| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 1843** | **Date: October 30, 2009** |
| | **Change Request 6686** |

**NOTE: CR 6686, Transmittal 1843 originally communicated as Sensitive/Controversial on October 30, 2009 is being re-issued as no longer Sensitive. The transmittal number, issue date and all other information remain the same.**

**SUBJECT: Outpatient Mental Health Treatment Limitation**

**I. SUMMARY OF CHANGES:** Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase in a 5-year reduction to the payment that Medicare patients are required to make for outpatient mental health servies that are subject to the outpatient mental health treatment limitation (the limitation). Payment for outpatient mental health services will gradually reduce from 2010-2014. Effective January 1, 2014, the limitation will no longer exist and Medicare will pay outpatient mental health services at the same level as other Part B services. Hence, the limitation will change as follows: 2009 and prior years=62.5 percent: 2010-2011=68.75 percent; 2012=75 percent; 2013=81.25 percent; and, 2014 and onward=100 percent.

**NEW / REVISED MATERIAL**
**EFFECTIVE DATE**: *January 1, 2010
**IMPLEMENTATION DATE:** January 4, 2010

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| R | 5/Table of Contents |
| R | 5/100.4/Outpatient Mental Health Treatment Limitation |
| R | 9/Table of Contents |
| R | 9/60/Outpatient Mental Health Treatment Limitation |
| D | 9/60.1/Definition of Mental Health Services in RHC/FQHC |
| D | 9/60.2/Application of Limit |
| R | 12/Table of Contents |

| | |
|---|---|
| R | 12/110.2/Outpatient Mental Health Treatment Limitation |
| R | 12/120/Nurse Practitioner (NP) And Clinical Nurse Specialist (CNS) Services |
| R | 12/170.1/Payment |
| R | 12/210/Outpatient Mental Health Treatment Limitation |
| R | 12/210.1/Application of the Limitation |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

**Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 1843 | Date: October 30, 2009 | Change Request: 6686 |
|---|---|---|---|

**NOTE: CR 6686, Transmittal 1843 originally communicated as Sensitive/Controversial on October 30, 2009 is being re-issued as no longer Sensitive. The transmittal number, issue date and all other information remain the same.**

**SUBJECT:** Outpatient Mental Health Treatment Limitation

**EFFECTIVE DATE**: January 1, 2010

**IMPLEMENTATION DATE:** January 4, 2010

## I. GENERAL INFORMATION

**A. Background:** Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase out the outpatient mental health treatment limitation (the limitation) over a 5-year period, from 2010-2014. The limitation has resulted in Medicare paying 50% of the approved amount for outpatient mental health treatment rather than the 80% that is paid for most other services. With the exception of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), when this MIPPA provision is fully implemented effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, that is, at 80% of the physician fee schedule. Also, when this MIPPA provision is fully implemented, RHCs and FQHCs will be paid at 80% of their encounter rate subject to the applicable upper payment limit.

**B. Policy:** Section 102 of MIPPA requires that the current 62.5% outpatient mental health treatment limitation (under which Medicare pays 50% of the approved amount and the patient pays 50%) will be reduced as follows: **2010-2011**=68.75% - Medicare pays 55% and the patient pays 45%; **2012**=75% - Medicare pays 60% and the patient pays 40%; **2013**=81.25% - Medicare pays 65% and the patient pays 35%; and, **2014 and onward**=100% - Medicare pays 80% and the patient pays 20%. For RHCs and FQHCs, the amount the patient owes may differ from the percentages listed above if the charges are not equal to the encounter rate. The type of bill (TOB) for RHCs is 71x. For FQHCs, the TOB is 73x for all dates of service (DOS) before April 1, 2010, and, 77x, for all DOS on or after April 1, 2010.

