510.5 PARTIAL HOSPITALIZATION SERVICES

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BACKGROUND

Partial Hospitalization Programs (PHP) provide a medically directed outpatient treatment program that offers intensive, coordinated, and structured services to adults and/or children within a stable therapeutic milieu. The member continues to reside at home, but commutes to a treatment center up to five days a week. Partial Hospitalization is designed to provide intensive treatment services for members who are able to be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an acute inpatient psychiatric hospitalization stay. Partial Hospitalization Programs can be off-site from the hospital but are considered an outpatient service of the General Acute or Critical Access Hospital. The treatment program must be under the general direction of a psychiatrist employed by or contracted with the Partial Hospitalization Program. The psychiatrist must direct the program and is responsible for ascertaining that the pharmacology and other medical and social needs of West Virginia Medicaid members are met.

POLICY

510.5.1 PROGRAM COVERAGE AND LIMITATIONS

Partial Hospitalization is a general term embracing day, evening, night and weekend treatment programs which provide an integrated, comprehensive, and complementary schedule of recognized treatment approaches. While specific program variables may differ, all Partial Hospitalization Programs pursue the goal of stabilization with the intention of diverting inpatient hospitalization or reducing the length of a hospital stay. Programs are designed to serve individuals with significant impairment resulting from a psychiatric, emotional, behavioral, and/or addictive disorder. They are also intended to have a positive clinical impact on the identified member's support system.

One of the strengths of Partial Hospitalization Programs is the applicability to a diverse array of clinical conditions and member populations. PHP's can be distinguished by their primary function. Ideally, only one function or type of service is provided within the therapeutic milieu.

510.5.2 PROVIDER ELIGIBILITY

Partial Hospitalization Programs may be operated by general acute care or critical access hospitals affiliated with a General Acute Care Hospital with a Medicare certified distinct part substance abuse and/or psychiatric unit, which are accredited by a nationally recognized accrediting organization. (Joint Commission, Healthcare Facilities Accreditation Program (American Osteopathic Association), De Norske Veritas (DNV)).

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In order to participate in the West Virginia Title XIX Medicaid program for reimbursement of covered services provided to West Virginia Medicaid members, providers of Partial Hospitalization Programs must be approved through the Bureau for Medical Services' fiscal agent contract enrollment process **prior** to billing for any service.

Documentation regarding the program description, including, but not limited to, the targeted population to be served, a proposed daily schedule and staff names with their credentials (including per diem staff) must be included with the application. (See Appendix 510.5A for Program Description Form). A description of direct service activities and time allocated providing billable services must also be provided. Any changes in the program content, target population or anything that was not previously reviewed and approved with the original application must be submitted to the fiscal agent at least 30 days prior to planned implementation for review, approval/denial **prior** to implementation. Changes in staff director, psychiatrist(s), psychologists, nursing director, or social worker must be reported within one week to BMS, Attention: Office Director, for Facility Based and Residential Care. Changes may be mailed to:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Attention: Facility Based and Residential Services Office Director
350 Capitol Street, Room 251
Charleston, West Virginia 25301

West Virginia does not enroll out-of-state Partial Hospitalization Programs.

510.5.3 STAFFING REQUIREMENTS

The multi-disciplinary team is central to the philosophy of staffing within a PHP setting. Staff characteristics will vary with the specific nature of the program. The program must be directed by a psychiatrist with appropriate academic credentials, administrative experience, and clinical experience in behavioral health settings. This individual's responsibilities will include fiscal and administrative support and ongoing assessment of the program effectiveness on a quarterly basis. A Physician's Assistant (PA), Advance Practice Registered Nurse (APRN), Licensed Psychologist, or a Licensed Independent Clinical Social Worker (LICSW) properly trained and certified in Behavioral Health can oversee the day-to-day operation of the program as long as the psychiatrist is available for the treatment team meetings and face-to-face assessments with the member. The psychiatrist would still be required to oversee the treatment team meeting and document findings related to treatment of the member in the member record.

