CareSource

REIMBURSEMENT POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Partial Hospitalization Program-Behavioral Health-NV MP-PY-1632	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Partial Hospitalization Program – Behavioral Health

B. Background

Partial hospitalization programs (PHPs) provide intensive psychiatric or substance use disorder (SUD) care through active, structured treatment combining clinically recognized services under §1861(ff) of the Social Security Act. Programs resemble short-term inpatient hospital programs but are less intensive than inpatient care.

PHPs use individualized treatment plans with multidisciplinary coordination led by a qualified provider. Treatment goals must be measurable, time-bound, medically necessary, and related to the admission reason. A qualified provider must certify that members require at least 20 hours per week of therapeutic services for comprehensive, medically supervised treatment due to a *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnosis that severely impairs daily functioning. Members must cognitively and emotionally participate and tolerate PHP intensity.

Programs usually best benefit members discharged from inpatient care to avoid rehospitalization or at risk of inpatient admission. When PHPs shorten inpatient stays, documentation must support necessity. Recertification should confirm ongoing serious psychiatric needs, and discharge planning must align with best practices to ensure coordinated follow-up and promote recovery in the least restrictive setting.

C. Definitions

- **Inpatient Services** – Behavioral health (BH) services provided during an inpatient admission or confinement for acute inpatient services in a hospital or treatment setting on a 24-hour basis under the direct care of a qualified provider, including psychiatric hospitalization, inpatient detoxification, and emergency evaluation and stabilization.
- **Intensive Outpatient Level of Care (LOC) 2.1** – 9 or more hours of SUD treatment services a week (adults) or 6 or more hours (adolescents) to treat multidimensional instability, particularly services meeting complex needs of members with addiction and co-occurring conditions.
- **Intensive Outpatient Program (IOP)** – Services addressing BH needs provided by facilities, group practices or clinics at least 3 hours a day, 2 to 3 days a week and usually as a step down from acute inpatient care, partial hospitalization care, or residential care but a step up from traditional outpatient services.
- **Partial Hospitalization** – Intensive and structured, multimodal, active treatment for BH needs with a treatment period of 3 or more hours per day or evening available 5 days a week with an intensity similar to inpatient setting with skilled nursing care and daily psychiatric care.
- **Residential Treatment** – Services for BH needs that can include individual, family and group therapy, nursing services, medication assisted treatment, detoxification (ambulatory or subacute), and pharmacological therapy in a congregate living community with 24-hour support.

D. Policy

I. Prior authorization is required after 5 days per calendar year. CareSource follows MCG criteria for reviews of medical necessity for mental health requests and American Society of Addiction Medicine (ASAM) criteria for review of SUD requests.

II. Billing

A. Some professional services are separately covered and unbundled. CareSource follows the Centers for Medicare and Medicaid Services (CMS) guidance. Additional instructions can be found in the *Medicare Claims Processing Manual*.

B. Under component billing, providers must include the following for service claims:

1. PHP ambulatory payment classifications (APCs) for each provider type
   a. days with 3 or fewer services a day
   b. days with 4 or more services a day
2. Type of bills (TOB) for institutional billing include the following:
   a. TOB 13X – outpatient hospital
   b. TOB 85X – critical access hospital (CAH)
   c. TOB 76X – community mental health center (CMHC)
3. Claims must be submitted in sequence for a continuing course of treatment. Consistency editing will be enforced for interim billing of PHP claims

Definition	TOB	Setting
Admit through discharge	131	13X
	851	85X
	761	76X
Interim – First	132	13X
	852	85X
	762	76X
Interim – Continuing	133	13X
	853	85X
	763	76X
Interim - Last	134	13X
	854	85X
	764	76X

4. Hospitals other than CAHs are required to report line-item dates of service per revenue code line for claims and the charge for each individual covered service furnished, including required Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) codes. Revenue codes can be found in *Chapter 4 of the Medicare Claims Processing Manual, 100-04*.
5. PHP services are identified using condition code 41 on claims.
6. Providers must report service units for billed codes. Patient status must be reported. Discharge status codes can be located in Chapter 25 of the *Medicare Claims Processing Manual, 100-04*.
7. When applicable, add on codes may be used following an appropriate initial code.

8. Modifiers, including the following, must be reported:

Modifier	Description
PN	Services provided in non-excepted, off-campus, provider-based departments of a hospital. Use will trigger a payment rate under the Medicare Physician Fee Schedule. PN should be reported with each non-excepted item and service, including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.
PO	Services provided in accepted, off-campus, provider-based departments of a hospital (services, procedures and surgeries provided at off-campus provider-based outpatient departments for all accepted items and services furnished).

III. The following activities and/or programs are considered not medically necessary:
   A. day care programs, providing primarily social, recreational, or diversionary activities, custodial or respite care
   B. programs that maintain psychiatric wellness with no risk of relapse of hospitalization of member
   C. services for members otherwise psychiatrically stable or requiring medication management only
   D. services to inpatient members at a hospital, including meals, self-administration of medication, transportation, and/or vocational training
   E. members who cannot or refuse to participate with treatment (eg, low cognitive status, volatile behavioral issues) or cannot tolerate the intensity of a PHP
   F. treatment of chronic conditions without acute exacerbation of symptoms that place the member at risk of relapse or hospitalization

E. Conditions of Coverage

I. In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

II. The inclusion of codes in this policy does not guarantee coverage, authorization or reimbursement. This list may not be all-inclusive:

Partial Hospitalization Programs	
Code	Code Description
H0035	Mental health partial hospitalization, treatment, less than 24 hours

F. Related Policies/Rules

Behavioral Health Rates
Behavioral Health Service Record Documentation Standards

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.

Date Revised	05/20/2026	Annual review. Simplified background. Added E.II. Updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

1. About the ASAM criteria. American Society of Addiction Medicine. Accessed April 27, 2026. www.asam.org
2. Centers for Medicare and Medicaid Services. *CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule*. Centers for Medicare and Medicaid Services; 2023. CMS Fact Sheet-CMS 1786-FC. Accessed April 27, 2026. www.cms.gov
3. Conditions for Fee Schedule Payment for Physician Services to Beneficiaries in Providers. 42 C.F.R. § 415.102 (2023).
4. Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459.
5. Definitions. 42 U.S.C. 1395 (2011).
6. *Diagnostic and Statistical Manual of Mental Disorders (5th ed, Text Revised).* American Psychiatric Association; 2022. Accessed April 27, 2026. doi:10.1176/appi.books.9780890425787
7. Further Additional Continuing Appropriations and Other Extensions Act, 2024, Pub. L. No. 118-35, 138 Stat. 3.
8. Medical Insurance (SMI) Benefits, 42 C.F.R. §§ 410.42, 410.71, 410.73 to 76, and 410.78 (2023).
9. *Medicare Benefit Policy Manual Chapter 6*. Centers for Medicare and Medicaid Services. Accessed April 27, 2026. www.cms.gov
10. *Medicare Claims Processing Manual, Chapter 4, 100-04*. Centers for Medicare and Medicaid Services. Accessed April 27, 2026. www.cms.gov
11. *Nevada Marketplace Evidence of Coverage*. CareSource; 2026. Accessed April 27, 2026. www.caresource.com
12. Partial Hospitalization Services: Conditions and Exclusions, 42 C.F.R. § 410.43 (2023).
13. Requirements for Medical and Other Health Services Furnished by Providers under Medicare Part B, 42 C.F.R. § 424.24 (2023).