FIRST COAST SERVICE OPTIONS
MAC - PART A
CODING GUIDELINES

LCD Database ID Number

L33972

Contractor Name

First Coast Service Options, Inc.

Contractor Number

09101 – Florida
09201 – Puerto Rico/Virgin Islands

LCD Title

Psychiatric Partial Hospitalization Program

Coding Guidelines

Community mental health centers (CMHCs) and hospital outpatient departments must report the following when billing for PHP services:

- Acceptable revenue codes (form locator 42). The following are allowable revenue codes for PHP services: 250, 43X, 904, 910, 914, 915, 916, 918 and 942.
- CMS specifies "Service Units" as the number of times the service or procedure, as defined by the CPT/HCPCS code, was performed when billing for the partial hospitalization services. When reporting service units for CPT/HCPCS codes where the definition of the procedure does not include any time frame (either minutes, hours, or days), providers should not bill for sessions of less than 45 minutes duration. When reporting service units for CPT/HCPCS codes where the procedure is not defined by a specific time frame, providers should report "1" unit in FL 46. Providers that have previously reported visits should no longer report these visits as units for these services. For each session billed, documentation should be maintained in the medical record to validate that a treatment session occurred

Note: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

HCPCS Coding and Line Item Date of Service Reporting (Form Locators 44 and 45)

Hospital providers are required to utilize the CPT/HCPCS coding structure when billing for outpatient partial hospitalization services. HCPCS codes are reported in FL 44 of the UB-92 claim form. Effective June 5, 2000, CMHCs will also be responsible for claim filing utilizing CPT/HCPCS codes and 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). The Intermediary will return to provider (RTP) claims if a line item reported falls outside of the statement coverage period. The HCPCS/CPT coding structure indicated below should be reported, as appropriate.

Revenue Codes	CPT/HCPCS Codes
43X	G0129
904	G0176

900	90791, 90792
910	90791, 90792
914	90832-90838, 90845, 90865 or 90880
915	G0410 or G0411
916	90846 or 90847
918	96101, 96102, 96103, 96116, 96118, 96119 or 96120
942	G0177

*National Coverage Determinations Manual Chapter 1, Part 1, Section 30.1 restricts the use of biofeedback. Biofeedback for the treatment of psychiatric disorders is not covered.

Note: Revenue code 250 (Pharmacy) does not currently require HCPCS/CPT coding.

In addition, Intermediary edits are performed to ensure that CPT/HCPCS are present when the above revenue codes are billed and that they are valid CPT/HCPCS codes.

- Supervisory duties, attending patient conferences, nursing assessments, psychosocial evaluations, participating in the development of the treatment plan, preparing clinical and progress reports, participating in discharge planning and inservice programs, etc. are considered administrative costs of the facility and are settled at cost audit. These must not be line item billed.
- A patient who requires inpatient hospitalization for a medical condition during the course of receiving PHP services must be discharged from the PHP services. There is not a patient "hold" status.

The hospital must also report Condition Code 41 (in form locator 24-30) to indicate the claim is for partial hospitalization services. If condition code 41 is not reported, the facility will be notified. CMHCs are not required to report a condition code.

Bundling Issues

The professional services (listed below) provided in a CMHC or hospital outpatient department are separately covered and paid as the professional services of physicians and independent practitioners. These direct professional services are "unbundled" and these practitioners (other than physician assistants, [PAs]), may bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient PHP patients and CMHC partial hospitalization patients. The hospital or CMHC can also serve as a billing agent for these professionals, by billing the Part B carrier on their behalf for their professional services (via the CMS-1500 billing format). The professional services of a PA can be billed to the carrier only by the PA's employer. The following direct professional services are **unbundled** and **not paid as partial hospitalization services**:

- Physician services that meet the criteria for payment on a fee schedule basis (in accordance with 42 CFR 414);
- Physician assistant services (as defined in section 1861(s)(2)(K)(I) of the Act);
- Clinical psychologist services (as defined in section 1861(ii) of the Act); and
- Advanced Registered Nurse Practitioners and Clinical Nurse Specialists (as defined in section 1861(s)(2)(K)(ii) of the Act).

The services of other practitioners, including licensed clinical social workers (LCSWs), are bundled when furnished under the PHP benefit. These bundled services are billed to the Medicare Part A intermediary via the CMS-1450 (UB-92) billing format, and payment is made on a reasonable cost basis. Administrative (rather than professional) services remain bundled. The distinction between professional and administrative services is whether the services are directly furnished to an individual patient or are performed indirectly under the partial hospitalization program (outpatient hospital or CMHC). Currently, reimbursement for administrative services is made via the provider's cost report settlement. Therefore, administrative services are not separately billable to either the Part A intermediary (via the CMS-1450) or the Part B carrier (via the CMS-1500). In addition, effective August 1, 2000 payment for partial hospitalization programs will be made under the hospital outpatient prospective payment system.

Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients.

However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the Intermediary as partial hospitalization services.

Other Comments

N/A

Revision History

Date	Revision
10/01/2015	This “Coding Guideline” replaces all previous “Coding Guidelines” to comply with ICD-10-CM based on Change Request 8112. The effective date of this “Coding Guideline” is based on date of service.

Document formatted: 07/02/2013(DA/et)