A multidisciplinary treatment team is comprised, at a minimum, of the following:

- Board certified/board eligible psychiatrist. For children under age 14, the psychiatrist must be a board certified/board eligible child psychiatrist,
- Registered Nurse (BA level or certified psychiatric nurse),
- Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or (Licensed Independent Clinical Social Worker (LICSW)
- WV Licensed Education specialist in the case of a child/adolescent program,

Partial Hospitalization Programs are staffed by multi-disciplinary teams. Team members are required to have backgrounds from various academic fields, including: medicine, psychology, social work, nursing,

education, chemical dependency, occupational therapy, and recreational therapy. Staff providing service must have the necessary skills, qualifications, training and supervision to provide the services specified in the individual plan of care. Documentation of educational qualifications/certifications must be verified prior to employment and updated as necessary. Annual verification of licensure/certification must be documented in the employee personnel file and readily available for review. Copies of documentation supporting personnel qualification/certification must be present in individual personnel files and readily available for review by all appropriate state entities upon request.

510.5.4 STAFF TO MEMBER RATIO

The program's clinical staff to member ratio is dependent on a number of interrelated factors which include, but are not limited to: function of the program, acuity of illness, target population, type of programming offered, age, developmental factors, goals and objectives of the program itself, number of hours of structured treatment provided each day, average daily program attendance, and average length of stay. The minimum staff to member ratio is no more than 1:12, one full-time equivalent staff member for each twelve adult members, and 1:5, one full-time equivalent staff member to five children/youth services members present with the ability to increase staff to client ratio based on the acuity of the members.

510.5.5 FINGERPRINT-BASED BACKGROUND CHECK REQUIREMENTS, RESTRICTIONS, AND MEDICAID EXCLUSION LIST

All providers of the Partial Hospitalization Program services and their staff, that have direct contact with Medicaid members must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, the agency must conduct an additional federal background check through the West Virginia State Police also upon hire and every 3 years of employment. Providers may do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;

- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in conviction status of an agency staff member providing PHP services, the PHP provider must take appropriate action, including notification to the BMS Program Manager for PHP Services.

It is the responsibility of the employer to check the list of excluded individuals/entities (LEIE) monthly at:

- (LEIE) at: http://exclusions.oig.hhs.gov/;
- (Formerly EPLS) https://www.sam.gov/;

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, on a monthly basis. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

510.5.6 QUALITY ASSURANCE

Partial Hospitalization Programs must have a written plan of quality assurance and outcomes management for Partial Hospitalization Programs which encompasses guidelines set forth by accrediting bodies, such as The Joint Commission, and regulatory agencies of local, state, and federal government. These activities are ongoing processes of the administration and staff of the program. They must address the program's mission as well as the needs of members and significant others. The results of quality assurance and outcomes management must be documented and incorporated into administrative, programmatic, and clinical decision making. Reviews of services must be conducted and documentation of the outcome of the review must be completed at least monthly.

Outcomes management processes must examine the impact of the program on the clinical status of the members served. Ongoing outcome studies must address:

- Level of functioning
- Severity of symptoms
- Satisfaction with services
- Drop-out rate
- Discharge disposition
- Post discharge plan includes follow up appointments prior to discharge to link to community providers
- Readmission rates
- Indices of cost-effectiveness

Other quality assurance measurements must include, but are not limited to clinical peer review, negative incident reporting, and goal attainment of programmatic clinical and administrative quality indicators. It may also incorporate length of stay data and discharge practices, concurrent and retrospective studies examining the distribution of services, as well as the necessity for treatment using agreed upon criteria as an internal program evaluation. All Quality Assurance measures will be monitored and reviewed by the UMC for compliance with documentation requirements for monthly reviews and analysis of outcomes and how this is incorporated into the program to improve program effectiveness and outcomes for individual members.

