REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Partial Hospitalization Program-Behavioral Health-MP-PY-1480	09/01/2024 Kentucky Inactive 01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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 agreement, 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other 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) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and 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.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Partial Hospitalization Program – Behavioral Health

B. Background

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric or substance use disorder (SUD) care through active treatment that utilizes a combination of the clinically recognized items and services described in § 1861(ff) of the Social Security Act. The treatment program closely resembles a highly structured, short-term hospital inpatient program, providing treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation.

PHPs involve incorporating an individualized treatment plan describing a coordination of services wrapped around the needs of the member and a multidisciplinary team approach to care under the direction of a physician with a high degree of structure and scheduling. According to current practice guidelines, treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

Items and services provided can include the following:

- individual and group therapy with physicians, psychologists, other mental health professionals to the extent authorized under state law
- occupational therapy requiring the skills of a qualified occupational therapist
- services of social workers, trained psychiatric nurses, and other staff trained to work with members with psychiatric diagnoses and SUD
- drugs and biologicals furnished for therapeutic purposes, which cannot as determined in accordance with regulations, be self-administered
- individualized activity therapies that are not primarily recreational or diversionary
- family counseling with a primary purpose for treatment of the individual's diagnosis, including counseling services for caregivers
- patient training and education to the extent that activities are closely and clearly related to an individual's care and treatment
- diagnostic services
- other items and services, in no event to include meals and transportation, reasonable and necessary for the diagnosis or active treatment of the condition, reasonably expected to improve or maintain the condition and functional level, to prevent relapse or hospitalization, and furnished pursuant to guidelines relating to frequency and duration of services established by regulations (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement)

A physician must certify a member's need for a minimum of 20 hours per week of therapeutic services for those requiring a comprehensive, structured, multimodal treatment with medical supervision and coordination due to a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis should severely interfere with multiple areas of daily life, including social, vocational, and/or educational functioning, generally of an acute nature. In addition, the member must be able to

participate cognitively and emotionally in the active treatment process while tolerating the intensity of a PHP.

Coverage requirements typically involve members discharged from an inpatient hospital treatment program with the PHP in lieu of continued inpatient treatment or members at reasonable risk of requiring inpatient hospitalization. When PHPs are used to shorten an inpatient stay and transition the member to a less intense level of care, there must be evidence of the need for PHP services. Recertification must address the continuing, serious nature of the psychiatric condition requiring continued active treatment.

Discharge planning reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a member's return to a higher level of functioning in the least restrictive environment.

C. Definitions

- **Concurrent Review** – A request for prior authorization or a predetermination that is submitted before or during the course of receiving a health care service.
- **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 physician, including psychiatric hospitalization, inpatient detoxification, and emergency evaluation and stabilization.
- **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** – Structured, multimodal, active treatment for BH needs with a treatment period of less than 24 hours, including individual, group and/or family psychotherapy, member education and training, and diagnostic services focusing on member reintegration into society.
- **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.
- **Retrospective Review** – A request for medical review that is submitted after the health care service has been received.

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 ASAM criteria for review of substance use disorder requests.

II. Billing

A. Some professional services are separately covered and unbundled. See section 260 of Chapter 4 of the *Medicare Claims Processing Manual* for additional instructions.
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 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. When applicable, add on codes may be used following an appropriate initial code.
   7. 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 excepted, off-campus, provider-based departments of a hospital (services, procedures and surgeries provided at off-campus

	provider-based outpatient departments for all excepted items and services furnished).

8. Providers must report service units for billed codes. Patient status must be reported. Discharge status codes can located in Chapter 25 of the *Medicare Claims Processing Manual, 100-04.*

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. State-Specific Information

West Virginia - Benefits for the first 5 days will be provided without any retrospective review of medical necessity. Benefits beginning day 6, and every 6 days thereafter, are subject to concurrent review of medical necessity.

F. Conditions of Coverage

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.

G. Related Policies/Rules

Medical Necessity Determinations
Behavioral Health Service Record Documentation Standards

H. Review/Revision History

	DATE	ACTION
Date Issued	05/22/2024	Merged AD-1264 & AD-1263. Converted to a PY policy.
Date Revised		
Date Effective	09/01/2024	
Date Archived		

I. References

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