STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, GOVERNOR

**DEPARTMENT OF MENTAL HEALTH**
1600 - 9TH STREET
SACRAMENTO, CA 95814
(916) 654-2309

July 16, 1996

DMH LETTER NO.: 96- 02

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: CLINICAL DOCUMENTATION REQUIREMENTS FOR MEDICARE PARTIAL HOSPITAL PROGRAMS WITH PATIENTS WITH MEDICARE AND MEDI-CAL COVERAGE

REFERENCE: HEALTH CARE FINANCING ADMINISTRATION JUNE PROGRAM MEMORANDUM AND AETNA CLINICAL POLICY MEMORANDUM

EXPIRES: HOLD UNTIL RESCINDED

Effective this date, counties have the option of using Medicare documentation requirements for all individuals in a partial hospitalization program regardless of payor source. Should counties elect to exercise this option, their Short-Doyle Medi-Cal Rehabilitation Option and Targeted Case Management (RO/TCM) Quality Management Plan (QMP) and local policies and procedures must be revised to reflect this change. In addition to the QMP revisions, counties need to send a request for a waiver of the Medi-Cal documentation requirements to the Medi-Cal Oversight office responsible for their region:

In the South, you may request a waiver from:

Moss Nader, Ph. D.
Medi-Cal Oversight/Southern
P. O. Box 59063
Norwalk, California 90652

In the North, you may request a waiver from:

Bob Cacic
Medi-Cal Oversight/ North Bay
Department of Mental Health
1600 9th Street, Room 120
Sacramento, California 95814

Currently county partial hospitalization programs serve individuals with various payor sources, such as Medicare, Medi-Cal, or private insurance. A large number have both Medicare and Medi-Cal. Meeting many different documentation standards has proved counter productive for county mental health service delivery staff. Per the request of the California Mental Health Directors Association (CMHDA), the Department has considered the RO/TCM requirements and has found that Medicare documentation, albeit somewhat different, meets or exceeds the standard set by RO/TCM. Thus, it should be a county option to use the Medicare standard in partial hospitalization programs.

In creating this option, the Department hopes to support the efficient delivery of partial hospitalization program services to those individuals who might otherwise require a more restrictive and expensive acute hospital admission.

For further assistance, please contact your Systems of Care Technical Assistance and Training staff liaison:

| | | |
|---|---|---|
| North | Jack Tanenbaum | (916) 224- 4724 |
| Central | Dee Lemonds | (916) 654-3001 |
| Bay | Ruth Walz | (707) 252-3168 |
| South | Anne Tracy | (916) 654-2643 |

STEPHEN W. MAYBERG, Ph. D.
Director

Enclosures

# INSTRUCTIONS FOR COUNTIES USING MEDICARE DOCUMENTATION REQUIREMENTS FOR ALL PARTIAL HOSPITAL CLIENTS

Medicare and Medi-Cal differ substantially in their scope, time lines, focus and frequency of documentation. The following information on coordination plans, service plans and progress notes will help counties transition from dual documentation requirements to a single (Medicare) plan, while maintaining the integrity of the coordinated care system

## COORDINATED CARE PLANS:

Currently the Rehabilitation Option Manual requires counties to develop and maintain a coordinated care plan for all patients receiving services for more than 60 days. This requirement will not change for patients in the partial hospital programs, however the care coordinator will be required to add "partial hospitalization" services to the coordinated care plan whenever a patient is in a partial hospital program. This allows the Department of Mental Health Program Compliance Reviewers to know that the charting documentation for that service will be based on Medicare standards. If a patient is in the program less than five days, it will not be necessary to list the service on the coordinated care plan, but it will be necessary to document in daily notes that this patient was in a partial hospital treatment program on a short term basis.

## SERVICE PLANS

Currently, Medi-Cal requires an approved service plan for all planned services over 30 days by a program. Medicare requires a physician approved treatment plan within five days of participation in the program. If the patient does not stay in the program for more than five days, a treatment plan is not required. The recommended change is that for a partial hospital program, the Medicare treatment plan can substitute for the service plan. It will be the plan which directs care while the patient is participating in the partial hospital program. It is reviewed and approved by the physician monthly. Two week treatment plan updates are also recommended by Aetna Medicare. No longer will a separate service plan be required for these programs in addition to the Medicare treatment plan.

