Local Coverage Determination (LCD):
Psychiatric Partial Hospitalization Program (L33972)

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Contractor Information

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<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
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<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
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<td>J - N</td>
<td>Florida</td>
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LCD Information

Document Information

- LCD ID: L33972
- Original Effective Date: For services performed on or after 10/01/2015
- Revision Effective Date: For services performed on or after 10/01/2015
- Revision Ending Date: N/A
- Retirement Date: N/A
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- Notice Period End Date: N/A

LCD Title: Psychiatric Partial Hospitalization Program

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CMS National Coverage Policy Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act, Section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Social Security Act, Sections 1861 (ff) and 1832 (a). These sections define the partial hospitalization benefit and provide coverage of partial hospitalization in a hospital or CMHC setting.

The Social Security Act, Section 1861(s) (2) (B). This section references partial hospitalization in a hospital outpatient setting.

The Social Security Act, Section 1835 (a). This section references physician certification.

The Social Security Act, Section 1833 (e). This requires services to be documented in order for payment to be made.

42 Code of Federal Regulations, Sections 410.2, 410.3, 410.43, 410.110, and 424(e)
Medicare Benefit Policy Manual, Chapter 6, Sections 70-70.3
Medicare Claims Processing Manual, Chapter 4, Sections 260-270
Program Memorandum, 6/95, HCFA Transmittal No. A-95-8
Program Memorandum, 7/96, HCFA Transmittal No. A-96-2
Program Memorandum, 10/96, HCFA Transmittal No. A-96-8
Program Transmittal 15 (Change Request 1346), dated 12/12/2000
Program Transmittal 15 (Change Request 1831), dated 10/29/2001
Program Transmittal 59 (Change Request 2937), dated 11/28/2003
CMS Transmittal 98, Change Request 3457
CMS Transmittal 1657, Change Request 6320, dated 12/31/2008
Change Request 6315, January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric 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 Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

A. Program Criteria

The PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified CMHC.

Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient, and includes a multidisciplinary team.
approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.

The following are facilities eligible for reimbursement for partial hospitalization services and the associated physician supervision requirements of each:

- **Outpatient hospital** - Partial hospitalization services rendered within a hospital outpatient department are considered “incident to” a physician’s (MD/DO) services and require physician supervision. The physician supervision requirement is presumed to be met when services are performed on hospital premises (i.e., certified as part of the hospital). If a hospital outpatient department operates a PHP off-site, the services must be rendered under the direct personal supervision of a physician (MD/DO) or non-physician practitioner. Direct supervision means that the physician or non-physician practitioner must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing the service.

- **Community mental health center (CMHC)** - The CMHC must meet applicable certification or licensure requirements of the state in which they operate, and additionally be certified by Medicare. A CMHC is a Medicare provider of services only with respect to the furnishing of partial hospitalization services under Section 1866(e)(2) of the Social Security Act. Health Care Finance Administration definition of a CMHC is based on Section 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.

The program must be prepared to appropriately treat the co-morbid substance abuse disorder when it exists (dual diagnosis patients). Dual diagnosed individuals suffer from concomitant mental illness and chemical dependency. Sobriety, as an initial clinical goal, is essential for further differential diagnosis and clinical decisions about appropriate treatment. It is not generally expected that a patient who is actively using a chemical substance be admitted to or engaged in a partial hospitalization program, as a patient under the influence of a chemical substance would not be capable of actively participating in his/her psychiatric treatment program. A physician must provide supervision and evaluation of the patient’s treatment and the extent to which the therapeutic goals are being met.

**B. Patient Eligibility Criteria**

**Benefit Category**

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization and require minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, PHP patients must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program.

Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patients psychiatric condition requiring active treatment in a PHP.

Prior to receiving partial hospitalization services, it would be expected that patients have failed attempts at outpatient psychotherapy. Clear, concise documentation of these attempts including date of last appointment, type of treatment provided or attempted shall be a part of the initial assessment.

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Discharge planning from PHP may 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 patient’s return to a higher level of functioning in the least restrictive environment.

Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements §1835(a)(2)(F) unless he/she also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the patient to receive the services identified in §1861(ff).

Reasonable and Necessary Services

This program of services provides for the diagnosis and active, intensive treatment of the individual’s serious psychiatric condition and, in combination, are reasonably expected to improve or maintain the individual’s condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual’s condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the PHP and must not be an imminent danger to themselves or others. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5, of the most current edition of the International Classification of Diseases (ICD), which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient’s presenting psychiatric condition.

For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition, professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.

