

Billing and Coding Guidelines
Psychiatric Partial Hospitalization Programs - PSYCH-016 - L30491

Contractor Name

Wisconsin Physicians Service

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402, 52280

Effective Date

10/16/2010

Revision Effective Date

07/16/2012

Ending Date

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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:

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 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(Rural Health Clinic) or FQHCs (Federally Qualified Health Center) 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.

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

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

Revenue Codes	Description	HCPCS Code
043X	<i>Occupational Therapy (Partial Hospitalization)</i>	*G0129
0900 <i>(effective 10/16/2003)</i>	<i>Behavioral Health Treatment/Services</i>	90801, 90802
0904	<i>Activity Therapy- (Partial Hospitalization)</i>	**G0176
0910 <i>(dates prior to 10/16/2003)</i>	<i>Psychiatric/Psychological Services</i>	90801, 90802, 90899
0914	<i>Individual Therapy</i>	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, or 90880
0915	<i>Group Therapy</i>	G01410 or G0411
0916	<i>Family Therapy</i>	90846, 90847
0918	<i>Testing</i>	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	<i>Education Training</i>	***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). (<http://www.cms.gov/manuals/downloads/clm104c04.pdf>)

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

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

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

		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).

Revision History Number/Explanation

06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

Publication Date

09/01/2010 and Summer Communiqué,

Notes:

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