CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 483 **Date: FEBRUARY 25, 2005**

CHANGE REQUEST 3297

NOTE: Transmittal 180, Dated May 14, 2004, is being rescinded and replaced by Transmittal 483, Dated February 25, 2005, to incorporate information erroneously omitted from the original document.

SUBJECT: Hospital Partial Hospitalization Services Billing Requirements

I. SUMMARY OF CHANGES: Use of revenue code 0910 to report certain psychiatric/psychological treatment and services was discontinued by the National Uniform Billing Committee on October 15, 2003. CMS has allowed for revenue code 0910 to be used until October 4, 2004, when necessary systems changes can be implemented. Revenue code 0900 will now be used in place of revenue code 0910.

In addition, we updated the manual to add existing provider range 4900 – 4999 in the list of applicable provider ranges for community mental health centers. Section 260.7 is being deleted and the information moved to the new section 260.1.1. Also, information that was included in Transmittal 1876, dated February 2003, which updated sections 3651 and 3661of the Medicare Intermediary Manual is being added to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, sections 260.1 and 260.1.1. This information was accidentally omitted during the transition from the paper based manuals to the on-line CMS Manual System.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Contents
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
N	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs)
D	4/260.7/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.483, 02-25-05)

260.1 – Hospital Outpatient Partial Hospitalization Services Billing Requirements

(Rev.483, Issued 02-25-05, Effective: 10-01-04, Implementation: 10-04-04)

A3-3661

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799 *and 4900-4999*. *See §261.1.1* for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 24-30 (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.

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 are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

All hospitals are required to report condition code 41 in FLs 24-30 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 Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	*Behavioral Health Treatment/Services*
0904	Activity Therapy
0910	Psychiatric/Psychological Services *(Dates of Service prior to October 16, 2003)*
0914	Individual Therapy

Revenue Code	Description
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 Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129
0900	*Behavioral Health Treatment/Services*	*90801, 90802, 90899*
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services *(Dates of Service prior to October 16, 2003)*	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Therapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115 or 96117
0942	Education Training	***G0177

The FI will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The FI will not edit for matching the revenue code to HCPCS.

*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 day,

**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).

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

Revenue code 250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

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.

C. 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 by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report 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.

You must RTP claims that contain more than one unit for HCPCS codes G0129 per day.

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

E. Line Item Date of Service Reporting

Hospitals other than CAHs 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). See §260.5 for a detailed explanation.

F. Payment

Beginning with services provided on or after August 1, 2000, for hospital outpatient departments, make payment under the hospital outpatient prospective payment system for partial hospitalization services.

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

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

(Rev.483, Issued 02-25-05, Effective: 10-01-04, Implementation: 10-04-04)

A3-3651

A - General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B - Special Requirements

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C - Billing Requirements

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. The FIs follow bill review instructions in Chapter 25 except for those listed below.

The acceptable revenue codes are as follows:

Code	***Description***
0250	*Drugs and Biologicals*
043X	*Occupational Therapy*
0900	*Behavioral Health Treatments/Services*
0904	*Activity Therapy*
0910	*Psychiatric/Psychological Services (Dates of Service prior to October 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	*Behavioral Health Treatments/Services*	*90801, 90802, 90899*

Revenue Codes	***Description***	***HCPCS Code***
0904	*Activity Therapy (Partial Hospitalization)*	***G0176*
0910	*Psychiatric General Services (Dates of Service prior to October 16, 2003)*	*90801, 90802, 90899*
0914	*Individual Psychotherapy*	*90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829*
0915	*Group Psychotherapy*	*90849, 90853, or 90857*
0916	*Family Psychotherapy*	*90846, 90847, or 90849*
0918	*Psychiatric Testing*	*96100, 96115, or 96117*
0942	*Education Training*	****G0177*

FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

**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 day.*

***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).*

Codes G0129, G0176, and G0177 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.

FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in Chapter 25.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The 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 professional services of a PA can be billed to the carrier only by the PAs employer.

The following 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;*
- *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 CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

PA services can be billed only by the actual employer of the PA. The employer of a PA may be such entities or individuals 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 CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

D - 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 FI as partial hospitalization services.*

E - Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in Form Locator (FL) 46, "Service Units," the number of times the service or procedure, as defined by the

HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE

A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during one day. The CMHC reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and "3" units in FL 46.

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.

The FI returns to the provider claims that contain more than one unit for HCPCS code G0129 or that does not contain service units for a given HCPCS code.

NOTE: *The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)*

F - Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. 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). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file as well as the HIPAA 837, FIs report as follows:

Record Type	***Revenue Code***	***HCPCS***	***Dates of Service***	***Units***	***Total Charges***
61	*0915*	*90849*	*19980505*	*1*	*$80*
61	*0915*	*90849*	*19980529*	*2*	*$160*

For the hardcopy UB-92 (Form CMS-1450), FIs report as follows:

FL 42	***FL 44***	***FL 45***	***FL 46***	***FL 47***
0915	*90849*	*050598*	*1*	*$80*
0915	*90849*	*052998*	*2*	*$160*

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, FIs report as follows:

*LX*1~*

*SV2*0915*HC:90849*80*UN*1~*

*DTP*472*D8*19980505~*
*LX*2~*

*SV2*0915*HC:90849*160*UN*2~*
*DTP*472*D8*19980529~*

FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 05, 2000.

G - Payment

Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual. FIs are to furnish each CMHC with one copy of that manual.

FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

***NOTE:** Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.*

H - Medical Review

FIs follow medical review guidelines in the Medicare Program Integrity Manual.

I - Coordination With CWF

See Chapter 27. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.