The patient must require comprehensive, multimodal treatment requiring medical supervision and coordination because of a mental disorder, which severely interferes with multiple areas of daily life including social, vocational, and/or educational functioning. Such dysfunction must be an acute illness or exacerbation of a chronic illness (acute in nature).

Patients with a diagnosis of psychosis must be aggressively treated with psycho-pharmacological agents to reduce symptoms that may impede benefit from the services provided by a PHP program. Partial stabilization allowing the patient to participate with insight-oriented therapy should be clearly documented. For example, a patient may interact in a one to one session rather than in a group therapy setting initially. It would be expected patient progression would be toward the group settings.

Patients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient’s clinical condition improves or stabilizes and he/she no longer requires structured, intensive, multimodal treatment.

Reasons for Denial

a.) Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the limitation on liability provision does not apply (HCFA Ruling 97-1). Examples of benefit category based in §1861(ff) or §1835(a)(2)(F) of the Act, for partial hospitalization services generally include the following:
Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;

Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or

Patients who are otherwise psychiatrically stable or require medication management only.

b.) Coverage denials made under §1861(ff) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Social Security Act:

- Services to hospital inpatients;
- Meals, self-administered medications, transportation; and
- Vocational training.

c.) Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply. The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:

- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or
- Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.

The following discussion illustrates the application of the above guidelines to the more common modalities and procedures used in the treatment of psychiatric patients and some factors that are considered in determining whether the coverage criteria are met.

Covered Services

Services generally covered for the treatment of psychiatric patients are:

- Individual and group therapy with physicians, psychologists, or other mental health professionals authorized by the State.
- Occupational therapy services are covered if they require the skills of a qualified occupational therapist and be performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.
- Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be selfadministered.
• Activity therapies but only those that are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient’s treatment.

• Family counseling services. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient’s condition.

• Patient education programs, but only where the educational activities are closely related to the care and treatment of the patient.

• Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan.

Noncovered Services

The following are generally not covered except as indicated:

• Meals and transportation.

• Activity therapies, group activities or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

• "Geriatric day care" programs are available in both medical and nonmedical settings. They provide social and recreational activities to older individuals who need some supervision during the day while other family members are away from home. Such programs are not covered since they are not considered reasonable and necessary for a diagnosed psychiatric disorder, nor do such programs routinely have physician involvement.

• Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they are covered. However, if an individual’s outpatient hospital program consists entirely of psychosocial activities, it is not covered.

• Vocational training. 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.

CPT code 90849 (Multiple family group psychotherapy) would not be considered treatment directly related to the patient’s care and therefore would not be considered medically necessary.

Frequency and Duration of Services

There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria to determine whether with continued treatment there is a reasonable expectation of improvement.

When participation in the therapeutic program produces no further functional improvement or movement towards the initial or revised goals documented in the treatment plan, the patient is deemed to have reached maximal improvement at which point further participation in the program is no longer subject to coverage.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

013x Hospital Outpatient
076x Clinic - Community Mental Health Center
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0250 Pharmacy - General Classification
043X Occupational Therapy - General Classification
0900 Behavioral Health Treatment/Services - General Classification
0904 Behavioral Health Treatment/Services - Activity Therapy
0914 Behavioral Health Treatment/Services - Individual Therapy
0915 Behavioral Health Treatment/Services - Group Therapy
0916 Behavioral Health Treatment/Services - Family Therapy
0918 Behavioral Health Treatment/Services - Testing
0942 Other Therapeutic Services - Education/Training

CPT/HCPCS Codes

Group 1 Paragraph: There are no specific CPT or HCPCS codes for partial hospitalization “programs”. However, outpatient hospitals are required to report the following appropriate CPT/HCPCS codes for the individual or specific partial hospitalization services provided. Effective for dates of services on or after June 5, 2000 Community Mental Health Centers will also be required to utilize the same HCPCS codes for reporting partial hospitalization services.

There are CPT/HCPCS codes on this list that may not be reimbursable due to existing National or Local Coverage Determinations. Please refer to the applicable Medicare manuals and Local Coverage Determinations for coverage criteria information regarding each service.