510.5.7 TARGET POPULATION

Partial Hospitalization Programs possess an inherent capacity to effectively treat a broad range of clinical behavioral health conditions. Programs may serve one or more of the following populations:

1. Individuals at risk for inpatient hospitalization. Without the ongoing, intensive services of this program, the member would require inpatient hospitalization; or
2. Individuals experiencing severe acute psychiatric symptoms or de-compensating clinical conditions that severely impair their capacity to function adequately on a day-to-day basis. The member's characteristic level of functioning is judged to have significantly declined as evidenced by the nature and degree of the presenting symptoms and impairments compared to baseline symptoms and impairments. Such acute states frequently follow a serious crisis situational stressor. A less intensive level of care is judged to be insufficient to provide the medically necessary treatment the individual requires, and there is a reasonable expectation that the member is likely to make timely and practical improvement; or
3. Individuals experiencing psychiatric symptoms or clinical conditions that severely and persistently impair their capacity to function adequately on a day-to-day basis, in spite of efforts to achieve clinical stability, symptoms reduction, and improved functioning in a less intensive level of care. Treatment in a less intensive level of care has been ineffective, a more intensive level of care is medically necessary to reduce severe symptoms and impairments, and the member is determined by a physician to have the capacity to make timely and practical improvement.

510.5.8 ADMISSION CRITERIA

All Partial Hospitalization Programs require initial medical necessity prior authorization review and continued stay authorization review through the Bureau for Medical Services' UMC. Prior authorizations are required for all adults and children under the age of 21 being admitted to a psychiatric and/or substance abuse Partial Hospitalization Program.

The Bureau for Medical Services uses the UMC to certify member medical necessity for admission and continued stays through the prior authorization process in all Partial Hospitalization Programs. The Bureau for Medical Services is not financially responsible for reimbursement for services provided to a member who is not prior authorized for admission or for continued stays treatment in the program by this UMC.

Members admitted to the PHP must be under the care of a psychiatrist who certifies the need for admission to the PHP. The West Virginia Medicaid member must require comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning.

All of the four following major criteria must be met in order for a member to be eligible for admission to a PHP:

1. Recent acute psychiatric symptoms including danger to self or others with current stability established although in jeopardy due to **1 or more** of the following:
   - Insufficient behavioral care provider availability,
   - Inadequate member support system,
   - Member characteristics such as high impulsivity or unreliability.
2. Psychiatric symptoms have resulted in impairment of psychosocial functioning and/or developmental progression from the individual's baseline due to a current DSM psychiatric disorder in one or more of the following:
   - education
   - vocation
   - family
   - social/peer relations
   - self-care deficits
   - personal safety
3. Risk status is appropriate for a partial hospital program as indicated by **ALL** the following:
   - Member is willing to participate in treatment voluntarily.
   - Clinical condition does not require 24 hour care.
   - No current attempt at self-harm or harm to others or has had sufficient relief from previous ideations or attempts.
   - Sufficient support network available for monitoring of member's condition.
   - Member is agreeable to contacting provider or support system if symptoms increase
4. The individual has failed to make sufficient clinical gains within an outpatient setting or has not attempted such outpatient treatment and the severity of presenting symptoms is such that prognosis of intensive outpatient treatment is poor.

510.5.9 ASSESSMENT

Upon admission to the Partial Hospitalization Program a certification by the psychiatrist is required in order for the member to be admitted to the PHP. The certification must indicate the member would require inpatient psychiatric hospitalization if this program were not provided. The certification must include the appropriate DSM diagnosis and psychiatric need for the Partial Hospitalization Program.

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At the time of admission to a Partial Hospitalization Program all members must undergo a formal comprehensive assessment by the psychiatrist certifying the required treatment which draws upon documented assessments made during the current episode of care and must summarize historical records. If the WV Medicaid member has just been discharged from an inpatient psychiatric admission to a partial hospitalization program, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable. All assessments must be documented in the medical record and must address medical, emotional, behavioral, social, spiritual, self-care, leisure, vocational, legal, nutritional needs, and resources. There must be a review of the patient's psychiatric and chemical abuse and dependency history (if present), presenting symptoms, results of a mental status exam, and a diagnostic impression based on the current DSM. The assessment must be carried out in a manner that is sensitive to cultural and ethnic factors. The initial assessment must serve to document the medical necessity of admission to the Partial Hospitalization Program and be in the medical record within two treatment days following the date of admission.