## II. BUSINESS REQUIREMENTS TABLE

*Use"Shall" to denote a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6686.1 | Contractors shall change the outpatient mental health treatment limitation (the limitation) for claims with dates of service on or after January 1, 2010, through December | X | | X | X | | X | X | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | 31, 2011, to 68.75%. | | | | | | | | | | |
| 6686.1.1 | For claims with dates of service on or after January 1, 2010, through December 31, 2011, that are subject to the limitation, contractors shall return the new Medicare Summary Notice message 16.61: "Outpatient mental health services are paid at 55% of the approved amount".<br><br>**Spanish Version: Por los servicios psiquiátricos ambulatorios se paga el 55% de la cantidad aprobada.** | X | | X | X | | X | X | | | |
| 6686.2 | Contractors shall change the limitation for claims with dates of service on or after January 1, 2012, through December 31, 2012, to 75%. | X | | X | X | | X | X | | X | |
| 6686.2.1 | For claims with dates of service on or after January 1, 2012, through December 31, 2012, that are subject to the limitation, contractors shall return the new Medicare Summary Notice message 16.62: "Outpatient mental health services are paid at 60% of the approved amount".<br><br>**Spanish Version: Por los servicios psiquiátricos ambulatorios se paga el 60% de la cantidad aprobada.** | X | | X | X | | X | X | | | |
| 6686.3 | Contractors shall change the limitation for claims with dates of service on or after January 1, 2013, through December 31, 2013, to 81.25%. | X | | X | X | | X | X | | X | |
| 6686.3.1 | For claims with dates of service on or after January 1, 2013, through December 31, 2013, that are subject to the limitation, contractors shall return the new Medicare Summary Notice message 16.63: "Outpatient mental health services are paid at 65% of the approved amount".<br><br>**Spanish Version: Por los servicios psiquiátricos ambulatorios se paga el 65% de la cantidad aprobada.** | X | | X | X | | X | X | | | |
| 6686.4 | Contractors shall eliminate the limitation for claims with dates of service on or after January 1, 2014. | X | | X | X | | X | X | | X | |
| 6686.5 | For claims with dates of service on or after January 1, 2010, through December 31, 2013, contractors shall continue to return the Claim Adjustment Reason Code(s) and Remittance Advice Remark Code(s) for claims subject to the limitation that they currently use. | X | | X | X | | X | X | | | |
| 6686.6 | Contractors shall not apply the limitation to TOB 75x. | X | | X | X | | X | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| | CPT code 96152 is the only CPT code allowed for behavioral health services provided in a CORF and it is not subject to the limitation. | | | | | | | | | | |
| 6686.7 | The Part B Shared Systems shall send the updated reduced psychiatric amount in the Psychiatric Charge Field found in MSPPAY for MSP claims. The Part A Shared System shall continue to send the appropriate amounts like it always has to MSPPAY for MSP psychiatric services. | X | | X | X | | X | | | X | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6686.8 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | | X | X | | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | |

**Section B: For all other recommendations and supporting information, use this space:**

## V. CONTACTS

**Pre-Implementation Contact(s):** Regina Walker-Wren at Regina.Walkerwren@cms.hhs.gov for Payment Policy; Gertrude Saunders at Gertrude.Saunders@cms.hhs.gov for Part A Claims Processing; Leslie Trazzi at Leslie.Trazzi@cms.hhs.gov for Part B Claims Processing; and, Richard Mazur at Richard.Mazur2@cms.hhs.gov for MSP issues.

**Post-Implementation Contact(s):** Regional Offices

## VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

# Medicare Claims Processing Manual
## Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

---

**Table of Contents**
***(Rev.18434, 10-30-09)***



## *100.4 - Outpatient Mental Health Treatment Limitation*

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

*The Outpatient Mental Health Treatment Limitation (the limitation) is not applicable to CORF services because CORFs do not provide services to treat mental, psychoneurotic and personality disorders that are subject to the limitation in section 1833(c) of the Act. For dates of service on or after July 7, 2008, CPT code 96152 is the only CPT code allowed for health and behavioral intervention services provided in a CORF. This service is not subject to the limitation because it is not a psychiatric mental health treatment service. For dates of service prior to July 7, 2008, the limitation was applied to certain outpatient mental health treatment services when provided in a CORF. For additional information on the limitation, see Publication 100-01, Chapter 3, section 30 and Publication 100-02, Chapter 12, sections 50-50.5.*

# Medicare Claims Processing Manual
## Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

---

**Table of Contents**
***(Rev.1843, 10-30-09)***



## 60 – *Outpatient* Mental Health *Treatment Limitation*
***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

*Most RHC/FQHC services for the treatment of mental, psychoneurotic, and personality disorders are subject to the outpatient mental health treatment limitation (the limitation) in Section §1833 of the Act. Certain diagnostic services and brief office visits for monitoring or changing drug prescription(s) are not subject to the limitation. For detailed information on the application of the limitation please see the General Information, Eligibility, and Entitlement Manual, Publication 100-01, chapter 3, section 30, the Medicare Benefit Policy Manual, Publication 100-02, chapter 13, sections 100.6 and 110.5, and the Medicare Claims Processing Manual, chapter 12, section 210.*

*The limitation has been 62.5 percent since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:*

- *January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%.*
- *January 1, 2012 – December 31, 2012, the limitation percentage is 75%.*
- *January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%.*
- *January 1, 2014 – onward, the limitation percentage is 100%.*

*FQHC services, including services subject to the outpatient mental health treatment limitation, are not subject to the Part B deductible. RHC services, including services subject to the outpatient mental health treatment limitation, are subject to the Part B deductible. Application of the coinsurance is the same as for other RHC and FQHC services. The mental health treatment limitation amount is applied before application of the coinsurance.*

# Medicare Claims Processing Manual
## Chapter 12 - Physicians/Nonphysician Practitioners

**Table of Contents**
*(Rev.1843, 10-30-09)*



## 110.2 - Outpatient Mental Health *Treatment* Limitation

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

*In general, PAs are paid for covered services at 85 percent of the Medicare Physician Fee Schedule.* The carrier must apply the outpatient mental health *treatment* limitation *(the limitation)* to all covered mental health therapeutic services furnished by PAs.

Refer to §210 below for a complete discussion of the limitation.

## 120 - Nurse Practitioner (NP) *and* Clinical Nurse Specialist (CNS) Services

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

See the Medicare Benefit Policy Manual Chapter 15, for coverage policy.

**A. General Payment**

In general, NPs and CNSs are paid for covered services at 85 percent of the Medicare Physician Fee Schedule.

**B. *Outpatient* Mental Health *Treatment* Limitation**

The carrier must apply the outpatient mental health *treatment* limitation *(the limitation)* to all covered mental health therapeutic services furnished by NPs and CNSs.

Refer to §210, below, for a discussion of the limitation.

## 170.1 - Payment

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

All covered therapeutic services furnished by qualified CPs are subject to the outpatient mental health *treatment* limitation *(the limitation)*. *Generally, t*he limitation does not apply to diagnostic services. Refer to §210 below for a discussion of the outpatient mental health *treatment* limitation.

Payment for the services of CPs is made on the basis of a fee schedule or the actual charge, whichever is less, and only on the basis of assignment.

CPs are identified by specialty code 68 and provider type 27. Modifier "AH" is required on CP services.

## 210 - Outpatient Mental Health *Treatment* Limitation

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

Regardless of the actual expenses a beneficiary incurs *in connection with the* treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare *approved* amount for those services. This limitation is called the outpatient mental health treatment limitation *(the limitation)*. *The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:*

- *January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%.*

  *(Medicare pays 55% and the patient pays 45%).*

- *January 1, 2012 – December 31, 2012, the limitation percentage is 75%.*

  *(Medicare pays 60% and the patient pays 40%).*

- *January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%.*

  *(Medicare pays 65% and the patient pays 35%).*

- *January 1, 2014 – onward, the limitation percentage is 100%.*

  *(Medicare pays 80% and the patient pays 20%).*

*For additional details concerning computation of the limitation, please see the examples under section 210.1 E.*

## 210.1 - Application of *the* Limitation

***(Rev.1843, Issued: 10-30-09, Effective: 01-01-10, Implementation: 01-04-10)***

### A. Status of Patient

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a person in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution, which is primarily engaged in providing to inpatients, by or under the supervision of *a* physician(s):

- Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons;
- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

### B. Disorders Subject to *the* Limitation

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric *diagnoses* described in the *International Classification of Diseases, 9th Revision (ICD-9), under the code range 290-319.*

When the treatment services rendered are both for a psychiatric *diagnosis* as defined in the *ICD-9* and one or more nonpsychiatric conditions, separate the expenses for the psychiatric aspects of treatment from the expenses for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric treatment component is not readily distinguishable from the nonpsychiatric treatment component, all of the expenses are allocated to whichever component constitutes the primary diagnosis.

1. Diagnosis Clearly Meets Definition - If the primary diagnosis reported for a particular service is the same as or equivalent to a condition described in the *ICD-9 under the code range 290-319 that represents mental, psychoneurotic and personality disorders*, the expense for the service is subject to the limitation except as described in subsection D.

2. Diagnosis Does Not Clearly Meet Definition - When it is not clear whether the primary diagnosis reported meets the definition of mental, psychoneurotic, and personality disorders, it may be necessary to contact the practitioner to clarify the diagnosis. In deciding whether contact is necessary in a given case, give consideration to such factors as the type of services rendered, the diagnosis, and the individual's previous utilization history.

### C. Services Subject to *the* Limitation

*Medicare Contractors must* apply the limitation to claims for professional services that represent mental health treatment furnished to individuals who are not hospital inpatients by physicians, clinical psychologists, clinical social workers, *nurse practitioners, clinical nurse specialists and physician assistants*. Items and supplies furnished by physicians or

other mental health practitioners in connection with treatment are also subject to the limitation.

*Generally, Medicare Contractors must* apply the limitation only to treatment services. *However, diagnostic psychological and neuropsychological t*esting services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.

**D. Services Not Subject to *the* Limitation**

1. Diagnosis of Alzheimer's Disease or Related Disorder - When the primary diagnosis reported for a particular service is Alzheimer's Disease or *an* Alzheimer's *related disorder*, *Medicare Contractors must* look to the nature of the service that has been rendered in determining whether it is subject to the limitation. *Alzheimer's disease is coded 331.0 in the "International Classification of Diseases, 9th Revision", which is outside the code range 290-319 that represents mental, psychoneurotic and personality disorders. Additionally, Alzheimer's related disorders are identified by contractors under ICD-9 codes that are outside the 290-319 code range. W*hen the primary treatment rendered to a patient with a diagnosis *of Alzheimer's disease or a related disorder* is psychotherapy, it is subject to the limitation. *However, t*ypically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (*such as described under CPT code 90862 or any successor code*) and is not subject to the limitation. *CPT code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.*

2. Brief Office Visits for Monitoring or Changing Drug Prescriptions - Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders are not subject to the limitation. These visits are reported using HCPCS code M0064 *or any successor code* (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders). Claims where the diagnosis reported is a mental, psychoneurotic, or personality disorder (other than a diagnosis specified in subsection A) are subject to the limitation except for the procedure identified by HCPCS code M0064 *or any successor code*.

3. Diagnostic Services –*Medicare Contractors* do not apply the limitation to *psychiatric diagnostic evaluations and diagnostic psychological and neuropsychological* tests performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric *diagnostic evaluations billed under CPT codes 90801 or 90802 (or any successor codes) and,* psychological *and neuropsychological* tests *billed under CPT code range 96101-96118 (or any successor code range)*.

