

Psychiatric Partial Hospitalization Programs

L34196

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
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LCD Information

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Issue

Issue Description

This LCD outlines limited coverage for this service with specific details under Coverage Indications, Limitations and/or Medical Necessity.

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (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 Section 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 (SSA):

Section 1862(a)(1)(A) of Title XVIII of the Social Security Act excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Sections 1861 (ff) and 1832 (a) of Title XVIII of the Social Security Act define the partial hospitalization benefit and provide for coverage of partial hospitalization in a hospital or CMHC setting. Section 1861 (ff) also provides coverage of partial hospitalization in a Critical Access Hospital (CAH) outpatient setting.

Section 1861 (s)(2)(B) of Title XVIII of the Social Security Act references partial hospitalization in a hospital outpatient setting.

Section 1835(a) of Title XVIII of the Social Security Act references physician certification.

Section 1833(e) of Title XVIII of the Social Security Act requires services to be documented in order for payment to be made.

Code of Federal Regulations:

42 CFR Section 410.43 describes conditions and exclusions from partial hospitalization services.

42 CFR Section 424.24 lists requirements for certification of partial hospitalization services.

Federal Register:

Federal Register, Vol. 59, No. 29, February 11, 1994, pages. 6570-6579 is the Partial Hospitalization Services in Community Mental Health Centers Interim Final Rule.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 2:

30.2.2 Active Treatment in Psychiatric Hospitals

30.2.2.1 Principles for Evaluating a Period of Active Treatment

30.2.3 Services Supervised and Evaluated by a Physician

30.3.1 Individualized Treatment or Diagnostic Plan

30.3.2 Services Expected to Improve the Condition or for Purpose of Diagnosis

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6:

70 Outpatient Hospital Psychiatric Services

70.3 Partial Hospitalization Services

CMS Publication 100-03, *Medicare National Coverage Determinations Manual (MNCDM)*, Chapter 1:

70.1 Consultations With a Beneficiary's Family and Associates

160.25 Multiple Electroconvulsive Therapy (MECT) (Transmittal 10, April 6, 2004)

170.1 Institutional and Home Care Patient Education Programs

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4:

260 Outpatient Partial Hospitalization Services

260.1 Hospital Outpatient Partial Hospitalization Services Billing Requirements

260.1.1 Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

260.2 Professional Services Related to Partial Hospitalization

260.3 Outpatient Mental Health Treatment Limitations for Partial Hospitalization Services

260.4 Reporting Service Units for Partial Hospitalization

260.5 Line Item Date of Service Reporting for Partial Hospitalization

260.6 Payment for Partial Hospitalization Services

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12:

150 Clinical Social Worker (CSW) Services

160 Independent Psychologist Services

160.1 Payment [for testing services performed by psychologists other than clinical psychologists]

CMS Publication 100-02, *Medicare Benefit Policy Manual* and CMS Publication 100-04, *Medicare Claims Processing Manual*, Change Request #6320, January 1, 2009, January 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS).

CMS Publication 100-20, *One-Time Notification Manual*, Transmittal No. 98, Change Request #3343, July 23, 2004, revises Change Request #3194 by changing the effective date for the discontinuation of revenue code 0910 to dates of service on or after October 16, 2003.

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1, Transmittal No. 167, Change Request #3194, April 30, 2004, provides instructions for discontinued use of revenue code 0910 effective 10/01/2004.

CMS [then HCFA] Ruling 97-1, February 1, 1997, defines Medicare policy for limitation of liability for PHP services for which Medicare payment is denied.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Psychiatric partial hospitalization is a distinct and organized intensive psychiatric outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Partial hospitalization services are furnished by a hospital or community mental health center (CMHC) to patients with acute mental illness in order to avoid inpatient care through this type of ambulatory care. The Medicare psychiatric partial hospitalization benefit was established and is intended to furnish services in lieu of inpatient psychiatric care. Partial Hospitalization requires admission and certification of need by a psychiatrist or physician (MD/DO) trained in the diagnosis and treatment of psychiatric illness. Partial hospitalization programs (PHPs) differ from inpatient hospitalization in the lack of 24-hour observation, and outpatient management in day programs in 1) the intensity of the treatment programs and frequency of participation by the patient and 2) the comprehensive structured program of services provided that are specified in an individualized treatment plan, formulated by a physician and the multidisciplinary team, with the patient's involvement.

Indications:

Patients admitted to a partial hospitalization program must be under the care of a physician who is knowledgeable about the patient and certifies the need for partial hospitalization. The patient or legal guardian must provide written informed consent for partial hospitalization treatment. 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 of an acute nature and not a chronic circumstance.