510.5.10 TREATMENT PLANNING

Partial Hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the member, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan must directly address the presenting symptoms and are the basis for evaluating the member's response to treatment. Treatment goals must be designed to measure the member's response to active treatment. The plan must document ongoing efforts to restore the individual member to a higher level of functioning that would promote discharge from the program, or reflect continued need for the intensity of the active therapy to maintain the member's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the member at risk, do not qualify as Partial Hospitalization Program services.

The clinical assessment must be translated into a formalized and documented treatment plan. An initial treatment plan will be completed within two treatment days following the date of admission, and will document minimally one primary treatment goal/problem, the member's treatment schedule, and preliminary treatment objectives. A more formalized, comprehensive treatment plan must be developed within five (5) days of admission to the program. This plan must comprehensively cover all aspects of treatment for the member while in the PHP. The treatment plan must be developed and reviewed by the multidisciplinary team every five (5) treatment days for the duration of the member's PHP treatment. The initial treatment plan and subsequent reviews of the plan must include a review of all the following:

- Assessments of individual, family, and community strengths/resources;
- Specific, multidisciplinary treatment recommendations targeting specific factors that precipitated the admission;
- Developmental milestones and course;
- Member support system dynamics;
- Member's current and past school, work or other social role;
- Member's ability to interact socially (including peer relationships);
- Substance use/abuse;

- Summary of all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services, medication trials, and other mental health/psychosocial interventions, including an assessment of their degree of success and/or failure.

Each review must include the date and signature of all multidisciplinary treatment team members on the treatment plan.

510.5.11 PROGRAM REQUIREMENTS

Partial Hospitalization Programs which make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization, which qualifies the member to receive the services of the Partial Hospitalization Program.

At a minimum, seventy-five percent (75%) of scheduled program hours must consist of active treatment that specifically addresses the presenting problems of the population served. Examples of active treatment include, but are not limited to the following: individual, group and family psychotherapy, medication evaluation and therapy, psychodrama, expressive therapies and theme specific therapy groups such as communication skills, assertiveness training, stress management, chemical dependency education and prevention, symptom recognition, problem solving, and relaxation training. The type of therapeutic involvement offered is dependent upon the nature of the member population and the overall goals of the individual treatment program.

West Virginia Medicaid defines the Partial Hospitalization Program (42 CFR §410.2 and 42 CFR §410.43) as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and that provides these services:

1. Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;
2. Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization;
3. Include any of the following:
    - Individual and group therapy with physicians or psychologists or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, nurse specialists, certified alcohol and drug counselors);
    - Occupational therapy services that address the symptoms and impairments that necessitated PHP admission which require the skills of a qualified occupational therapist. Occupational therapy must be a component of the physician's treatment plan for the individual;
    - Services of other staff (social workers, trained psychiatric nurses, and others trained to work with psychiatric patients);
    - Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR §410.29);
    - Individualized activity therapies that are not primarily recreational or diversionary (not to be billed as individual or group psychotherapies). These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals. Music therapy, art therapy, movement therapy, stress reduction and similar

activities, when they are individualized, essential for treatment of the patient's condition, and ordered by the physician, may constitute covered individualized activity therapies;
- Family counseling, the primary purpose of which is treatment of the patient's condition;
- Patient training and education, to the extent that training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition; and
- Medically necessary diagnostic services.

Involvement of the member's family and/or Support System (as available) must be clearly addressed in the individualized treatment plan and reflected in the individual programming offered.