When no longer billing Medicare, a service plan would be required for continued treatment in coordinated care.

## PROGRESS NOTES:

Progress note rules for Medicare recommend a daily and weekly note for patients in the partial hospital program. Regardless of which Short-Doyle/Medi-Cal billing mode and service function is being provided and billed, the Medicare charting requirements will be considered sufficient for meeting the progress note documentation requirements for these patients.

For information on the Medicare requirements for California's CMHC's, see the Aetna Clinical Policy Memorandum (95-14) from August 1995 and the HCFA program memorandum for June of 1995 (Transmittal No. A-95-8). Technical Assistance can be obtained from Aetna on their charting requirements if needed. The phone number is (707) 664-0365. The Medical Review Section is the most familiar with charting requirements for Medicare partial hospital services.

# SAMPLE WAIVER LETTER

*Month, Day, Year*

Name
Address
City, State Zip

Dear Chief, Medi-Cal Oversight:

**Subject:** Waiver Of Clinical Documentation Requirements For Medicare Partial Hospitalization Programs With Patients With Medicare And Medi-Cal Coverage

(*Name of County)* requests permission to use Medicare documentation for all individuals in our partial hospital program, regardless of payor source.

The following providers will be using the Medicare documentation standards for all patients in their Partial Hospital Program:

| Name of Provider | Address | Provider Number |
|---|---|---|
| | | |
| | | |
| | | |

The following providers will use a mix of Medicare and Medi-Cal documentation:

| Name of Provider | Address | Provider Number |
|---|---|---|
| | | |
| | | |
| | | |

Please find enclosed an amendment to our Quality Management Plan and an update to our Policy and Procedures Manual.

Sincerely,

Signature Name
County Mental Health Director

Enclosures

# Program Memorandum
## Intermediaries

Department of Health and Human Services

Health Care Financing Administration

ADVANCE COPY OF FINAL ISSUANCE

Transmittal No. A-95-8

Date JUNE 1995

SUBJECT: Medicare's Partial Hospitalization Benefit-Eligibility and Scope of Services.

Section 1835 of the Social Security Act (the Act) establishes a specific test for eligibility for the partial hospitalization benefit and also describes the range of benefits available to beneficiaries that are eligible.

This program memorandum (PM) provides clarification of the requirements applicable to the Medicare partial hospitalization benefit. The clarification is based on the law, HCFA's regulations and program manuals, and from our consultation with clinicians and national associations representing partial hospitalization providers. Although this PM does not restate every statutory, regulatory or manual section applicable to the benefit, all existing provisions apply. An interim final regulation was published in the Federal Register on February 11, 1994. HCFA intends to publish a final rule pertaining to this benefit. This PM provides a broad discussion of the partial hospitalization benefit and is intended to help providers understand the conditions and limits of Medicare coverage and to assist you in reviewing claims for payment.

To the extent that this instruction contains specific references to guidelines or frequency of services, these references are based on professional consultation and are offered as benchmarks for review of medical necessity and not as absolute coverage rules.

**SCOPE OF PARTIAL HOSPITALIZATION BENEFIT**

To be considered eligible for payment under the Medicare partial hospitalization benefit, the services must be:

- Reasonable and necessary for the diagnosis or active treatment of the individual's condition; and

- Reasonably expected to improve or maintain the individual's condition and functional level to prevent relapse or hospitalization. (See §1861(ff)(2)(I) of the Act.)

A partial hospitalization program for Medicare purposes is a comprehensive structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

THESE INSTRUCTIONS SHOULD BE IMPLEMENTED WITHIN YOUR CURRENT OPERATING BUDGET.

NOTE: This Program Memorandum may be discarded after JUNE 30, 1996.

Contact person for this Program Memorandum is Susan Levy (410) 966-9364.

