Inpatient Psychiatric Hospitalization- Supplemental Coding and Billing Article

Contractor Name
Wisconsin Physicians Service

Contractor Number
52280
05101
05201
05301
05401

Contractor Type
FI
MAC A

Article ID Number
PSYCH-020

Article Type
Billing and Coding

Key Article
Yes

Article Title
Inpatient Psychiatric Hospitalization

Primary Jurisdiction

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, Puerto Rico, U.S. Virgin Islands

MAC A: Iowa, Missouri, Nebraska, Kansas

Original Article Effective Date
03/18/2010

Article Revision Effective Date
03/18/2010

Article Text
The information in this supplemental instructions article (SIA) contains coding or other guidelines that complement the local coverage determination (LCD) for Inpatient Psychiatric Hospitalization. The LCD con be accessed on our contractor website at www.wpsmedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd.

Coding Guidelines:

General Guidelines for Submitting Claims for Carriers or Intermediaries or MAC Part A or Part B:

Procedure codes may be subject to National Correct Coding Initative (NCCI) edits or OPPS (OCE) 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 printed 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.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient Services):
Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

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, for complete instructions.

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 Part 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:

Guidelines for claims submitted on UB-04 to the Fiscal Intermediary

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 co-existed 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 on 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 the 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 the FLs 67A-67Q for up to eight other diagnoses that co-existed 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 TOB 71x or 73x…Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers…Technical services/compenents associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provdier 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 Medicatre 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 supplemental payment…: 0521, 0522, 0524, 0525, 0527, and 0528 (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100[B]).

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

Coverage Topic
Mental Health Care (Inpatient)

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 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.

11X	Hospital-inpatient (including Part A)
12X	Hospital or home health visits (Part B only)

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. 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 codes.

Use of revenue code 0910 to report certain psychiatric/psychological treatment and services was discontinued by the National Uniform Billing Committee on 10/15/03. Revenue code 0900 will now be used in place of revenue code 0910 effective for claims with dates of service on or after

October 16, 2003 (CMS Publication 100-20, *Medicare One-Time Notification Manual,* Transmittal No. 98, Change Request #3343, July 23, 2004).

All revenue codes billed on the inpatient claims for the dates of service in question may be subject to review.

XX000 Not Applicable

CPT/HCPCS Codes
The ICD-9-CM codes listed below represent conditions that often support medical necessity for inpatient psychiatric hospitalization. The list is not all inclusive. 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. The codes selected are generally those codes that appear in the *ICD-9-CM* and that are also defined in the *Diagnostic and Statistical Manual,* fourth edition (DSM-IV-TR™).

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Final Rule says substance abuse is rarely the primary diagnosis for inpatient psychiatric treatment, and in those rare cases, there are generally mitigating factors to justify why the patient cannot be treated in an outpatient setting. (42 CFR parts 412 and 413 pg. 66938). The principal diagnosis is not necessarily what brought a patient to the hospital, but ultimately, what the IPF treats the patient for as his/her principal problem while in the facility. To be covered as an inpatient hospital service, it must meet the criteria for being medically necessary.

290.11	Presenile dementia with delirium
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.3	Senile dementia with delirium
290.41	Vascular dementia, with delirium
290.42	Vascular dementia, with delusions
290.43	Vascular dementia, with depressed mood
291.0	Alcohol Withdrawal Delirium
291.3	Alcohol-induced psychotic disorder with hallucinations
291.5	Alcohol-induced psychotic disorder with delusions
291.81	Alcohol withdrawal
291.89	Other specified alcohol-induced mental disorders
291.9	Unspecified alcohol-induced mental disorders
292.11	Drug-induced psychotic disorder with delusions
292.12	Drug-induced psychotic disorder with hallucinations
292.81	Drug-induced delirium
292.84	Drug-induced mood disorder
292.89	Other specified drug-induced mental disorders
292.9	Unspecified drug-induced mental disorder
293.81 - 293.89	Psychotic disorder with delusions in conditions classified elsewhere - other Specified transient mental disorders due to conditions classified elsewhere, other
293.9	Unspecified transient mental disorder in conditions classified elsewhere
294.11	Dementia in conditions classified elsewhere with behavioral disturbance

295.01 - 295.04	Simple type schizophrenia subchronic state - simple type schizophrenia chronic state with acute exacerbation
295.11 - 295.14	Disorganized type schizophrenia subchronic state - disorganized type schizophrenia chronic state with acute exacerbation
295.21 - 295.24	Catatonic type schizophrenia subchronic state - catatonic type schizophrenia chronic state with acute exacerbation
295.31 - 295.34	Paranoid type schizophrenia subchronic state - paranoid type schizophrenia chronic state with acute exacerbation
295.41 - 295.44	Schizophreniform disorder, subchronic - schizophreniform disorder, chronic with acute exacerbation
295.71 - 295.74	Schizoaffective disorder, subchronic - schizoaffective disorder, chronic with acute exacerbation
296.01 - 296.05	Bipolar I disorder, single manic episode, mild - bipolar I disorder, single manic 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	Bipolar disorder, unspecified
296.89	Other and unspecified bipolar disorders, other
296.90	Unspecified episodic mood disorder
297.1	Delusional disorder
297.3	Shared psychotic disorder
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
299.00	Autistic disorder, current or active state
299.10	Childhood disintegrative disorder, current or active state
299.80	Other specified pervasive developmental disorders, current or active state
299.90	Unspecified pervasive developmental disorder, current or active state
300.01	Panic disorder without agoraphobia
300.21	Agoraphobia with panic disorder
300.3	Obsessive-compulsive disorders
301.83	Borderline personality disorder
303.90	Other and unspecified alcohol dependence unspecified drinking behavior
307.1	Anorexia nervosa
307.51	Bulimia nervosa
308.3	Other acute reactions to stress

309.24	Adjustment disorder with anxiety
309.0	Adjustment Disorder with depressed mood
309.28	Adjustment disorder with mixed anxiety and depressed mood
309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.81	Posttraumatic stress disorder
311	Depressive disorder not elsewhere classified
312.34	Intermittent explosive disorder
780.09	Alteration of consciousness other
V62.84	Suicidal Ideation

ICD-9 Codes that are Covered
XX000 Not Applicable.

ICD-9 Codes that are Not Covered
XX000 Not Applicable

Other Information

Other Comments
If the facility portion of inpatient psychiatric services is denied as not medically necessary this does not mean that the physician services is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in an inpatient psychiatric facility is not medically necessary. **Please refer to Medicare Part B publications, regulations, billing, and/or applicable LCDs for services that apply to Part B Medicare services.**

Physician visits to a patient must involve a face-to-face encounter. Physician visits that only comprise team conferences or discussion with staff can not be billed to the carrier.

These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated Wisconsin Physicians Service to process their claims.

Related Documents
Psychiatric Inpatient Hospitalization LCD

Revision History Number/Explanation