Group 1 Codes:

90785 INTERACTIVE COMPLEXITY (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90791 PSYCHIATRIC DIAGNOSTIC EVALUATION
90792 PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES
90832 PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90833 EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90834 PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90835 PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90836 EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90837 PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90838 EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)
90846 FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)  
90847 FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)  
90875 MODALITY (FACE-TO-FACE WITH THE PATIENT), WITH PSYCHOTHERAPY (EG, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORTIVE PSYCHOTHERAPY); 30 MINUTES  
90876 MODALITY (FACE-TO-FACE WITH THE PATIENT), WITH PSYCHOTHERAPY (EG, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORTIVE PSYCHOTHERAPY); 45 MINUTES  
96101 PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY, INTELLECTUAL ABILITIES, PERSONALITY AND PSYCHOPATHOLOGY, EG, MMPI, RORSCHACH, WAIS), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, LANGUAGE, MEMORY, PLANNING AND PROBLEM SOLVING, AND VISUAL SPATIAL ABILITIES), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY, WECHSLER MEMORY SCALES AND WISCONSIN CARD SORTING TEST), PER HOUR OF THE PSYCHOLOGIST'S OR PHYSICIAN'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PREPARING THE REPORT DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING (INCLUDES COMPENSATORY TRAINING), DIRECT (ONE-ON-ONE) PATIENT CONTACT, EACH 15 MINUTES SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT, EACH 15 MINUTES  
96116 OCCUPATIONAL THERAPY SERVICES REQUIRING THE SKILLS OF A QUALIFIED OCCUPATIONAL THERAPIST, FURNISHED AS A COMPONENT OF A PARTIAL HOSPITALIZATION TREATMENT PROGRAM, PER SESSION (45 MINUTES OR MORE)  
96118 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)  
97532 TRAINING AND EDUCATIONAL SERVICES RELATED TO THE CARE AND TREATMENT OF PATIENT'S DISABLING MENTAL HEALTH PROBLEMS PER SESSION (45 MINUTES OR MORE)  
97533 INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES  

ICD-10 Codes that Support Medical Necessity  

Group 1 Paragraph: N/A  

Group 1 Codes:  

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<td>Vascular dementia without behavioral disturbance - Unspecified mental disorder due to known physiological condition</td>
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<td>F10.10 - F19.99</td>
<td>Alcohol abuse, uncomplicated - Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder</td>
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<td>F20.0 - F29</td>
<td>Paranoid schizophrenia - Unspecified psychosis not due to a substance or known physiological condition</td>
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<td>F30.10 - F39</td>
<td>Manic episode without psychotic symptoms, unspecified - Unspecified mood [affective] disorder</td>
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<td>F40.00 - F48.9</td>
<td>Agoraphobia, unspecified - Nonpsychotic mental disorder, unspecified</td>
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<td>F50.00 - F50.9</td>
<td>Anorexia nervosa, unspecified - Eating disorder, unspecified</td>
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<td>F51.01</td>
<td>Primary insomnia</td>
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<td>F51.3</td>
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<td>F51.8</td>
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<td>Hypoactive sexual desire disorder - Unspecified sexual dysfunction not due to a substance or known physiological condition</td>
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<td>F53</td>
<td>Puerperal psychosis</td>
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<td>F54</td>
<td>Psychological and behavioral factors associated with disorders or diseases classified elsewhere</td>
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<td>F55.0 - F55.8</td>
<td>Abuse of antacids - Abuse of other non-psychoactive substances</td>
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<td>F56.0 - F56.9</td>
<td>Paranoid personality disorder - Unspecified disorder of adult personality and behavior</td>
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<td>Phonological disorder - Developmental disorder of speech and language, unspecified</td>
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ICD-10 Codes that DO NOT Support Medical Necessity N/A
ICD-10 Additional Information

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General Information

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Associated Information

**Documentation Requirements**

Physical examination upon admission (if not done within the past 30 days and/or not available from another provider) must be included in the medical record.

Medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the psychotherapy session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the psychotherapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patients’ problems.
- Interaction of the patient on the unit with staff members as well as other participants when applicable.
- Clear, concise documentation of individual and group therapy sessions, updates regarding diagnoses as evidenced by changes in signs and symptoms and interactions within the facility.

**Psychotherapy notes** are defined in 45 CFR §164.501 as “notes recorded by a mental health professional which document or analyze the contents of a counseling session and that are separated from the rest of a medical record.” The definition of psychotherapy notes expressly excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date etc., and this class of information does not qualify as psychotherapy note material. Physically integrating information excluded from the definition of psychotherapy notes and protected information into one document or record does not transform the non-protected information into protected psychotherapy notes.

Under no circumstances shall a contractor request a provider to submit notes defined in 45 CFR §164.501. The refusal of a provider to submit such information shall not result in the denial of a claim.

If the medical record includes any of the information excluded from the definition of psychotherapy notes in §164.501, as stated above, the provider is responsible for extracting the information required to support that the claim is reasonable and necessary. Contractors must review the claim using all supporting documentation submitted by the provider. If the provider does not submit sufficient information to demonstrate that services were medically necessary, the claim will be denied.