An initial visit to a practitioner for professional services often combines diagnostic evaluation and the start of therapy. Such a visit is neither solely diagnostic nor solely therapeutic. Therefore, *contractors must* deem the initial visit to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible, unless the practitioner already has separately identified them on the bill. Determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made and

certainly before therapy can be instituted. Moreover, the patient should not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit. In the rare cases where a practitioner's diagnostic services take more than one visit, *Medicare contractors must* not apply the limitation to the additional visits. However, it is expected such cases are few. Therefore, when a practitioner bills for more than one visit for professional diagnostic services, *Medicare contractors may find it necessary to* request documentation to justify the reason for more than one diagnostic visit.

4. Partial Hospitalization Services Not Directly Provided by *a* Physician *or a Practitioner* - The limitation does not apply to partial hospitalization services that are not directly provided by a physician*, clinical psychologist, nurse practitioner, clinical nurse specialist or a physician assistant*. *Partial hospitalization* services are billed by *hospital outpatient departments* and community mental health centers (CMHCs) to *Medicare Contractors*. *However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to partial hospitalization patients are billed separately from the partial hospitalization program of services. Accordingly, these professional's mental health services to partial hospitalization patients are paid under the physician fee schedule by Medicare Contractors and may be subject to the limitation. (See chapter 4, section 260.1C).*

**E. Computation of Limitation**

*Medicare Contractors* determine the Medicare *approved* payment amount for services subject to the limitation. They:

- Multiply *the approved* amount by *the limitation percentage amount*;
- Subtract any unsatisfied deductible; and,
- Multiply the remainder by 0.8 to obtain the amount of Medicare payment.

The beneficiary is responsible for the difference between the amount paid by Medicare and the full *Medicare approved* amount.

*The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA). Please note that although the calendar year 2009 Part B deductible of $135 is used under these examples, the actual deductible amount for calendar year 2010 and future years is unknown and will be subject to change.*

*Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68 ¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as follows:*

1. *Actual charges……..$200.00*
2. *Medicare-approved amount……..$180.00*
3. *Medicare incurred expenses (0.6875 x line 2)……..$123.75*
4. *Unmet deductible……..$0.00*
5. *Remainder after subtracting deductible (line 3 minus line 4)….$123.75*
6. *Medicare payment (0.80 x line 5)……..$99.00*
7. *Patient liability (line 2 minus line 6)……..$81.00*

*<u>Example #2:</u> In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet. The Medicare payment and patient liability are computed as follows:*

1. *Actual charges……..$135.00*
2. *Medicare-approved amount……..$120.00*
3. *Medicare incurred expenses (0.75 x line 2)……..$90.00*
4. *Unmet deductible……..$65.00*
5. *Remainder after subtracting deductible (line 3 minus line 4)….$25.00*
6. *Medicare payment (0.80 x line 5)……..$20.00*
7. *Patient liability (line 2 minus line 6)……..$100.00*

*<u>Example #3:</u> In calendar year 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in excess charges. The patient has not satisfied any of the $135 Part B annual deductible. The Medicare payment and patient liability are computed as follows:*

1. *Actual charges……..$780.00*
2. *Medicare-approved amount……..$750.00*
3. *Medicare incurred expenses (0.8125 x line 2)……..$609.38*
4. *Unmet deductible……..$135.00*
5. *Remainder after subtracting deductible (line 3 minus line 4)……$474.38*
6. *Medicare payment (0.80 x line 5)……..$379.50*
7. *Patient liability (line 1 minus line 6)……..$400.50*

*Example #4: A patient's Part B expenses during calendar year 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient. The Medicare payment and patient liability are computed as follows:*

1. *Actual charges……$780.00*
2. *Medicare-approved amount……$750.00*
3. *Medicare incurred expenses (1.00 x line 2)……$750.00*
4. *Unmet deductible……$135.00*
5. *Remainder after subtracting deductible (line 3 minus line 4)……$615.00*
6. *Medicare payment (0.80 x line 5)……$492.00*
7. *Beneficiary liability (line 2 minus line 6)……$258.00*