510.5.12 CONTINUED STAY CRITERIA

An individual's length of stay in a Partial Hospitalization Program is dependent upon the nature of presenting problems and an ongoing authorization of the medical necessity for continued stay in the program. The necessity of and rationale for continued stay must be documented in the medical record and treatment plan review. Globally, a program's average length of stay must reflect the member population and primary program function. West Virginia Medicaid members must meet the following criteria for continued stay:

1. Risk status continues to be appropriate for this level of care.
2. Emergence of new and/or previously unidentified symptoms consistent with a current DSM diagnosis
3. Limited progress has been made and a modification in the treatment plan and/or discharge goals has been made specifically to address lack of expected treatment progress.
4. Progress toward treatment goals has occurred, as evidenced by measurable reductions in signs, symptoms, and/or behaviors to the degree that indicate continued responsiveness to treatment; and
   a. Member is currently involved and cooperating with the treatment process.
   b. The family/support system is involved and cooperating with the treatment process (except where clinically counterproductive or legally prohibited).

The Association for Ambulatory Behavioral Healthcare in its Standards and Guidelines for Partial Hospitalization recognizes that there is a regulatory presumption against the appropriateness of Partial Hospitalization Program services in excess of 30 days. While this is the recognized standard for care, WV Medicaid will allow the 30 day limit to be waived by the UMC for up to 10 additional days of service in certain circumstances.

Consideration may be given for 10 additional days of Partial Hospitalization Program services in situations in which the care plan and treatment documentation supports the need for additional services as follows:

- Additional days/sessions are necessary to complete essential elements of the treatment prior to discharge from the Partial Hospitalization Program.
- The member exhibits well documented **new** symptoms or maladaptive behaviors.

There must be documentation of a reassessment that reasonably can be accomplished within the time frame of the additional 10 days/sessions or less of coverage requested under the waiver provisions.

The physician responsible for the member's care is responsible for documenting the need for additional days/sessions and must establish an estimated length of service beyond the date of the 30 day/session limit up to the ten days/sessions. The waiver must be requested prior to the end date of the authorization for the 30 day/session limit.

510.5.13 DISCHARGE PLANNING

To ensure a smooth transition to a lower level of service, discharge planning must begin at the time of admission to the program. The program must have in place standardized policy and procedures for ongoing informal and periodic formal assessment of the member's readiness for discharge (see Quality Assurance).

The following medical indicators must be in evidence in the discharge plan from a Partial Hospitalization Program:

- Goals for treatment have been substantially met as evidenced by abatement of admission symptoms and the member has returned to a level of functioning that allows reintegration into their previous or newly acquired living arrangement and/or use of a less intensive outpatient service.
- Risk status is appropriate for services at a lower level of care.
- Functional impairments are more manageable or have diminished, indicating services are appropriate at a less intensive level of care.
- An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.

OR

- The member exhibits symptoms and functional impairment that requires services in a more restrictive setting.
- The member becomes medically unstable and requires treatment related to their physical health condition.

510.5.14 NON-COVERED SERVICES

A program comprised primarily of diversionary 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. A program that only provides medical management of medication for members whose psychiatric condition is otherwise stable is not the combination, structure, and intensity of services required in a Partial Hospitalization Program. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization which qualifies the member to receive Partial Hospitalization Program services.

The items listed below are **not** included for coverage under the Partial Hospitalization Program benefit:

- Meals for individuals while participating under the Partial Hospitalization Program benefit;
- Primarily recreational or diversional activities (i.e., activities primarily social in nature) not documented in the treatment plan;
- Self-administered drugs;
- Training that is designed for the purpose of fostering vocational skills;
- Services to hospital inpatients.

510.5.15 DOCUMENTATION

The medical record is an essential tool in treatment. It is the central repository of all pertinent information about each member. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. There must be a permanent medical record maintained in a manner consistent with applicable state and federal licensing regulations and agency record keeping policies.

Documentation must include:

1. The psychiatrist's certification of the need for services,
2. A comprehensive treatment plan,
3. Physician progress notes (completed at least once weekly)
4. Date of service, amount of time, type of service, focus/content of service, level of member participation, symptoms/impairments, interventions, progress made toward attainment of objectives outlined in the individualized treatment plan, and signature/credentials of services provider.
5. Negative incident occurrence where applicable.
6. Educational plan with specific recommendations based on the individual's presenting behaviors,
7. Discharge plan.

