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# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

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

Transmittal 180

Date: MAY 14, 2004

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### CHANGE REQUEST 3297

- I. SUMMARY OF CHANGES:** We are moving Chapter 4 of the Medicare Claims Processing Manual, Section 260.7, “Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs)” to Section 260.1.1.

In addition, we are moving information from Transmittal #1876, dated February 2003, of the Medicare Intermediary Manual which updated Sections 3661 and 3651, to Chapter 4, Sections 260.1 and 260.1.1 of the Medicare Claims Processing Manual. This information was accidentally left out during the transition from the paper-based manuals to the on-line CMS Manual System.

**MANUALIZATION – EFFECTIVE/IMPLEMENTATION DATE: Not Applicable**

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

**II. CHANGES IN MANUAL INSTRUCTIONS:**

**(R = REVISED, N = NEW, D = DELETED –**

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
<b>R</b>	4/Chapter of Contents
<b>R</b>	4/ 260.1/Hospital Partial Hospitalization Services Billing Requirements
<b>N</b>	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs)
<b>D</b>	4/260.7/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHCs)

**\*III. FUNDING:**

**These instructions should be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Notification</b>

**\*Medicare contractors only**

# Medicare Claims Processing Manual

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

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### Table of Contents

*(Rev. 180, 05-14-04)*

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

## 260.1 –Hospital Outpatient Partial Hospitalization Services Billing Requirements

*(Rev. 180, 05-14-04)*

### 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 and 4600-4799. *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
0904	Activity Therapy
0910	Psychiatric/Psychological Services
0914	Individual Therapy
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
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services	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. 180, 05-14-04)*

**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 and 4600-4799.*

### **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:*

<b>Code</b>	<b>Description</b>
0250	Drugs and Biologicals
043X	Occupational Therapy
0904	Activity Therapy
0910	Psychiatric/Psychological Services
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:*

<b>Revenue Codes</b>	<b>Description</b>	<b>HCPCS Code</b>
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services	90801, 90802, 90899



<i>Revenue Codes</i>	<i>Description</i>	<i>HCPCS Code</i>
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 one hour intervals) for a total of three hours during one day. The CMHC reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and "three" 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:

<b>Record Type</b>	<b>Revenue Code</b>	<b>HCPCS</b>	<b>Dates of Service</b>	<b>Units</b>	<b>Total Charges</b>
61	0915	90849	19980505	1	\$80
61	0915	90849	19980529	2	\$160

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

<b>FL 42</b>	<b>FL 44</b>	<b>FL 45</b>	<b>FL 46</b>	<b>FL 47</b>
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 OPSS 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.*