



IOP, PHP, and Inpatient Treatment Services for Substance Abuse and Psychiatric Care

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PROVIDER/ENTITY IMPACTED

<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input checked="" type="checkbox"/> OTHER
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LINES OF BUSINESS IMPACTED

<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP ¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA ²	<input checked="" type="checkbox"/> FEP ³	<input type="checkbox"/> DENTAL
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¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

PHP (Partial Hospitalization Programs) and IOP (Intensive Outpatient Programs) are levels of mental health and

substance abuse treatment offering structured care with daily therapy, medication management, and skill-building, but PHP is more intensive (like a full day program) for severe symptoms needing stabilization, while IOP offers fewer hours (half-day) for those balancing daily life, both bridging inpatient care and traditional outpatient therapy, with PHP often serving as a step down to IOP as recovery progresses.

Policy

Partial Hospitalization

HCPCS code/s

S0201 - Partial hospitalization services, less than 24 hours per diem

H0035 - Mental health partial hospitalization, treatment, less than 24 hours

Rev Code/s often used – **0912, 0913 (Require CPT/HCPS)**

Condition Code 41

Condition codes provide extra information about the patient, service, or claim status, to help insurers process claims correctly. They give context beyond basic diagnosis and procedure codes.

This program is defined as structured and medically supervised day, evening, and/or night treatment programs. The services include medical and nursing, but at less intensity than that provided in a hospital setting. The patient is not considered a resident on the program. The range of services offered is designed to address a mental health and/or substance-related disorder through an individualized treatment plan.

In addition, PHP patients must be able to participate cognitively and emotionally in the active treatment process and be capable of tolerating the intensity of a program. Should documentation show the patient refused or was unable to participate in the treatment plan, services may be denied.

Documentation Requirements

Initial Psychiatric Evaluation and certification should identify the diagnosis and psychiatric need for the partial hospitalization. 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.

An individualized treatment plan, prescribed and signed by a physician, should,

- identify treatment goals
 - Treatment goals should directly address the presenting symptoms, be measurable, functional, time-framed, medically necessary, and related to the reason for admission
- describes a coordination of services
- be structured to meet the particular needs of the patient
- include a multidisciplinary team approach to patient care
 - A multidisciplinary treatment program occurs five days a week and provides twenty hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan.

Please refer to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf> for program criteria, specifically pages 28-33.

Intensive Outpatient**HCPCS Code/s**

H0015 - Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education

S9480 - Intensive outpatient psychiatric services, per diem

Rev Code/s often used – **0905, 0906 (Require CPT/HCPS)**

Condition Code 92

Condition codes provide extra information about the patient, service, or claim status, to help insurers process claims correctly. They give context beyond basic diagnosis and procedure codes.

A multidisciplinary treatment program must occur three days per week and provides a minimum of nine hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan.

The intent of the standard for nine hours of weekly treatment program (groups, activities, and psychotherapies) is that they are evidence-based and are explicitly focused on the alleviation of the current condition as opposed to providing general recreation activities, watching videos, etc. and other facility offerings that are not tied back directly to the treatment plan.

Family treatment should be provided at an appropriate frequency. If family treatment is not rendered, the facility/provider specifically lists the contraindications to family Therapy.

Documentation Requirements

- Individualized treatment plan including assessment, counseling, crisis intervention, and activity therapies or education
- Safety plan including access for the member and/or family/support system to professional supports outside of program hours
- Evaluation of member on each program day by a licensed behavioral health practitioner
- Documentation of at least one individual counseling session weekly or more as clinically indicated

Residential Treatments**HCPCS Code**

H0018 - Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem

H0010 - Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)

H0018 - A nonhospital residential treatment program takes place at a 24-hour rehabilitation facility other than a hospital. The patients do not require 24-hour medical or nursing monitoring. The duration of stay for this treatment program is less than 30 days. The program provides residential treatment to patients for behavioral health issues, such as drug or alcohol use disorders. This code covers rehabilitation care and treatment, but it does not include room and board. Report this code once per day. The stay is short term, typically less than 30 day

H0010 - Report this code for detoxification services for alcohol and drugs in which a licensed provider monitors, observes, and provides a residential inpatient addiction program to the patient under medical supervision for subacute withdrawal symptoms of alcohol or drug abuse

Detoxification refers to quitting addictive substances and removing the substance from the body. Subacute detoxification is a type of drug and alcohol abuse treatment that aims to provide detoxification care to medically stable individuals. Such individuals may only need medication and monitoring for a successful detoxification program. For the individuals who require drug and alcohol treatment, residential inpatient treatment programs provide long term recovery support to the patient under medical management. Trained staff are available to the patient 24 hours per day. The program keeps the patient busy in a healthful environment, aiming to help the patient stop abusing drugs or alcohol. Following an inpatient program, the patient may transition to a separately reportable outpatient program, as it may help the patient to move smoothly back to a home and work environment.

CMS Provider Reimbursement Manual³ shows that in inpatient residential additional programs, routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

H0010 is often billed with,

- Rev code 0126 (Room & Board - Semi-Private Two Bed – Detoxification)
- Rev code 1002 Residential Treatment

Residential treatment is a non-hospital 24-hour level of care typically licensed at a residential intermediate level or an intermediate care facility (ICF). This level of care offers an organized set of services, including diagnostic, medical management and monitoring, and therapeutic services, as well as daily living skill development; require on-site nursing services; provide an individually planned regimen of care.

Residential care also includes training in the basic skills of living as determined necessary for each patient. Residential treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care.

Residential Treatment Center (RTC)

Services provided by medical professionals employed by or contracted with the RTC are part of the all-inclusive per-dem rate and cannot be billed separately. These routine services are made available to all patients entering the facility.

Examples of routine services include room and board, CLIA waived tests, all therapies and services of social workers, licensed addiction counselors, psychiatric nurses, occupational therapists, dietitians, etc. Services by a psychologist, psychiatrist, psychiatrist nurse practitioner, and psychiatrist physician assistant inherent to the treatment program, such as group therapy, should not be billed separately on the CMS-1500 Claim Form.

Psychiatrists, psychologists, psychiatrist nurse practitioners, and psychiatrist physician assistants may bill separately on the CMS-1500 Claim Form for services outside of the treatment program such as psychological testing, individual therapy, and E/M services. Appropriate licensed health care providers can also bill separately

for psychiatric diagnostic evaluations without medical services. Group or family counseling cannot be billed in addition to the RTC stay.

If the patient has a leave of absence (LOA) during the residential treatment stay, the LOA day(s) must be identified with Revenue Code 018X, and units equal to the number of LOA days.

Examples

- If the patient leaves the facility on Saturday afternoon and returns on Sunday afternoon, there is no LOA as the patient received services on both days.
- If the patient leaves the facility on Saturday afternoon and returns on Monday afternoon, one (1) LOA day should be billed.

When a patient requires an inpatient level of care at another medical center an LOA cannot be used. In this scenario, the date the patient left the facility would be the through date on the claim and the appropriate discharge status code must be reported. If the patient returns to an inpatient level of care, a new inpatient claim for the readmission would be submitted.

Documentation Requirements

Documentation must include,

- master treatment plan specific to the patient
- the attendance, time patient was present, and participation of the patient for each date billed
- medication monitoring/administration for detox services by licensed provider
- intake assessment including medical/nursing note and comprehensive examination
- individual/group notes including the date, start/stop time, rendering licensed provider name/credentials, client participation, and a detailed description of the group
- progress notes

Any interventions noted in group or individual sessions must tie back to the patient's diagnosis.

Group Therapy

CPT Code/s

90853- Psychotherapy, Other Than Multiple-Family Group

G0410- Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, 45 to 50 minutes as maintained by CMS falls under Psychological Services

Group psychotherapy is psychotherapy administered in the group setting, involving no more than 10-12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients. The group therapy session typically lasts 45 to 60 minutes.

Personal group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group therapy, since it involves psychotherapy, must be led by a person who is licensed or otherwise authorized by the state in which he or she practices performing this service. This means a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service.

Group psychotherapy is not considered necessary when services include music therapy, socialization, recreational activities, recreational therapy, art classes, art therapy, excursions, sensory stimulation, cognitive stimulation, or motion therapy.

Please refer to this hyperlink for specific guidance on how to properly bill group therapy as well as adding a modifier/s to this HCPCS code. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57480>

Individual Therapy

90832-90838: (Psychotherapy) Not separately payable when a component of Residential Treatment. Time must be documented to support the appropriate level of therapy provided. Documentation must show the intervention applied and the patient's response to the intervention. The intervention must be supported by the patient's treatment plan.

Initial Evaluation:

CPT Code/s

90791 - Psychiatric diagnostic evaluation

90792 - Psychiatric diagnostic evaluation with medical services

Documentation Requirements

- Elicitation of a complete medical and psychiatric history (including past, family, social)
- Mental status examination
- Establishment of an initial diagnosis
- Evaluation of the patient's ability and capacity to respond to treatment'
- Initial treatment plan

Initial evaluation is covered once at the outset of an illness or suspected illness and is **not** to be on the same day as an E/M service performed by the same individual for the same patient. See CMS LCD L33632, Psychiatry and Psychology Services, for exceptions.

<https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33632&ContrId=275>

Case Management

CPT Code

99484 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with required elements

Documentation Requirements

- initial assessment or follow-up monitoring, including the use of applicable validated rating scales

- behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation
- continuity of care with a designated member of the care team

Coding

Codes	Description
N/A	N/A

References and Resources

Blue KC Provide Reference Guide
Centers for Medicare and Medicaid Services

Related Documents

POL-PP-242 Modifier AS, Assistant Surgeon

Revision History

Version	Date	Summary of Revisions
001	2/1/2023	Initial Version
002	4/6/2023	Update -Removed incorrect rev code 0914 and replaced with correct code 0913 for partial hospitalization
003	3/1/2024	Annual review, no updates, or changes were made to the policy
004	2/1/2025	Annual review, no updates, or changes were made to the policy
005	2/1/2026	Annual review, updated policy to say condition code 40 is required when billing partial hospitalization programs and condition code 92 when billing for Intensive Outpatient programs