Medical records must be complete, accurate, accessible, legible, signed and dated by the professional providing the service, and organized. Documentation must support claims submitted for reimbursement. The progress notes must include a description of the nature of the treatment, the West Virginia Medicaid member's response to the therapeutic intervention, and the relation to the goals developed in the treatment plan.

510.5.16 COVERED SERVICES

The interdisciplinary program of medical therapeutic services may be delivered through any one of the following program formats (services may not be provided under multiple PHP formats concurrently):

1. Day PHP programming, which must provide a minimum of 20 hours of scheduled treatment, delivered in sessions of four hours duration and extending over a minimum of five days per week; or
2. Evening PHP programming, which must provide a minimum of 16 hours of scheduled treatment, delivered in sessions of four hours duration and extending over a minimum of four days per week; or

3. A shortened PHP program for those individuals whose needs can be met through group psychotherapy consisting of 6 to 10 hours of group therapy per week, delivered in two hour per day group therapy sessions.

The abbreviated treatment session (H0015) is a one hour unit of service limited to a maximum of three units per date of service. This one hour service unit may be billed for individuals who have been approved for either a four hour day or evening program or the two hour program in instances when the patient is unable to complete the full four hour or two hour treatment session. This abbreviated treatment session is **not** intended to replace either the four hour day or evening program, or the two hour program. It is intended only for use in those instances when the patient is unable to complete either a four hour day or evening program, or a two hour session. It may not be billed in addition to or with either the evening/day program or the intensive outpatient procedure code. Use of the abbreviated code for more than five sessions during a treatment course will result in a review by the UMC to determine if PHP services are appropriate for the West Virginia Medicaid member.

Both the 20 hour per week day program, and the 16 hour per week evening program (H0035), will be reimbursed on a per diem basis, at the rate of $125.00 per day.

The PHP session which consists of three to five, two hour group psychotherapy sessions (units) per week (90853), will be reimbursed at the rate of $50.00 per session.

The abbreviated treatment session (H0015) one hour service unit will be reimbursed at the rate of $25.00 per one hour unit, to a maximum of three units for a date of service. This procedure may not be billed in combination with any other treatment modality for that date of service.

Services must be reported using CPT/HCPCS codes as follows:

Partial Hospitalization 4 Hour Session
Procedure Code: H0035
Service Unit: One (1) Unit per day
Service Limit: One (1) per day (Minimum of four hours)
Prior Authorization Required: Yes

Partial Hospitalization 2 Hour Session
Procedure Code: 90853
Service Unit: One (1) Unit per day
Service Limit: One (1) per day (Minimum of two hours)
Prior Authorization Required: Yes

Partial Hosp. Abbreviated Treatment Session
Procedure Code: H0015
Service Unit: One (1) Unit = 1 hour
Service Limit: Three (3) Per Day if Enrolled in H0035
One (1) Per Day if Enrolled in 90853
Prior Authorization Required: Yes (Retroactive Authorization will be considered)

If H0015 is used more than five times in a 30 day period a UMC review will be required

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The Medicaid Program will not be responsible for reimbursement of any services provided prior to issuance of an authorization, nor for any dates of service which exceed the authorization, unless Retroactive Authorization is approved by the UMC.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Multimodal Treatment: This treatment often includes interventions such as medical treatment, educational interventions, behavior modification programs and psychological treatment and is recommended by the National Institute of Mental Health for the provision of behavioral health services.

Partial Hospitalization Program (PHP): Is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. While specific program variables may differ, all Partial Hospitalization Programs pursue the goal of stabilization with the intention of averting inpatient hospitalization or reducing the length of a hospital stay.

Therapeutic Milieu: A structured group setting in which the existence of the group is a key force in the outcome of treatment. Using the combined elements of positive peer pressure, trust, safety and repetition, the therapeutic milieu provides an idealized setting for group members to work through their psychological issues. The keys to a successful therapeutic milieu are support, structure, repetition and consistent expectations.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD