

- **Psychiatric Treatment Services**

The department reimburses hospitals for certain outpatient psychiatric services when provided by a hospital that is enrolled by the department to provide inpatient psychiatric services or was previously enrolled with the department for the provision of inpatient psychiatric services on or after June 1, 2002, but is no longer enrolled.

The two categories of ambulatory psychiatric services for which the department provides payment to appropriately enrolled hospitals are: Psychiatric Clinic Services, Type A (COS 27) and Psychiatric Clinic Services, Type B (COS 28). See Topic H-201.26 for specific enrollment information for these categories.

Psychiatric clinic Type A and B services must be billed using one of the specified procedure codes identified on the final page of the [APL](#).

Type A Services

The department defines Type A ambulatory psychiatric services as an ambulatory service package consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling.

Services are reimbursed at the EAPG PPS all-inclusive payment. This payment is considered by the department to include services provided by salaried hospital personnel (except as noted in this section), all drugs administered and/or provided for home use and all equipment, drugs and supplies used for diagnostic and/or treatment purposes during the ambulatory visit.

Type B Services

Type B ambulatory psychiatric services are defined by the department as an active treatment program in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four (4) hours per day at a minimum of three (3) half days of active treatment per week. The duration of an individual patient's participation in the Ambulatory Psychiatric Services, Type B, treatment program is limited to six (6) months in any twelve (12) month period.

When Type B services have been provided, the reimbursement is made at the EAPG PPS all-inclusive reimbursement. This reimbursement is considered by the department to include services provided by salaried professional and ancillary personnel (except as noted in this section) and any expenses incurred for supplies and materials, etc., in the provision of the services.

H-270.2 Salaried Physicians Providing Services in an Outpatient Department

A claim may be submitted for one salaried physician involved in direct patient care in **any** outpatient setting, in conjunction with an APL procedure(s). This policy excludes billing for a salaried pathologist, radiologist, nurse practitioner, or certified registered nurse anesthetist (CRNA).

For this purpose only, salaried physician is defined as a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide Emergency Department care.

The fee-for-service (FFS) claim for a salaried outpatient department physician service will be subject to the following requirements:

- For each patient, a professional claim may be submitted under the practitioner's name and NPI for a visit or procedure for only one salaried physician's services in an outpatient department. The hospital may also bill on the institutional claim format for the APL procedure for that patient for that date of service.
- If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive APL reimbursement and cannot be billed as FFS.

=H-270.3 Physical Rehabilitation Services

Revised Effective November 16, 2015

Ambulatory physical rehabilitation services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an ambulatory basis.

Prior to July 1, 2012, hospitals billed physical therapy services as outpatient institutional services from APL Group 6 - Rehabilitation Services. Occupational and speech therapy services were billed as fee-for-service under the hospital's fee-for-service NPI. Effective with dates of service on and after July 1, 2012 [Public Act 097-0689\(pdf\)](#) prompted changes resulting in physical therapy also being billed as fee-for-service on the paper HFS 1443 claim form or on the 837P electronic claim format under the hospital's fee-for-service NPI. APL Group 6 – Rehabilitation Services was removed from the APL; however, the payment rates for the fee-for-service billable physical therapy codes remain the same as they were under the APL as of June 30, 2012.

[Public Act 097-0689\(pdf\)](#) also mandated a cap of 20 visits per year per discipline for physical therapy, as well as occupational and speech therapy services, for adults age 21 and over. The department implemented prior approval for adults to track the number of visits. Later changes to state law in [Public Act 098-0651\(pdf\)](#), removed

the cap but required prior approval for all therapy disciplines, regardless of the age of the patient. Prior approval for physical, occupational, and speech therapies for adults was implemented with dates of service beginning October 1, 2014. Prior approval for physical and occupational therapies for children through age 20 was implemented with dates of service on and after November 16, 2015.

The billable codes for adults as well as children are restricted to the codes identified in the [Therapy Fee Schedule](#). CPT code 97001 (Physical Therapy Evaluation) does not require prior approval. Refer to the [Handbook for Providers of Therapy Services](#) for prior approval and claim submission instructions.

Prior approval may be needed for certain durable medical equipment, supplies, braces, or prosthetic devices. See the [Handbook for Providers of Medical Equipment and Supplies](#) for further information.

H-270.4 Series Claims

Certain outpatient services provided on multiple dates of service can be submitted on one institutional claim form. Submission of ambulatory series claims must be in accordance with the UB-04 Data Specifications Manual. A series claim must contain an appropriate series revenue code (shown in Appendix H-3) and series-billable procedure code from the APL. **All** services rendered to the patient on series-billable days are to be shown on the same claim.

Renal dialysis claims may also be submitted as series bills. Refer to Appendix H-2 for billing instructions.

Series bills may be submitted for up to a maximum of thirty-one (31) days from the date of the first visit. If the series is longer than thirty-one (31) days, the claim must be split. **Claims for patients in the State Chronic Renal Disease Program cannot cross calendar months.**

The date range for a series claim must encompass the beginning and ending service dates for the time period being billed. Do **not** automatically bill from the first day of the month through the last day of the month if a service was not provided on those days.

Hospitals may, but are not required, to split series ambulatory claims around an inpatient stay. Ambulatory claims that are not split must identify the inpatient days as non-covered.

H-270.5 Expensive Drugs and Devices

For outpatient dates of service through June 30, 2014, a hospital or ambulatory surgical treatment center (ASTC) may be eligible for an additional payment called an “outlier” payment for specified expensive drugs and devices provided in an

outpatient setting, in addition to the APL service. Those drugs and devices are identified in the [Expensive Drugs and Devices Listing](#) on the department's website.

Medicare/Medicaid crossover claims will not be eligible for an outlier payment.

The reimbursement level for the **procedure** will remain at the amount assigned to the highest payable APL procedure.

To be eligible for an outlier payment, the drug or device:

1. Must be medically necessary for the patient; and
2. May be subject to prior approval by the department

If any drug or device requires prior approval, it will be noted in the Expensive Drugs and Devices Listing with a link to the appropriate approval form:

- A drug approval request must be submitted on Form HFS 3082, Request for Drug Prior Approval,
- A device approval request must be submitted on Form HFS 1409, Prior Approval Request form.

Both forms are also available on the department's [Medical Forms page](#) of the website.

The provider will receive written notification of the department's decision. The provider must render the approved service, or the first treatment in a series of approved treatments, within thirty (30) days from the date of approval by the department. All prior approval requests must be mailed or faxed to the department; no telephone requests will be accepted. The department will accept requests for post approval for consideration, but approval is not guaranteed.