

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MENTAL HEALTH SERVICES

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This publication provides the following information:

- Covered and non-covered mental health services;
- Eligible professionals (EP);
- Supplier charts;
- Assignment;
- Outpatient and inpatient psychiatric hospital services;
- Same day billing guidelines; and
- National Correct Coding Initiative (NCCI).

COVERED MENTAL HEALTH SERVICES

The following mental health services **may** be covered under the Medicare Program:

- Psychiatric diagnostic interviews;
- Individual psychotherapy;
- Interactive psychotherapy;
- Family psychotherapy (with the patient present and the primary purpose is treatment of the individual's condition);
- Family psychotherapy (without the patient present, is medically reasonable and necessary, and the primary purpose is treatment of the individual's condition);
- Group psychotherapy;
- Psychoanalysis;
- Pharmacologic management;
- Electroconvulsive therapy (ECT);
- Diagnostic psychological and neuropsychological tests;
- Hypnotherapy;
- Narcosynthesis;
- Biofeedback therapy;
- Individualized activity therapy (as part of a Partial Hospitalization Program [PHP] and that is not primarily recreational or diversionary); and
- Screening for depression (The Centers for Medicare & Medicaid Services [CMS] may cover annual screening up to 15 minutes for Medicare patients when staff-assisted depression care supports are in place to assure accurate diagnosis,

effective treatment, and follow-up. At a minimum level, staff-assisted supports consist of clinical staff [for example, nurses and physician assistants] in the primary care setting who can advise the physician of screening results and facilitate and coordinate referrals to mental health treatment.)

MENTAL HEALTH SERVICES THAT ARE NOT COVERED

The following mental health services are not covered under the Medicare Program:

- Environmental intervention;
- Geriatric day care programs;
- Individual psychophysiological therapy that incorporates biofeedback training (any modality);
- Marriage counseling;
- Pastoral counseling;
- Report preparation;
- Interpretation or explanation of results or data;
- Transportation and meals; and
- Telephone services.

ELIGIBLE PROFESSIONALS (EP)

Medicare recognizes the following suppliers who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders. Most of these suppliers, with the exception of independently practicing psychologists, are also authorized to furnish Medicare structured assessment, brief intervention, and referral to treatment (SBIRT) services, to the extent permitted under State law:

- Physicians (medical doctors [MD] and doctors of osteopathy [DO]), particularly psychiatrists;
- Clinical psychologists (CP);
- Clinical social workers (CSW);
- Clinical nurse specialists (CNS);
- Nurse practitioners (NP);
- Physician assistants (PA);
- Certified nurse-midwives (CNM); and
- Independently Practicing Psychologists (IPP).

SUPPLIER CHARTS

The charts on the following pages provide information on required qualifications and coverage and payment criteria for each supplier type.

Psychiatrists

When “you/your” is used in this chart, we are referring to psychiatrists.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are a MD or a DO; and ○ Are acting within the scope of your license. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized to practice medicine in the State in which the services are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ You may perform the general supervision assigned to diagnostic psychological and neuropsychological tests; and ○ Services and supplies may be furnished incident to your professional services. 	<ul style="list-style-type: none"> • The following payment criteria apply: <ul style="list-style-type: none"> ○ Payment for assigned services is made at 100% of the amount a physician is paid under the Medicare Physician Fee Schedule.

Clinical Psychologists (CP)

When “you/your” is used in this chart, we are referring to CPs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Have a Doctoral degree in psychology; and ○ Are licensed or certified, on the basis of the Doctoral degree in psychology, by the State in which you practice at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Upon the patient’s consent, you must attempt to consult with the patient’s attending or primary care physician about the services being furnished and: <ul style="list-style-type: none"> – Document the date of consent or declination of consent to consultations and the date of consultations in the patient’s medical record; or – If consultations do not succeed, document the date and manner of notification to the physician in the patient’s medical record (does not apply if the physician referred the patient to you); ○ You may perform the general supervision assigned to diagnostic psychological and neuropsychological tests; and ○ Services and supplies may be furnished incident to your professional services, with the exception of services furnished to hospital patients. 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; and ○ Services are paid at 100% of the amount a physician is paid under the Medicare Physician Fee Schedule.