There are two critical points which affect the determination of coverage for partial hospitalization services: 1) the initial decision as to the medical appropriateness of entrance into the program for treatment; and 2) the decision about discharge. Both determinations should take into account both the diagnosis and the individual's treatment needs.

Partial hospitalization programs are designed to treat patients who exhibit severe or disabling conditions related to an acute psychiatric/psychological conditions or an exacerbation of a severe and persistent mental disorder.

Partial hospitalization may occur in lieu of either:

- Admission to an inpatient hospital; or
- A continued inpatient hospitalization.

Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis. This is an individual determination.

Persons who require a low frequency of participation may indicate that the partial hospitalization program is no longer reasonable and necessary and he/she could be managed in an outpatient setting and should no longer be covered in the partial hospitalization program.

A partial hospitalization program differs from inpatient hospitalization and outpatient management in day programs (i.e., adult day programs or psychosocial programs) and periodic office visits for management of medication and psychotherapy in:

- The intensity of the treatment programs and frequency of participation by the patient; and
- The comprehensive structured program of services provided that are specified in an individualized treatment plan which is formulated by a physician and the multidisciplinary team with the patient's involvement.

Active treatment refers to the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a documented treatment plan. Examples of active treatment include, but are not limited to, individual therapy, group therapy, and occupational therapy. In order to be considered active treatment, the following criteria must be met:

- Treatment is directed toward the alleviation of the impairments that precipitated entrance in the program or which necessitate continued level of intervention;
- Treatment enhances the patient's coping abilities; and
- Treatment is individualized to address the specific clinical needs of the patient.

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

SITE OF PARTIAL HOSPITALIZATION PROGRAMS

Partial hospitalization services may be covered under Medicare when they are provided in a hospital outpatient department or a community mental health center (CMHC). (A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under §1866(e)(2) of the Act.)

HCFA's definition of a CMHC is based on §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. HCFA defines a CMHC as an entity that provides:

- Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health services area who have been discharged from inpatient treatment at a mental health facility;
- 24-hour a day emergency care services;
- Day treatment or other partial hospitalization services or psychosocial rehabilitation services;
- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and
- Consultation and education services.

NOTE: Not all of these services can be covered. (See COVERAGE CRITERIA FOR INDIVIDUAL SERVICES below.)

A CMHC must also meet applicable licensing or certification requirements for CMHCs in the State in which it is located.

The individuals rendering services to partial hospitalization patients must meet applicable State licensing or certification requirements.

ELIGIBILITY

In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify (and recertify where such services are furnished over a period of time):

1) That the individual would require inpatient psychiatric care in the absence of such services,

This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.

2) An individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and

3) Such services are or were furnished while the individual is or was under the care of a physician. (Physician certification is required under the procedures for payment of claims to providers of partial hospitalization services under §1835(a)(2)(F) of the Act.)

A Medicare partial hospitalization program is an appropriate level of active treatment intervention for individuals who:

- Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment on the continuum of care for the mentally ill;

- Do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;

- Have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e., 290 through 319). However, the diagnosis in itself is not the sole determining factor for coverage; and

- Are not judged to be dangerous to self or others.

## INDIVIDUALS WHO ARE INELIGIBLE FOR MEDICARE PARTIAL HOSPITALIZATION PROGRAMS

- Patients who refuse or who cannot participate (due to their behavioral, cognitive, or emotional status) with the active treatment process or who cannot tolerate the intensity of the partial hospitalization program;

- Patients who are gravely suicidal, homicidal, or severely demented that require 24-hour supervision and present significant security risks;

- Patients who demonstrate inadequate impulse control manifested by self-mutilating or self-destructive behavior requiring 24 hour supervision;

- Patients who require primarily social, custodial, recreational or respite care (e.g., moderately to severely demented patients with no evidence that active treatment would modify the clinical course);

- A patient with multiple unexcused absences or a patient who is present and is non-compliant. A patient with multiple unexcused absences is not receiving "active treatment" and, therefore, is not appropriate to participate in partial hospitalization program. A patient who attends sessions and is non-compliant may be in an inappropriate group or may not be at a functional level to understand instructions;

- Patients who have achieved sufficient stabilization of the presenting symptoms and sufficient intervention in skills or coping ability and mobilization of family and/or community supports to no longer require the intense, frequent involvement of a partial hospitalization program (e.g., a patient who needs only one day a week on an ongoing basis would not need Medicare covered partial hospitalization programs); and

- Patients who have achieved sufficient stability so that they now require limited intervention (medication management and psychotherapy as an individual or in a group) on an intermittent basis which may be performed in the outpatient or office setting.

