hospitalization. Alexandria, VA: American Association for Partial Hospitalization, Inc; 1993.

Washington Peer Review Organization. Admission and discharge review criteria for psychiatric hospitalization. [no date]

Wisconsin Physicians Services LCD L2403 for Legacy A jurisdiction and other contractor LCDs.

Advisory Committee Meeting Notes

Illinois	09/16/2009
Michigan	09/09/2009
Minnesota	09/24/2009
Wisconsin	09/25/2009
J5 MAC	10/08/2009
Jurisdictional Open Meeting	08/19/2009

Start Date of Comment Period

10/08/2009

End Date of Comment Period

11/23/2009

Start Date of Notice Period

Revision History Number

Revision Explanation

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with advisory groups, which includes representatives from Gastroenterology, Pathology and Laboratory.

This policy consolidates and replaces all previous policies and publications of this subject by the fiscal intermediary predecessors of Wisconsin Physician Services (WPS) and has been transitioned to incorporate MAC A and Legacy A providers.

Last Reviewed

07/28/2009

Related Documents

See coding and billing guideline attachment entitled [Psychiatric Partial Hospitalization Programs – Supplemental Coding and Billing Guideline](#)

LCD Attachments**Notes**

Does this LCD contain a "Least Costly Alternative" Provision?

No

Psychiatric Partial Hospitalization Programs – Supplemental Coding and Billing Guideline

Attachment

Contractor Name

Wisconsin Physicians Service

Contractor Number

00951, 00952, 00953, 00954
5101, 5201, 5301, 5401
05102, 05202, 05302,
05402, 52280

Contractor Type

Carrier
Fiscal Intermediary (FI)
MAC A
MAC B

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INTRODUCTION

The information in this attachment contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Psychiatric Partial Hospitalization Programs.

The carrier or MAC B medical necessity determinations for individual professional services furnished to partial hospitalization patients are separate and independent from the Fiscal Intermediaries determinations regarding coverage of the partial hospitalization program services.

Please refer to Medicare Part B publications, regulations, billing, and/or applicable LCDs for services that apply to Part B Medicare services for Psychiatric Partial Hospitalization Programs for information beyond those provided in this coding and billing guideline.

General Guidelines for claims submitted to Carriers, Intermediaries, MAC Part A, or MAC Part B:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Claims for the professional services of physicians, clinical psychologists, psychiatric clinical nurse specialists, and evaluation and management services rendered by nurse practitioners and physician assistants may be billed by the professional provider directly to the carrier or MAC Part B, or the facility may bill the carrier on behalf of the professional provider. All of these professional services are potentially subject to the outpatient mental health treatment limitation.

Procedure codes 90817, 90819, 90822, 90824, 90827, and 90829 include medical evaluation and management (E/M) services which include continuing medical diagnostic evaluation as well as pharmacological management. Therefore, pharmacological management (90862) and E/M service codes may not be billed separately on the same day as a psychotherapy service by the same physician. Services of nurse practitioners and physician assistants would include medical evaluation and management (E/M) services only. Clinical psychologists and clinical social workers are not permitted to bill for the psychotherapy codes that include the medical evaluation and management component.

Professional services furnished by physicians, physician assistants, clinical psychologists, nurse practitioners, and psychiatric clinical nurse specialists to patients in partial hospitalization programs must be billed to the carrier or MAC Part B. The claim should show place of service code 52 (psychiatric facility partial hospitalization) for hospital outpatient programs, or 53 for CMHC programs.

Advance Beneficiary Notice (ABN) of Noncoverage Modifier Guidelines (for outpatient services):

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons (refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30 revised 09/05/2008).

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The -GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or MAC A, occurrence code 32 and the date of the ABN is required.

The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

For claims submitted to the carrier or MAC Part B:

See the "Other Comments" section of this SIA.

For claims submitted to the fiscal intermediary or MAC Part A:
Hospital Inpatient Claims

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75 for additional instructions).

Hospital Outpatient Claims

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67.*

Bill Type Guidelines

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B) states that *no type of technical services, such as...a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers...Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base provider on the TOB for the base-provider and submitted to the FI.*

Per CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100(B), *only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); ...telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.*

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment...: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9, Section 100[B].)