Clinical Social Workers (CSW)

When “you/your” is used in this chart, we are referring to CSWs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Have a Master’s or Doctoral degree in social work; ○ Have performed at least 2 years of supervised clinical social work; and ○ Are licensed or certified as a CSW by the State in which the services are performed; or ○ If you practice in a State that does not provide for licensure or certification, have completed at least 2 years or 3,000 hours of post Master’s degree supervised clinical social work practice under the supervision of a Master’s level social worker in an appropriate setting (for example, a hospital, Skilled Nursing Facility [SNF], or clinic). 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Services are for the diagnosis and treatment of mental illnesses; ○ CSW services furnished to hospital inpatients are not covered as CSW services; ○ CSW services to hospital outpatients are covered and paid under the CSW benefit when billed by the hospital to a Medicare Administrative Contractor under the CSW’s National Provider Identifier; ○ CSW services furnished to patients under a Partial Hospitalization Program that is provided by a hospital outpatient department or Community Mental Health Center are not covered and paid under the CSW benefit; ○ CSW services furnished to SNF inpatients and patients in Medicare-participating End-Stage Renal Disease facilities are not covered and paid under the CSW benefit if the 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; and ○ Services are paid at 75% of the amount a CP is paid under the Medicare Physician Fee Schedule.

Required Qualifications	Coverage	Payment
	<p>services furnished are required under the respective requirements for participation;</p> <ul style="list-style-type: none"> ○ Incident to services that you furnish for physicians, CPs, CNSs, NPs, PAs, or CNMs may be covered; and ○ Services furnished as an incident to your personal professional services are not covered. 	

Clinical Nurse Specialists (CNS)

When “you” is used in this chart, we are referring to CNSs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are a registered nurse currently licensed to practice in the State where you practice and are authorized to furnish the services of a CNS in accordance with State law; ○ Have a Doctor of Nursing Practice or Master’s degree in a defined clinical area of nursing from an accredited educational institution; and ○ Are certified as a CNS by a recognized national certifying body that has established standards for CNSs. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized and qualified to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Services are the type considered physicians’ services if furnished by a MD or a DO; ○ Services are performed in collaboration with a physician; ○ Assistant-at-surgery services you furnish may be covered; ○ You may personally perform diagnostic psychological and neuropsychological tests in collaboration with a physician as required under the CNS benefit and to the extent permitted under State law; and ○ Incident to services and supplies may be covered. 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; ○ Services are paid directly to you at 85% of the amount a physician is paid under the Medicare Physician Fee Schedule (PFS); and ○ Payment is made directly to you for assistant-at-surgery services at 85% of 16% of the amount a physician is paid under the Medicare PFS for assistant-at-surgery services.

Nurse Practitioners (NP)

When “you” is used in this chart, we are referring to NPs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are a registered professional nurse authorized by the State in which the services are furnished to practice as a NP in accordance with State law and meet one of the following criteria: <ul style="list-style-type: none"> – Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003, and: <ul style="list-style-type: none"> ▪ Are certified as a NP by a recognized national certifying body that has established standards for NPs; and ▪ Have a Master’s degree in nursing or a Doctor of Nursing Practice Doctoral degree; – Obtained Medicare billing privileges as a NP for the first time before January 1, 2003, and meets the certification requirements described above; or – Obtained Medicare billing privileges as a NP for the first time before January 1, 2001. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized and qualified to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Services are the type considered physicians’ services if furnished by a MD or a DO; ○ Services are performed in collaboration with a physician; ○ Assistant-at-surgery services you furnish may be covered; ○ You may personally perform diagnostic psychological and neuropsychological tests in collaboration with a physician as required under the NP benefit and to the extent permitted under State law; and ○ Incident to services and supplies may be covered. 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; ○ Services are paid at 85% of the amount a physician is paid under the Medicare Physician Fee Schedule (PFS); and ○ Payment is made directly to you for assistant-at-surgery services at 85% of 16% of the amount a physician is paid under the Medicare PFS for assistant-at-surgery services.