## CERTIFICATION REQUIREMENTS

In order for an individual's partial hospitalization program to be covered, the following must be certified and recertified by a physician:

1) The individual would require inpatient psychiatric care in the absence of such services;

NOTE: This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.

2) The services are or were furnished while the individual was under the care of a physician; and

3) The services were furnished under a written plan of individualized treatment that meets the plan of treatment requirements described in the treatment plan section of this PM.

**INDIVIDUALIZED TREATMENT**

A physician must order the partial hospitalization services, establish the plan of treatment and periodically recertify the need for continued care. Partial hospitalization services must be prescribed by a physician and furnished under the supervision of a physician.

**PHYSICIAN SUPERVISION**

Partial hospitalization services provided by a hospital outpatient department must be incident to a physician's services, which requires physician supervision. The physician supervision requirement for partial hospitalization services rendered in a hospital outpatient department is generally assumed to be met where the services are performed on hospital premises. The hospital medical staff that supervises the services need not be in the same department as the ordering physician. (See Medicare Intermediary Manual, §3112.4.)

However, if the services are furnished outside of the hospital (e.g., an off-site location that is not certified as part of the hospital), they must be rendered under the direct personal supervision of a physician who is treating the patient.

For example, if a partial hospitalization program is provided at a skilled nursing facility, the physician must be present, personally supervising at all times, while the partial hospitalization services are rendered. A skilled nursing facility is an example of an off-site location that is not certified as part of the hospital.

Partial hospitalization services provided in a CMHC require general supervision by a physician. 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.

**INDIVIDUALIZED TREATMENT PLAN**

Partial hospitalization is active treatment that incorporates an individualized treatment plan, a coordination of services wrapped around the needs of the patient, and a multidisciplinary team approach to patient care.

The individualized treatment plan is established and periodically reviewed by a physician in consultation with appropriate staff participating in the program. The treatment plan must include, but is not limited to:

- Physician's diagnosis,
- Treatment goals under the plan,
- Type of services,

- Amount of services,
- Duration of services, and
- Frequency of services.

The treatment goals are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the impact of treatment. Objective treatment goals are a vital resource for the determination of whether a partial hospitalization program is the appropriate level of intervention for the individual's condition.

In addition, treatment goals are a tool for determining whether a service is covered. The services defined in §1861(ff) of the Act that are rendered to partial hospitalization patients and are linked to specified treatment goals in the individualized active treatment plan may constitute Medicare covered services when provided as components of a partial hospitalization program.

**CHART ENTRIES**

Chart entries are an appropriate method to document a patient's response to treatment. Chart entries should be written on each day that there is an encounter and should reflect, but are not limited to the following:

- Observation of the patient's status and responses in the course of therapeutic contact; and
- The patient's response to treatment as it relates to the individualized active treatment goals.

The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition or maintenance of an appropriate functional level.

It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient's participation in the program, and periodic reviews to be performed at least every 31 days thereafter.

**COVERAGE CRITERIA FOR INDIVIDUAL SERVICES**

Covered services furnished under partial hospitalization programs must be reasonable and necessary for the diagnosis or active treatment of the individual's condition, and must be expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

For coverage purposes, the key to whether a particular type or group of services and activities may be covered as a partial hospitalization program depends primarily on the services provided in the program and how the services are being utilized in the care of the individual patient.

Eligible individuals must need and receive:

- A level of active treatment intervention that incorporates a program of partial hospitalization services as defined in §1861(ff) of the Act;
- A physician's plan of treatment that is individualized and essential for the treatment of the patient's condition;

- A coordinated multidisciplinary approach to patient care; and

- Services that are linked to specific treatment goals in the individualized plan of treatment.

