Priority Health	BILLING POLICY No. 045
PARTIAL HOSPITALIZATION PROGRAM (PHP)	
Date of origin: Oct. 7, 2024	**Review dates: 10/24, 12/24, 2/25**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Partial hospitalization is a distinct and organized intensive treatment program for patients who would otherwise require inpatient psychiatric care. It's treatment 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.

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

Resources

- Medicare Claims Processing Manual (CMS)

DISCLAIMER
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 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 standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, 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 for 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 to 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