Patients eligible for Medicare coverage of a partial hospitalization program comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the partial hospitalization program is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would require inpatient hospitalization. There must be a reasonable expectation of improvement in the patient's disorder and level of functioning as a result of the active treatment provided by the partial hospitalization program. Active treatment directly addresses the presenting problems requiring admission to the partial hospitalization program. Active treatment consists of clinically recognized therapeutic interventions including individual, group, and family psychotherapies, occupational, activity, and psycho-educational groups pertinent to the patient's illness. Medical and psychiatric diagnostic evaluation and medication management are also integral to active treatment. The patient must have the capacity for active participation in all phases of the multidisciplinary and multimodal program. If a substance abuse disorder is also present, the program must be prepared to appropriately treat the co-morbid substance abuse disorder (dual diagnosis patients). A program comprised primarily

of activity, social, or recreational therapy does not constitute a partial hospitalization program. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare.

Admission Criteria (Intensity of Service)

In general, patients should be treated in the least intensive and restrictive setting which meets the needs of their illness. Patients admitted to a partial hospitalization program do not require the 24-hour-per-day level of care provided in an inpatient setting, and must have an adequate support system to sustain/maintain themselves outside the partial hospitalization program and must not be a danger to themselves or others.

At the same time, a partial hospitalization program level of care must be necessary to prevent inpatient hospitalization, and there must be evidence of failure at or inability to benefit from a less intensive outpatient program.

The acute psychiatric condition being treated by a partial hospitalization program must require active treatment, including a combination of services such as intensive nursing and medical intervention, psychotherapy, occupational and activity therapy. Patients must require partial hospitalization program services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses.

Admission Criteria (Severity of Illness):

Patients admitted to a partial hospitalization program generally must have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR™)* published by the American Psychiatric Association (2000) (see the "ICD-10-CM Codes That Support Medical Necessity" section) which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary structured program, but not so severe that patients are incapable of participating in and benefiting from an active treatment program, and able to be maintained outside the program. For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary, 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.

Patients admitted for treatment to a partial hospitalization program will not be in immediate/imminent danger to self, others, or property, but there may be a recent history of self-mutilation, serious risk taking, or other self-endangering behavior.

Discharge Criteria (Intensity of Service):

Patients in partial hospitalization programs may be discharged by either stepping up to an

inpatient level of care, or stepping down to a less intensive level of outpatient care. Inpatient admission would be required for patients needing 24-hour supervision because of probability for self-harm, harm to others, or inability to care for self outside the hospital. Stepping down to a less intensive level of service than partial hospitalization would be considered when patients no longer require a multidisciplinary and multimodal program as described above. These patients would become outpatients and individual mental health services could then be billed by appropriate providers. Although partial hospitalization programs may have program availability of 20 hours or more per week, and patients upon entering a partial hospitalization program generally would require this higher level of participation, three hours per day at four days per week would be the minimum level of active treatment at which it would be reasonable and necessary for a patient to participate in a partial hospitalization program *must require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care.** Although there may be occasions of unavoidable absences to a day of PHP participation, patient participation in the program four days per week, with a total of 20 hours per week of program services as specified in the plan of care, is the minimum level of active treatment at which it would be reasonable and necessary for a patient to participate in a partial hospitalization program. Absences from the partial hospitalization program and their cause must be documented in the medical record.

*CR 6320

Discharge Criteria (Severity of Illness):

Patients whose clinical condition improves or stabilizes and who cannot benefit from or do not still require the intensive, multimodal treatment available in a partial hospitalization program should be stepped down to outpatient care. Patients unwilling or unable to participate in a partial hospitalization program would also be appropriate for discharge.

Covered Services:

- Medically necessary diagnostic services related to mental illness.
- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the state in which they practice (e.g. licensed clinical social worker, certified alcohol and drug counselor). Group therapy size should be limited to ten or fewer individuals participating.
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual. While occupational therapy may include prevocational and vocational assessment and training, when the services are related primarily to specific employment opportunities, work skills, or work settings, they are not covered.

- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients. Individual, family and group psychotherapy must be performed by individuals authorized or licensed by the state in which they practice to provide these services. With the exception of hospitals receiving payments under Graduate Medical Education (GME) program, Medicare does not pay for the professional services of individuals who are in training and have not yet obtained licensure.
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to the limitations specified in 42 CFR 410.29). For example, oral medications that can be self-administered are not covered. Note: medication must be safe and effective, and approved by the Food and Drug Administration. It cannot be experimental or administered under an investigational protocol.
- Individualized activity therapies that are individualized to the patient's goals and not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. The physician's treatment plan must clearly justify the need for each particular activity therapy modality utilized, and define its role in the treatment of the patient's illness and functional deficits. Providers should not bill activity therapies as individual or group psychotherapy services.
- Family counseling services for which the primary purpose is the treatment of the patient's condition. Such services include the need to observe the patient's interaction with the family for diagnostic purposes, or to assess the capability of and assist the family members in aiding in the management of the patient. Counseling the family to aid in the management of the patient may include attempts to modify the behavior of the family members. This may be covered if such services are related to the treatment of the patient's condition (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 70.1).
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of their diagnosed psychiatric condition (CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 170.1).

Limitations:

The following services do not represent reasonable and necessary partial hospitalization services and coverage is excluded under Section 1862 (a)(1)(A) of the Social Security Act:

- day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- programs attempting to maintain psychiatric wellness, e.g. day care programs for the chronically mentally ill;

- treatment of chronic conditions without acute exacerbation;
- services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
- vocational training.

The following services are excluded from the scope of partial hospitalization services defined in Section 1861(ff) of the Social Security Act:

- services to hospital inpatients;
- meals, self-administered medications, transportation;
- professional physician services, physician assistant services, and clinical psychologist services.

It is not reasonable and necessary to provide partial hospitalization services to the following types of patients and coverage is excluded under Section 1862(a)(1)(A) of the Social Security Act:

- patients who cannot or refuse to participate (due to their behavioral, cognitive, or emotional status, e.g. individuals with persistent substance abuse, moderate to severe mental retardation or organic brain syndrome) with active treatment of their mental disorder, or who cannot tolerate the intensity of a partial hospitalization program;
- patients who require 24-hour supervision because of the severity of their mental disorder or their safety or security risk;
- patients who require primarily social, custodial, recreational, or respite care;
- patients with multiple absences or who are persistently non-compliant;
- patients whose plan of care does not support the need for active treatment a total of 20 hours per week of program services;
- patients who have met the criteria for discharge from the partial hospitalization program, or who require inpatient hospitalization.

General Comments:

Sites of Service:

Partial hospitalization services may be covered under Medicare when they are provided in a hospital outpatient department or a Medicare-certified Community Mental Health Center (CMHC). 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 partial hospitalization program offsite, the services must be rendered under the direct supervision of a physician (MD/DO). Partial hospitalization services provided in a CMHC require general supervision by a physician (MD/DO). This

means that a physician must be at least available by telephone but is not required to be on the premises of the CMHC at all times. CMHCs 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 Sec. 1866(e)(2) of the Act. CMS's definition of a CMHC is based on Sec. 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.

Professional Services Related to Psychiatric Partial Hospitalization:

Note: The following billing requirements also apply to CMHC providers. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1 [B].) *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 PA's 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 [their FI] for such nonphysician practitioner services as partial hospitalization services. [P]ayment for the services [is made] 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 is responsible for billing the carrier on Form CMS 1500 for the services of the PA (CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1[B]). (See Appendix for a list of the professional services of physicians, physician assistants, nurse practitioners, psychiatric*

clinical nurse specialists and clinical psychologists to partial hospitalization patients that are billed to the carrier.)

See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 260.1.1[C] for billing requirements for CMHCs.

Per 42 CFR 424.24 The 20 hour per week requirement is a patient eligibility requirement for the PHP benefit, and not a weekly hours billing requirement.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. CGS Administrators, LLC is not responsible for the continuing viability of Web site addresses listed below.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 2000.

Block BM, Lefkovitz PM. *Standards and Guidelines for Partial Hospitalization*. Alexandria, VA: American Association for Partial Hospitalization, Inc; [no date].

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treatment of substance abuse disorders. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center For Substance Abuse Treatment. Rockville, MD. [no date]

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Wagner BD, Plotkin D, Lefkovitz PM, Block BM. *Standards and Guidelines for Partial Hospitalization: Geriatric Partial Hospitalization*. Alexandria, VA: American Association for Partial Hospitalization, Inc; 1993.

Washington Peer Review Organization. Admission and discharge review criteria for psychiatric hospitalization. [no date]

Bibliography

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
04/03/2025	R18	Revision Effective: 04/03/2025 Revision Explanation: Annual review, no changes. <i>03/26/2025 At this time 21st Century Cures Act will apply to new and revised</i>	<ul style="list-style-type: none">• Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
01/01/2025	R17	<p>Revision Effective: 01/01/2024 (retro effective)</p> <p>Revision Explanation: Updated the third list under limitations to align with CMS guidelines. Removed "<i>patients who do not participate in active treatment for a minimum of 3 hours per day</i>", 4 days per week; and minimum of 4 days in the sixth bullet.</p> <p><i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Provider Education/Guidance
04/04/2024	R16	<p>R16</p> <p>Revision Effective: 04/04/2024</p> <p>Revision Explanation: Annual Review, no changes were made.</p>	<ul style="list-style-type: none"> • Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>03/29/2024: <i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	
03/02/2023	R15	<p>R15</p> <p>Revision Effective: 03/02/2023</p> <p>Revision Explanation: Annual Review, no changes were made.</p> <p>02/24/2023: <i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
03/03/2022	R14	<p>R14</p> <p>Revision Effective: 03/03/2022</p> <p>Revision Explanation: Annual Review, no changes were made</p> <p><i>02/23/2022: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Other (Annual Review)

03/04/2021

R13

R13

Revision Effective:

02/04/2021

Revision Explanation:

Annual Review, no changes were made

02/24/2021: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment

- Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.

11/07/2019	R12	<p>R12</p> <p>Revision Effective: n/a</p> <p>Revision Explanation: Annual Review, no changes</p> <p><i>02/24/2020:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> Other (Annual Review)
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11/07/2019

R11

R11

Revision Effective:
11/07/2019

Revision Explanation:
Supplemental instruction article is being retired as

- Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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the information in the article is listed in the new billing and coding article A57053. The other comments information has been moved to the billing and coding article and the associated information section was placed in the billing and coding article so this was removed from the policy.

11/07//2019:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.

09/26/2019	R10	R10 Revision Effective: 09/26/2019 Revision Explanation: Converted to new policy template that no longer includes coding section based on CR 10901. Also, retired Psychiatric Partial	<ul style="list-style-type: none"> • Revisions Due To Code Removal
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Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p>Hospitalization Programs A52413-Supplemental Instructions Article.</p> <p><i>09/20/2019:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	

01/01/2019

R9

R9

- Typographical Error

Revision Effective:
10/01/2018

Revision Explanation:
Correcting typo for effective date for revision 8. effective is 10/01/2018 not 10/012019. Codes F53.0, F53.1, and F12.23 added effective 10/01/2018.

3/18/2019:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
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and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy

01/01/2019	R8	<p>R8</p> <p>Revision Effective: 10/01/2019</p> <p>Revision Explanation: During annual ICD-10 update F53 was end date and replaced with F53.0 and F53.1 new code F12.23 was added. These were left off in error from the review.</p> <p><i>3/18/2019:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Revisions Due To CPT/HCPCS Code Changes
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Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
01/01/2019	R7	<p>R7</p> <p>Revision Effective: N/A</p> <p>Revision Explanation: No changes made, annual review.</p> <p><i>2/20/2019:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> Other (Annual Review)
01/01/2019	R6	<p>R6</p> <p>Revision Effective: 01/01/2019</p> <p>Revision Explanation: During annual HCPCS update codes 9610196103 and 96118-96120 were deleted and replaced with codes 96130, 96131, 96136-96139, and 96146.</p> <p><i>12/20/2018:At this time 21st Century Cures Act will</i></p>	<ul style="list-style-type: none"> Revisions Due To CPT/HCPCS Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<p><i>apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	
10/01/2016	R5	<p>R5 Revision Effective: N/A Revision Explanation: Annual review no changes made.</p> <p><i>02/26/2018:At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
10/01/2016	R4	R4 Revision Effective: N/A Revision Explanation: Annual review no changes made.	<ul style="list-style-type: none"> Other (annual review)
10/01/2016	R3	R3 Revision Effective: 10/01/2016 Revision Explanation: During ICD-10 annual update F42 was deleted and replaced F42.2, F42.3, F42.4, F42.8, F42.9.	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes
01/01/2016	R2	R2 Revision Effective: 01/01/2016 Revision Explanation: Removed appendix B as information is outdated.	<ul style="list-style-type: none"> Other (Annual review)
10/01/2015	R1	R1 Revision Effective: 10/01/2015 Revision Explanation: Accepted revenue code description changes.	<ul style="list-style-type: none"> Other (revenue code)

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

[A57053 - Billing and Coding: Psychiatric Partial Hospitalization Programs](#) 

Related National Coverage Documents


NCDs


[70.1 - Consultations with a Beneficiary's Family and Associates](#) 

[170.1 - Institutional and Home Care Patient Education Programs](#) 

[160.25 - Multiple Electroconvulsive Therapy \(MECT\)](#) 

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Keywords

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