Partial hospitalization services provided by Community Mental Health Centers (CMHCs)

All *italicized* text below is from CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1.1 unless otherwise specified.

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent

under bill type 76X. ...The acceptable revenue codes are as follows:

Revenue Codes	Description
025	Drugs and Biologicals
043X	Occupational Therapy (Partial Hospitalization)
0900	(effective 10/16/2003) Behavioral Health Treatment/Services
0904	Activity Therapy (Partial Hospitalization)
0910	Psychiatric/Psychological Services (dates of service prior to 10/16/2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900 (effective 10/16/2003)	Behavioral Health Treatment/Services	90801, 90802
0904	Activity Therapy- (Partial Hospitalization)	**G0176
0910 (dates prior to 10/16/2003)	Psychiatric/Psychological Services	90801, 90802, 90899
0914	Individual Therapy	[90816-90819] [90821-90824] [90826-90829] 90845, 90865 or 90880
0915	Group Therapy	G01410 or G0411
0916	Family Therapy	90846, 90847
0918	Testing	90101, 90102 or 96103, 96116, 96118, 96119 or 96120
0942	Education Training	***G0177

*The definition of code G0129 is as follows:

Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more). May be used in both partial hospitalization programs and outpatient mental health settings.

Codes G0129 and G0176 are used only for partial hospitalization programs.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000 (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1.1).

Section 4523 of the Balanced Budget Act (BBA)(P.L. 105-33), requires payment to be made under a prospective payment system for partial hospitalization services furnished by a CMHC.

CMHCs must:

- Report HCPCS codes and modifiers
- Report line item dates of service; and
- Report in Form Locator (FL) 46, "Service Units," the number of times a particular service or procedure based on the HCPCS that was performed (not the total number of visits for the billing period). (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1.1[E].)

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes. (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1.1[E].)

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours, or days), CMHCs should not bill for sessions less than 45 minutes. The CMHC should not report units for revenue code 0250 for drugs and biologicals. Refer to CMS Publication, 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1.1[E].

Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000. CMHCs are required to report line item dates of service per revenue code line for partial hospitalization claims. *This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45, "Service Date," (MMDDYY).* Claims that lack a line item date of service for each HCPCS code reported will be returned to the provider. Similarly, claims reporting line item dates outside the period the statement covers will be returned to the provider. (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1.1[F].)

For CY 2009, Medicare created two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which was deleted for CY 2009. When a community mental health center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital will be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital will be paid through APC 0173.

Partial hospitalization services provided by hospital outpatient departments:

All *italicized* text below is from CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1 unless otherwise specified.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to HCPCS code for this benefit (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1[A]).

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments [other than CAHs] are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under Section 1861(ff) of the Act are paid by the Medicare program (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1[A]).

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Codes	Description
0250	Drugs and Biologicals
043X	Occupational Therapy (Partial Hospitalization)
0900 (effective 10/16/2003)	Behavioral Health Treatment/Services
0904	Activity Therapy (Partial Hospitalization)
0910 (dates of service prior to 10/16/2003)	Psychiatric/Psychological Services
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue codes	Description	HCPCS code
043X	Occupational Therapy	*G0129
0900	Behavioral health Treatment/ Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910 (dates of service prior to 10/16/2003)	Psychiatric General Services	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, or 90880
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

**The definition of code G0129 is as follows:*

Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

***The definition of code G0176 is as follows:*

Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

****The definition of code G0177 is as follows:*

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more). May be used in both partial hospitalization programs and outpatient mental health settings.

Codes G0129, and G0176 are used only for partial hospitalization programs.

Revenue code [0]250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1[A]).

Under component billing, Critical Access Hospitals (CAHs) are required to report an acceptable revenue code, in accordance with those listed above, and the charge for each individual covered service furnished under a partial hospitalization program.

Reporting of Service Units: *Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 260.1[D]).*

Claims submitted by either CMHCs or hospital outpatient departments for partial hospitalization services must include a mental health diagnosis, and at least three partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS code (other than brief). Claims that do not pass the [Outpatient Code Editor] OCE edits will undergo further prepayment review (65 FR 18454, April 7, 2000).