When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an additional documentation request (ADR). Contractors must request records related to the claim(s) being reviewed.

**Documentation Requirements and Physician Supervision**

The following components will be used to help determine whether the services provided were accurate and appropriate.

a.) Initial Psychiatric Evaluation/Certification. Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided. The certification should identify the diagnosis and psychiatric need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms and to prevent relapse or hospitalization.

b.) Physician Recertification Requirements.

- Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient’s response to treatment.
• Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

• Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:

  o The patient’s response to the therapeutic interventions provided by the PHP;
  o The patient’s psychiatric symptoms that continue to place the patient at risk of hospitalization; and
  o Treatment goals for coordination of services to facilitate discharge from the PHP.

c.) Treatment Plan. Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient’s response to treatment.

Treatment goals should be designed to measure the patient’s response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program, or reflect the continued need for the intensity of the active therapy to maintain the individual’s condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the patient at risk, do not qualify as partial hospitalization services.

An individualized formal treatment plan must be signed and dated by a physician and established within 7 days of admission to the program, and must include the following:

• Formulation of the patient’s status, including an assessment of the reasonable expectation that the patient will make timely and significant practical improvement in the presenting acute symptoms, as a result of the active treatment provided by the partial hospitalization program; and
• ICD-10/DSM-IV diagnoses, including all five axes of the multiaxial assessment as described in DSM-IV, to assist in establishing the patient’s baseline functioning and,
• Documentation listing treatment goals under the individualized plan, modalities of therapy and/or services rendered including amount, frequency and planned duration.

The frequency of treatment plan updates is always contingent upon an individual patient’s needs. The treatment planning updates must be based on the physician’s periodic consultation with therapists and staff, review of medical records, and patient interviews.

A treatment plan review or ‘team’ conference should take place a minimum of every 2 weeks to review and update treatment plan, medication changes, and patient’s response to treatment modalities.

d.) Progress Notes. Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient’s response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

The progress note must be written by the team member rendering the service, including the credentials of the rendering provider and must include the following:

• The type of service rendered (name of the specific psychotherapy group, educational group, etc. if applicable);
• The problem/functional deficit to be addressed during the session, and how it relates to the patient’s current condition, diagnosis, and problem/deficit identified in the treatment plan;
• The content of the therapeutic session, as well as a clear description of the intervention used to assist the patient in reaching the related treatment goal;
• The patient’s status (behavior, verbalizations, mental status) during the session; and
• The patient’s response to the therapeutic intervention including benefit from the session and how it relates to progress made toward the short/long term goal in measurable and functional terms. Functional improvement is considered to be the patient’s increasing ability to function outside of the direction or support of a therapist and or therapeutic environment. Measures of functional improvement may include, but are not limited to, patient appearance, patient participation in therapy, or the patient’s performance of activities of daily living. See the Medicare Claims Processing Manual, Chapter 4, “Hospital Outpatient Services,” §100, for billing instructions for partial hospitalization services. Eligibility Criteria and Documentation Requirements can be found in the Coverage Determinations Manual.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. Patient progress may be small or not be measurable at each session, however a trend should be measurable presenting signs of progression or regression in changes relating to behavior, thought processes or medication management. When services are performed in excess of established parameters, they may be subject to review for medical necessity. Code 90821-Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient; should only be used in exceptional instances. Additional documentation must be maintained in the patient’s record to show medical necessity for this length of therapy in the acute setting. Code 90849 (multiple family psychotherapy) is generally non-covered. Such group therapy is directed to the effect of the patient’s condition on the family and does not meet standards of being part of the personal service to the patient.

Other Comments

Psychotherapy is the treatment of mental illness and behavior disturbances, in which definitive therapeutic communication attempts to alleviate the emotional disturbances, reverse or change the maladaptive patterns of behavior and encourage personality growth and behavior.

Sources of Information and Basis for Decision
FCSO reference LCD number – L28975

Revision History Information

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Reason(s) for Change

• Revisions Due To ICD-10-CM Code Changes

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### Associated Documents

**Attachments** [Coding guidelines 2015](#) (PDF - 103 KB)

**Related Local Coverage Documents** N/A

**Related National Coverage Documents** N/A

**Public Version(s) Updated on 10/13/2016 with effective dates 10/01/2015 - N/A Updated on 02/09/2016 with effective dates 10/01/2015 - N/A Updated on 07/01/2014 with effective dates 10/01/2015 - N/A Updated on 04/01/2014 with effective dates 10/01/2015 - N/A**

### Keywords

N/A Read the [LCD Disclaimer](#)