Physician Assistants (PA)

When “you/your” is used in this chart, we are referring to PAs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are licensed by the State to practice as a PA and one of the following criteria: <ul style="list-style-type: none"> - Have graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs, and the Committee on Allied Health Education and Accreditation); or - Have passed the national certification examination administered by the National Commission on Certification of Physician Assistants. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Services are the type considered physicians’ services if furnished by a MD or a DO; ○ Services are performed by an individual who meets all PA qualifications; ○ Services are performed under the general supervision of a MD or a DO; ○ The physician supervisor or designee need not be physically present when a service is being furnished unless State law or regulations require otherwise; ○ Assistant-at-surgery services you furnish may be covered; ○ You may personally perform diagnostic psychological and neuropsychological tests under the general supervision of a physician as required under the PA benefit 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; ○ Payment may be made only to your: <ul style="list-style-type: none"> - Qualified employer who is eligible to enroll in the Medicare Program under existing provider/supplier categories; or - Contractor; ○ Services are paid at 85% of the amount a physician is paid under the Medicare Physician Fee Schedule (PFS); and ○ Payment is made to the your employer or contractor for assistant-at-surgery services at 85% of 16% of the amount a physician is paid under the Medicare PFS for assistant-at-surgery services.

Required Qualifications	Coverage	Payment
	and to the extent permitted under State law; and <ul style="list-style-type: none"><li data-bbox="898 316 1369 381">○ Incident to services and supplies may be covered.	

Certified Nurse-Midwives (CNM)

When “you” is used in this chart, we are referring to CNMs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are a registered nurse who is legally authorized to practice as a nurse-midwife in the State where services are performed; ○ Have successfully completed a program of study and clinical experience for nurse-midwives that is accredited by an accrediting body approved by the United States (U.S.) Department of Education; and ○ Are certified as a nurse-midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ You are legally authorized and qualified to furnish the services in the State where they are performed; ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Services are the type considered physicians’ services if furnished by a MD or a DO; ○ Services are performed without physician supervision and without association with a physician or other health care provider, unless otherwise required by State law; ○ You may personally perform diagnostic psychological and neuropsychological tests without physician supervision or oversight as authorized under the CNM benefit and to the extent permitted under State law; and ○ Incident to services and supplies may be covered. 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Payment is made only on an assignment basis; and ○ Services are paid at 80% of the lesser of the actual charge or 100% of the amount a physician is paid under the Medicare Physician Fee Schedule (effective January 1, 2011).

Independently Practicing Psychologists (IPP)

When “you/your” is used in this chart, we are referring to IPPs.

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • You must meet the following qualifications: <ul style="list-style-type: none"> ○ Are a psychologist who is not a CP; and ○ Meet one of the following criteria: <ul style="list-style-type: none"> - Practice independently of an institution, agency, or physician’s office and are licensed or certified to practice psychology in the State or jurisdiction where the services are performed; or - Are a practicing psychologist who performs services in a jurisdiction that does not issue licenses. 	<ul style="list-style-type: none"> • The following coverage criteria apply: <ul style="list-style-type: none"> ○ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ○ Performs services on your own responsibility, free of the administrative and professional control of an employer (for example, a physician, an institution, or an agency); ○ The individuals treated are your own patients; ○ When you practice in an office that is located in an institution: <ul style="list-style-type: none"> - The office is confined to a separately-identified part of the facility that you use solely as an office and cannot be construed as extending throughout the entire institution; and - You conduct a private practice (you furnish services to patients outside the institution as well as to institutional patients); ○ You may perform diagnostic psychological and neuropsychological tests when a physician orders such tests; and 	<ul style="list-style-type: none"> • The following payment guidelines apply: <ul style="list-style-type: none"> ○ Diagnostic psychological and neuropsychological tests are not subject to assignment; however, you must include the name and address of the physician who ordered the tests on the claim form; and ○ Assigned payment is made to the IPP at 100% of the Medicare Physician Fee Schedule amount.

Required Qualifications	Coverage	Payment
	<ul style="list-style-type: none"> ○ You have the right to bill directly and collect and retain the fee for your services. 	

ASSIGNMENT

If a psychiatrist is a Medicare participating physician who chooses to accept assignment for his or her services, assigned payment must be accepted for all covered services for all Medicare patients. If a psychiatrist chooses not to participate under Medicare, he or she can choose to accept assignment on a case-by-case basis. However, if this nonparticipating physician does not choose to accept assignment, payment is made at 95 percent of the Medicare PFS amount.

The services of CPs, CSWs, CNSs, NPs, PAs, and CNMs are always subject to assignment. Accordingly, regardless of whether these non-physician practitioners (NPP) participate in the Medicare Program, payment for their services is always made under assignment.

IPPs who are authorized by Medicare to perform only diagnostic psychological and neuropsychological tests are not required to accept assigned payment for these tests. Therefore, payment for these tests is made to participating IPPs at 100 percent of the Medicare PFS amount and to nonparticipating IPPs at 95 percent of the Medicare PFS amount.