The following services may be covered as elements of a partial hospitalization program. A partial hospitalization program is a distinct and organized intensive treatment service offering less than 24-hour daily care. Items and services under a partial hospitalization program may include:

- Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law;

- Occupational therapy requiring the skills of a qualified occupational therapist;

NOTE: An occupational therapy service is covered only if it is a component of a physician's treatment plan for the individual. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered.

- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;

- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic services, 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, effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under an investigational protocol.

- Individualized activity therapies that are not primarily recreational or diversionary;

NOTE: The determination of coverage depends on the individual case. Individualized activity therapies that are essential to the treatment of the patient's condition, indicated by a physician in the patient's treatment plan, linked to specified treatment goals in the treatment plan, and are not primarily recreational and diversional can constitute covered elements of a partial hospitalization program.

For example, when they are individualized and essential for the treatment of the partial hospitalization patient's condition, art therapy, music therapy, movement therapy, stress reduction, conflict resolution, and similar activities may constitute covered activity therapies.

Providers should not bill for activity therapy services as individual or group psychotherapy services.

- Family counseling, the primary purpose of which is treatment of the individual's condition;

NOTE: The Coverage Issues Manual (CIM) §35-14 provides guidance for the coverage of family counseling. This section provides the following covered examples of family counseling services:

-- There is a need to observe the patient's interaction with family member(s); and/or

-- There is a need to assess the capability of family members to aid the patient and aid in the patient's management.

o Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment;

NOTE: Section 80-1 of the CIM provides guidance for the coverage of patient training and education.

o Diagnostic services; and

NOTE: Diagnostic services covered under the partial hospitalization benefit include those:

- For purposes of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions;

- To identify problem areas; and

- To modify/formulate a treatment plan.

o Other items and services specified by HCFA.

NOTE: No services other than the services listed in this PM have been specified as partial hospitalization services by HCFA.

NONCOVERED SERVICES

o Services are noncovered when the patient's condition would not permit them to participate or to benefit or the patient chooses not to participate;

o Meals;

o Transportation;

o Activities that are primarily recreational or diversional in nature for which the individual participating does not have a specific individual treatment goal. Examples of activities include social hours, television, shopping trips, and attending or participating in sports;

o Drugs and biologicals that can be self-administered;

o General education programs or education of the general public; and

o Any service that does not have a specific treatment goal.

NOTE: A skilled nursing facility (SNF) cannot qualify to provide a partial hospitalization program. However, a partial hospitalization program provided by a hospital or CMHC may be covered for a resident of a SNF under limited circumstances when the patient's need for treatment and the nature of the treatment fits the requirement of the benefit. Partial hospitalization services are not covered when a nursing home patient is experiencing adjustment difficulties that are expected to be addressed by the nursing home facility staff, with rare involvement of professional psychiatric intervention. Patients who are in a hospital and receiving inpatient services cannot participate in an outpatient partial hospitalization program.

## BUNDLING ISSUES

The professional services (found at 42 CFR 410.43(b) and listed below) provided in a CMHC and a 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 can bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization 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. The following direct professional services are unbundled and not paid as partial hospitalization services. (See 42 CFR 410.43(b).):

- Physician services that meet the criteria of 42 CFR 405, Subpart F, for payment on a fee schedule basis in accordance with 42 CFR 414;
- Physician assistant services, as defined in §1861(s)(2)(K)(i) of the Act; and
- Clinical psychologist services, as defined in §1861(ii) of the Act.

There are some independent practitioners, e.g., clinical social workers whose services are bundled when furnished to hospital patients, including partial hospitalization patients. The CMHC must bill you for such nonphysician practitioner services listed under the regulatory provision for partial hospitalization services. Make payment for the services to the CMHC.

## ACCEPTABLE PARTIAL HOSPITALIZATION REVENUE CODES

| | |
|---|---|
| Drugs/Biologicals | 250 |
| Occupational Therapy | 43X |
| Activity Therapy | 904 |
| General Psychiatric/ Psychological | 910 |
| Individual Therapy | 914 |
| Group Therapy | 915 |
| Family Therapy | 916 |
| Testing | 918 |
| Education/Training | 942 |

Revenue Code 560, "Medical Social Services," has been deleted from the list of acceptable revenue codes. Report the charges for medical social services under one of the remaining codes above based on the nature of the services provided.

