

PARTIAL HOSPITALIZATION PROGRAM (PHP)

Date of origin: Oct. 7, 2024

Review dates: 10/2024, 12/2024, 2/2025, 5/2025,
5/2026**DEFINITION**

Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. It's more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities aren't considered partial hospitalization.

MEDICAL POLICY

- [Medical Necessity \(#91447\)](#)

[See our Provider Manual](#) for information on partial hospitalization authorizations for mental health services.

POLICY SPECIFIC INFORMATION

There are no specific limits on the length of time that services may be covered, however:

- Authorization is required. Members/participants/beneficiaries must meet InterQual® Behavioral Health medical necessity criteria for partial hospitalization.
- You must request authorization prior to sending a member to these programs.

The primary diagnosis used should be a mental health/psychiatric diagnosis

Treatment goals should be identified.

Place of service

Below is an example place of service code applicable to these services:

- **POS 52:** Psychiatric Facility Partial Hospitalization

Revenue code

Listed below are example revenue codes applicable to these services:

- **0250:** Drugs and Biologicals
- **043X:** Occupational Therapy
- **0900:** Behavioral Health Treatment/Services
- **0904:** Activity Therapy
- **0910:** Psychiatric/Psychological Services
- **0911:** Rehabilitation
- **0912:** Psychiatric Partial Hospitalization (less intensive)
- **0913:** Psychiatric Partial Hospitalization (intensive)
- **0914:** Individual Therapy
- **0915:** Group Therapy
- **0916:** Family Therapy
- **0918:** Behavioral Health/Testing
- **0942:** Education/Training

Documentation requirements

Documentation must identify and describe the services performed. If appealed, documentation must be submitted with the appeal.

Bill Type

Feature	013X (Hospital Outpatient)	076X (CMHC)
Facility Type	Hospital Outpatient Department	Community Mental Health Center (CMHC)
Setting	Hospital- based PHP	Non-hospital, community-based PHP
Provider Structure	Part of hospital system	Independent mental health organization
Patient Population	Broad (medical + Psych)	Primarily psychiatric
Billing Oversight	Hospital outpatient billing rules	CMHC – specific Medicare requirements
Cost Structure	Typically, higher overhead (hospital setting)	Lower-cost, community-based care
Medicare Recognition	Standard outpatient hospital benefit	Special designation for PHP coverage
Common Use in PHP	Most hospital PHP's bill this	Required for CMHC PHP programs

Condition codes

Hospitals and critical access hospitals (CAHs) report condition code 41 to indicate claim for partial hospitalization services.

Frequency

Rev code 0912: Psychiatric Partial Hospitalization (less intensive) this service is considered per day. Billing more than one unit per day is not appropriate.

Resources

- [Medicare Claims Processing Manual \(CMS\)](#)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and

abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
Oct. 23, 2024	Added revenue codes 0912 and 0913
Dec. 12, 2024	Added revenue code 0911
Feb. 15, 2025	Added "Disclaimer" section
May 13, 2025	Added "Frequency" information, which is already reflected in our system setup
May 11, 2026	Added Bill Type Table