For CY 2009, Medicare created two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which was deleted for CY 2009. When a community mental health center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital will be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital will be paid through APC 0173.

Repetitive Part B services to a single individual from providers that bill FIs shall be billed monthly (or at the conclusion of treatment)...Examples of repetitive Part B services with applicable revenue codes include...Psychological Services, 0900... 0911-0919 (in a psychiatric facility) (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 50.2.2, Rev. 270, Issued 08/03/04, Effective 01/01/05).

Hospitals and Community Mental Health Centers (CMHCs) are required to report all OPPS services that are provided on the same day on the same claim with the exception of claims containing condition codes 20, 21, or G0 (zero) or containing repetitive Part B services. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service must be billed separately, with all related services, from the OPPS monthly repetitive claim. However, if some of the services are for partial hospitalization, the provider shall place condition code 41 on the claim. For claims containing condition code 41, all services billed on the same day are to be included on the monthly bill for repetitive services. Nonrepetitive OPPS services, exclusive of partial hospitalization services, are to be put on a single claim along with any packaged services. Repetitive services are billed monthly on a separate claim (CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 170, Rev. 239, Issued 07/23/04, Effective 01/01/05).

Coverage Topic

Mental Health Care (Partial Hospitalization)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
76x	Clinic-CMHC (eff 4/97)
85x	facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

Use of revenue code 0910 to report certain psychiatric/psychological treatment and services was discontinued by the National Uniform Billing Committee on 10/15/2003. Revenue code 0900 is used in place of revenue code 0910 effective for claims with dates of service on or after October

16, 2003 (CMS Publication 100-02, Medicare One-Time Notification Manual, Transmittal No. 98, Change Request 3343, July 23, 2004).

Revenue codes 096X, 097X, and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing their services at the CAH may elect to bill their carrier or MAC Part B or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI or MAC Part A using revenue codes 096X, 097X or 098X.

0250	Pharmacy-general classification
043X	Occupational therapy-general classification
0900	Psychiatric/psychological treatments-general classification
0904	Psychiatric/psychological treatments-activity therapy (eff 4/94)
0914	Psychiatric/psychological services-individual therapy
0915	Psychiatric/psychological services-group therapy
0916	Psychiatric/psychological services-family therapy
0918	Psychiatric/psychological services-testing
0942	Other therapeutic services-education/training (include diabetes diet training)
0961 - 0969	Professional fees-psychiatric - Professional fees-other
0971 - 0979	Professional fees-laboratory - Professional fees-speech pathology
0981 - 0989	Professional fees-emergency room - Professional fees-private duty nurse

CPT/HCPCS Codes

Effective for dates of service on or after 01/01/2009, HCPCS codes G0410 and 0411 replace CPT codes 90853 and 90857 for PHP services. Effective for dates of service on or after 01/01/2009, CPT codes 90899 and 90849 are no longer accepted as billable PHP codes.

90801	Psychiatric Diagnostic Interview
90802	Interactive Psychiatric Diagnostic Interview Examination Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Communication
90816	Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An Inpatient Hospital, Partial Hospital or Residential Care setting, Approximately 20 to 30 Minutes Face-To-face With The Patient;
90817	Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An

- Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 20 to 30 Minutes Face-To-Face With the Patient; With Medical Evaluation and Management Services
- 90818 Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 45 to 50 Minutes Face-To-face With the Patient;
- 90819 Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 45 to 50 Minutes Face-To-Face With the Patient; With Medical Evaluation and Management Services
- 90821 Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 75 to 80 Minutes Face-To-Face With the Patient;
- 90822 Individual Psychotherapy, Insight Oriented, Behavior Modifying and/or Supportive, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 75 to 80 Minutes Face-To-face With the Patient; With Medical Evaluation and Management Services
- 90823 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, or Other Mechanisms of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 20 to 30 Minutes Face-To-face With the Patient;
- 90824 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, Or Other Mechanisms Of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 20 to 30 Minutes Face-To-face With The Patient; With Medical Evaluation And Management Services
- 90826 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, Or Other Mechanisms Of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 45 to 50 Minutes Face-To Face With The Patient;
- 90827 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, Or Other Mechanisms Of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 45 to 50 Minutes Face-To-face With The Patient; With Medical Evaluation And Management Services