Hospitals are to report condition code 41 in FLs 24-30 of the HCFA-1450 to indicate the claim is for partial hospitalization services.

Hospitals billing for psychiatric services use HCPCS codes 90801 through 90889. Where hospitals provide a psychiatric service under the partial hospitalization benefit and an appropriate HCPCS code is not available in the 90801-90889 series, hospitals may use HCPCS code 90899. Activity therapy services are billed with HCPCS code Q0082 and occupational therapy services with HCPCS code H5300. The remaining services do not require HCPCS coding. However, ensure that all services are reported with the appropriate revenue code and related charges. (See Hospital Manual, §482)

# Aetna Medicare Clinical Policy
# on
# Partial Hospitalization Program (PHP)

Partial Hospitalization Programs (PHP) are furnished by a hospital or Community Mental Health Center (CMHC) as a distinct and organized intensive ambulatory treatment of less than twenty-four (24) hours daily care.

These programs are designed to provide patients who exhibit severe or disabling conditions related to a psychiatric/psychological condition or a severe and persistent mental disorder, with an individualized, coordinated, intensive, comprehensive and multi-disciplinary treatment program not provided in a regular outpatient setting.

A partial hospitalization program is an intensive level of treatment for patients in acute crisis that may require diagnostic, medical, psychiatric, psychosocial, occupational therapy and pre-vocational treatment modalities usually found in a comprehensive program. The program is structured to offer an intensive milieu of various clinical services that would apply to clients transitioning to community living following an inpatient hospitalization for an acute psychiatric illness or to provide intensive therapeutic modalities to those where traditional outpatient clinic or office visits are not meeting their needs. At a minimum, the program should have available twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. An average program day is between four (4) and six (6) hours. However, fewer hours may be acceptable based on a patient's individual needs i.e., preparation for discharge.

## Revenue Codes:

The following revenue codes are the only codes that are currently allowed when billing Partial Hospitalization Services:

| | |
|---|---|
| 250 | Drugs and Biologicals |
| 43X | Occupational Therapy |
| 904 | Activity Therapy (effective for services of April 1, 1994 and after) |
| 910 | Psychiatric/Psychological Services |
| 914 | Individual Therapy |
| 915 | Group Therapy |
| 916 | Family Therapy |
| 918 | Testing |
| 942 | Education Training |

## HCPCS (CPT) Codes:

| | |
|---|---|
| Q0082 | Activity Therapy Services |
| H5300 | Occupational Therapy |
| 90899 | Hospital Partial Hospitalization |

## Billing Requirements:

- Professional services are not bundled and should be billed separately to the carrier (i.e.,physician, physician assistant and clinical psychologist services).
- Component billing requires a HCPCS/CPT code (if appropriate) and a charge for each individual covered service furnished.
- Condition Code 41 (field 24-30) is required on the HCFA 1450 to indicate PHP services.
- Social Worker services should be bundled and billed to the intermediary if part of the Partial Hospitalization program.
- Social Worker services should be billed to the carrier if the services are outpatient psychiatric services or community mental health services.

## Indications and Limitations on Coverage

The Medicare Program provides benefits for partial hospitalization services when the following criteria are met:

- The services are reasonable and necessary for the active treatment of the patient's condition.
- There is a reasonable expectation that the patient will improve or be maintained at a functional level to prevent relapse or hospitalization.
- The services must be prescribed by a physician and provided under an individualized written plan of treatment.
- The services must also be under the supervision of a physician and periodically evaluated by this physician to determine the extent to which treatment goals are being realized.