- 90828 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, Or Other Mechanisms Of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital or Residential Care Setting, Approximately 75 to 80 Minutes Face-To-face With The Patient;
- 90829 Individual Psychotherapy, Interactive, Using Play Equipment, Physical Devices, Language Interpreter, Or Other Mechanisms Of Non-Verbal Communication, In An Inpatient Hospital, Partial Hospital Or Residential Care Setting, Approximately 75 to 80 Minutes Face-To-face With The Patient; With Medical Evaluation And Management Services
- 90846 Family Psychotherapy (Without the Patient Present)
- 90847 Family Psychotherapy (Conjoint Psychotherapy) (With Patient Present)
- 96101 Psychological Testing (Includes Psychodiagnostic Assessment of Emotionality, Intellectual Abilities, Personality And Psychopathology, Eg, Mmpi, Rorschach, Wais), Per Hour Of The Psychologist's Or Physician's Time, Both Face-To-Face Time Administering Tests To The Patient And Time Interpreting These Test Results And Preparing The Report
- 96102 Psychological Testing (Includes Psychodiagnostic Assessment of Emotionality, Intellectual Abilities, Personality And Psychopathology, Eg, Mmpi And Wais), With Qualified Health Care Professional Interpretation And Report, Administered By Technician, Per Hour Of Technician Time, Face-To-Face
- 96103 Psychological Testing (Includes Psychodiagnostic Assessment of Emotionality, Intellectual Abilities, Personality And Psychopathology, Eg, Mmpi), Administered By A Computer, With Qualified Health Care Professional Interpretation And Report
- 96116 Neurobehavioral Status Exam (Clinical Assessment Of Thinking, Reasoning And Judgment, Eg, Acquired Knowledge, Attention, Language, Memory, Planning And Problem Solving, And Visual Spatial Abilities), Per Hour Of The Psychologist's Or Physician's Time, Both Face-To-Face Time With The Patient And Time Interpreting Test Results And Preparing The Report
- 96118 Neuropsychological Testing (Eg, Halstead –Reitan Neuropsychological Battery, Wechsler Memory Scales And Wisconsin Card Sorting Test), Per Hour Of The Psychologist's Or Physician's Time, Both Face-To-face Time Administering Tests To The Patient And Time Interpreting These Test Results And Preparing The Report
- 96119 Neuropsychological Testing (Eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), With Qualified Health Care Professional Interpretation And Report,

Administered By Technician, Per Hour Of Technician Time, Face-To-Face

- 96120 Neuropsychological Testing (Eg, Wisconsin Card Sorting Test), Administered By A Computer, With Qualified Health Care Professional Interpretation and Report
- G0129 Occupational Therapy Requiring the Skills of A Qualified Occupational Therapist, Furnished As A Component Of A Partial Hospitalization Treatment Program, Per Session (45 Minutes Or More)
- G0176 Activity Therapy, Such As Music, Dance, Art or Play Therapies Not For Recreation, Related To The Care And Treatment Of Patient's Disabling Mental Health Problems, Per Session (45 Minutes Or More)
- G0177 Training and Educational Services Related to the Care And Treatment Of Patient's Disabling Mental Health Problems Per Session (45 Minutes Or More)
- G0410 Group Psychotherapy Other Than of a Multiple-Family Group, In A Partial Hospitalization Setting, Approximately 45 To 50 Minutes
- G0411 Interactive Group Psychotherapy, In a Partial Hospitalization Setting, Approximately 45 to 50 Minutes

ICD-9 Codes that are Covered

Please see LCD

ICD-9 Codes that are Not Covered

Not applicable

Other Comments

If the facility portion of partial hospitalization programs is denied as not medically necessary this does not mean that the physician service is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in a partial hospitalization facility is not medically necessary.

Revision History

Related Documents

Psychiatric Partial Hospitalization Program LCD