*The "incident to" direct supervision requirement for partial hospitalization services rendered in a hospital outpatient department is generally assumed to be met where the services are performed on hospital premises.*

*However, if the services are furnished outside of the hospital (at an off-site location not authorized by the State to be licensed and certified as part of the hospital, such as a skilled nursing facility), they must be rendered under the direct personal supervision of a physician who is treating the patient. Therefore, the physician must be present and immediately available on the premises at all times while the partial hospitalization services are being performed outside of the hospital.*

*In the CMHC setting, general supervision by a physician providing partial hospitalization services is required. 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.*

- The patient's diagnosed mental disorder must meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, with emphasis on Axis I and Axis II. The patient's diagnosis should fall within the range of ICD-9CM codes for mental illness. However, the diagnosis in itself is not the sole factor for coverage.

Requirements for Medicare Coverage on Admission: (The patient must meet at least three (3) of the following provisions.)

- The patient has symptoms and/or behavioral manifestations of a mental disorder which interferes with social, vocational and/or educational functioning.
- The patient does not require 24 hour care and has an adequate support system outside the hospital setting while not actively engaged in the program.
- The patient is not judged to be dangerous to self or others and has adequate control of his/her behavior.
- Despite the degree of emotional impairment present, the patient has sufficient intact functioning to benefit from an active intensive treatment program.
- Active professional monitoring and psychiatric medical treatment of aberrant behavior, mood and/or thought disorder is essential to prevent inpatient treatment.

## Individuals Who are Ineligible for Medicare Partial Hospitalization Programs:

- Patients who refuse or who cannot participate (due to their behavioral, cognitive, or emotional status) with the active treatment process or who cannot tolerate the intensity of the partial hospitalization program;

- Patients who are gravely suicidal, homicidal, or severely demented that require 24-hour supervision and present significant security risks;

- Patients who demonstrate inadequate impulse control manifested by self-mutilating or self-destructive behavior requiring 24 hour supervision;

- Patients who require primarily social, custodial, recreational or respite care,(e.g., moderately to severely demented patients with no evidence that active treatment would modify the clinical course);

- A patient with multiple unexcused absences or a patient who is present and is non-compliant. A patient with multiple unexcused absences is not receiving "active treatment" and therefore, is not appropriate to participate in the partial hospitalization program. A patient who attends sessions and is non-compliant may be in an inappropriate group or may not be at a functional level to understand instructions;

- Patients who have achieved sufficient stabilization of the presenting symptoms and sufficient intervention in skills or coping ability and mobilization of family and/or community supports to no longer require the intense, frequent involvement of a partial hospitalization program (e.g., a patient who needs only one day a week on an ongoing basis would not need Medicare covered partial hospitalization program services); and

- Patients who have achieved sufficient stability so that they now require limited intervention (medication management and psychotherapy as an individual or in a group) on an intermittent basis which may be performed in the outpatient or office setting.

## Covered Services include the following:

- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized by the state in which they practice within their scope of work, i.e., Registered Clinical Social Workers, Registered Nurses with additional training/experience and licensed to run psychotherapy, licensed marriage, family and child counselors, and certified alcohol and drug counselors.
- Occupational therapy requiring the skills of a qualified occupational therapist. Services can be performed by a certified Occupational Therapy Assistant (C.O.T.A.) under the supervision of a qualified occupational therapist.
- If medication management is part of the program, the medications, administration and any changes should be noted in the medical record (e.g., self-administered drugs are not covered; experimental drugs or drugs administered under an investigational protocol are not covered).
- Activity therapies that improve functional outcome. These activities must be individualized and essential for treatment of the patient's diagnosed condition and should be directly related to skill development (e.g., communication, coping skills, problem solving, ADL skills). The treatment plan must clearly state how these activity therapies fit into the patient's functional outcomes.
- Family counseling for which the primary purpose is treating the patient's condition.
- Diagnostic services.
- Training and education services.
- Crisis intervention visits if it was part of the treatment plan for patients already involved in a partial hospitalization program (PHP) or if the patient was admitted to a PHP immediately following a crisis intervention service.

## Reasons for Non Coverage:

- Maintenance services where the patient has reached a consistently stable level of functioning and no longer requires or can benefit from the level of care provided by a PHP.
- Activities that are primarily recreational or diversional in nature for which the individual participating does not have a specific individual treatment goal. Examples of activities that are primarily recreational or diversionary in nature include sports, craft hours, social hours, television, shopping trips, sewing and cooking classes, driving instructions, leisure education and physical restoration.

- Services that are not reasonable and necessary for the diagnosis or treatment of the patient's illness.
- Individuals with a primary diagnosis of mental retardation, chronic organic brain syndromes e.g., Alzheimer and other dementia's or severe head trauma unless;

  - the reasonableness and necessity for active treatment can be demonstrated: AND
  - treatment can reasonably be expected to improve or maintain the patient's condition and functional level; AND
  - prevent relapse or hospitalization.

- Meals and transportation.
- Billing for self administration of medication and/or take-home medication.
- Managing, dispensing or administering medication(s) as the only service rendered does not meet the definition of a PHP.
- Vocational training, when services are related solely to specific employment opportunities work skills or work settings.
- Geriatric day care programs available in both medical and nonmedical settings.
- Custodial care of patients residing in 24-hour Board and Care or Skilled Nursing Facilities.
- Services that are not explicitly related to functional outcome.

Note: A skilled nursing facility (SNF) cannot qualify to provide a partial hospitalization program. However, a partial hospitalization program provided by a hospital or CMHC may be covered for a resident of a SNF under limited circumstances when the patient's need for treatment and the nature of the treatment fits the requirement of the benefit. Partial hospitalization services are not covered when a nursing home patient is experiencing adjustment difficulties that are expected to be addressed by the nursing home facility staff, with rare involvement of professional psychiatric intervention. Patients who are in a hospital and receiving inpatient services cannot participate in an outpatient partial hospitalization program.

## Documentation:

### Individualized Treatment Plan

Partial hospitalization is active treatment that incorporates an individualized treatment plan, a coordination of services wrapped around the needs of the patient, and a multidisciplinary team approach to patient care.

The individualized treatment plan is established and periodically reviewed by a physician in consultation with appropriate staff participating in the program. The treatment plan must include, but is not limited to:

- Physician's diagnosis,
- Treatment goals under the plan,
- Type of services,
- Amount of services,
- Duration of services, and
- Frequency of services.
- Current psychiatric evaluation

The treatment goals are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the impact of treatment. Objective treatment goals are a vital resource for the determination of whether a partial hospitalization program is the appropriate level of intervention for the individual's condition.

In addition, treatment goals are a tool for determining whether a service is covered. The services defined in Section 1861(ff) of the Act that are rendered to partial hospitalization patients and are linked to specified treatment goals in the individualized active treatment plan may constitute Medicare covered services when provided as components of a partial hospitalization program.

### Chart Entries

Chart entries are an appropriate method to document a patient's response to treatment. Chart entries should be written on each day that there is an encounter and should reflect, but are not limited to the following:

- Observation of the patient's status and responses in the course of therapeutic contact; and
- The patient's response to treatment as it relates to the individualized active treatment goals.

The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition or maintenance of an appropriate functional level.

It is reasonable to expect the plan of treatment to be established within the first 7 days of a patient's participation in the program, and periodic reviews to be performed at least every 14 days.

**Requirements for Continued Coverage:**

- Services are reasonable and necessary for the diagnosis or treatment of illness and injury or to improve the function of a malformed body member.
- Ability to participate in the treatment program.
- The patient's clinical condition continues to require intensive therapeutic treatment.
- Ability to benefit from further treatment.

**Certification:**

- A physician who has knowledge of the case must sign a certification and periodic (every 30 days) recertification statement that:

  - The individual would require inpatient psychiatric care or continued inpatient services if the partial hospitalization services were not provided.

Note: Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis.

  - The services were furnished while under the care of a physician, AND
  - The services were furnished under a written Plan of Treatment (42 CFR 424.24 [e]), and written within the first 7 days of a patients' participation in the program.

Note: **Stamped signatures are NOT acceptable.** The certification must be signed by the physician within the first 2-5 days of treatment. Recertification statements are required every thirty (30) days thereafter by the physician who reviewed the plan of care. A psychologist is not considered a physician for the purpose of establishing a certification or recertification.