Assignment means the provider or supplier:

- Will be paid the Medicare-allowed amount as payment in full for his or her services; and
- May not bill or collect from the patient any amount other than unmet copayments, deductibles, and/or coinsurance.

All services provided to Medicare patients must be furnished by practitioners who, by virtue of their specific State licensure, certification, and training, are professionally qualified to provide medically necessary services.

OUTPATIENT PSYCHIATRIC HOSPITAL SERVICES

Outpatient psychiatric hospital services and supplies must be:

- Medically reasonable and necessary for the purpose of diagnostic study or be reasonably expected to improve the patient's condition (see the Same Day Billing Guidelines section on pages 21-22 for more information about medically reasonable and necessary services and supplies);
- Furnished under an individualized written plan of care (POC) that states:
 - The type, amount, frequency, and duration of services to be furnished;

- The diagnosis; and
- Anticipated goals (except when only a few brief services are furnished);
- Supervised and periodically evaluated by a physician who:
 - Prescribes the services;
 - Determines the extent to which treatment goals have been reached and whether changes in direction or emphasis are needed;
 - Provides supervision and direction to the therapists involved in the patient's treatment; and
 - Documents his or her involvement in the patient's medical record; and
- For the purpose of diagnostic study or, at a minimum, designed to reduce or control the patient's psychiatric symptoms to prevent a relapse or hospitalization **and** improve or maintain the patient's level of functioning.

In general, the following services may be covered for the treatment of outpatient hospital psychiatric patients:

- Medically necessary diagnostic services for the purpose of diagnosing individuals for which extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and formulate a POC;
- Individual and group psychotherapy with physicians, CPs, CSWs, or other EPs authorized or licensed by the State where the services are performed;
- Services of social workers, psychiatric nurses, and other staff trained to work with individuals with mental disorders;
- Occupational therapy services, as part of a PHP, that:
 - Require the skills of a qualified occupational therapist;
 - Are performed by or under the supervision of a qualified occupational therapist; and
 - Are included in the patient's POC;
- Activity therapies, as part of a PHP, that are:
 - Individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals; and
 - Clearly justified in the POC and state the need for each particular therapy utilized (may not be primarily recreational or diversionary);
- Family counseling services with members of the patient's household when the **primary** purpose is the treatment of the individual's condition;
- Patient training and education when they are closely and clearly related to the care and treatment of the individual's diagnosed mental disorder; and
- Drugs and biologicals that are furnished for therapeutic purposes and that cannot be self-administered.

In general, the following services are not covered for the treatment of outpatient hospital psychiatric patients:

- Meals and transportation;
- Activity therapies, group activities, or other services and programs that are primarily recreational or diversionary;
- Psychosocial programs (psychosocial components of an outpatient program that are not primarily for social or recreational purposes may be covered); and
- Vocational training related **solely** to specific employment opportunities.

Partial Hospitalization Program (PHP)

A PHP is furnished by a hospital to outpatients or by a Community Mental Health Center (CMHC) that provides partial hospitalization services. Partial hospitalization services are a distinct and organized intensive ambulatory psychiatric treatment program that offers less than 24-hour daily care to patients who either:

- Have been discharged from inpatient hospital treatment, and the PHP is in lieu of continued inpatient treatment; or
- Would be at reasonable risk of requiring inpatient hospitalization in the absence of partial hospitalization.

The following Program and patient criteria must be met:

- Active treatment is furnished that incorporates an individual POC with a coordination of services designed for the needs of the patient;
- Treatment includes a multidisciplinary team approach to care under the direction of a physician who certifies the patient's need for partial hospitalization and for a minimum of 20 hours per week of therapeutic services, as evidenced by the POC;
- Treatment goals should be:
 - Measurable;
 - Functional;
 - Time-framed;
 - Medically necessary; and
 - Directly related to the reason for admission;
- The patient requires comprehensive, highly structured and scheduled multimodal treatment that requires medical supervision and coordination under an individualized POC because of a mental disorder that severely interferes with multiple areas of daily life (social, vocational, activities of daily living (ADL)/instrumental ADLs, and/or educational functioning); and
- The patient is able to cognitively and emotionally participate in the active treatment process and is capable of tolerating the intensity of a PHP.

Community Mental Health Centers (CMHC)

A CMHC is an entity that provides partial hospitalization services under Part B of the Medicare Program. To be authorized to provide these services, a CMHC must:

- Meet applicable licensing or certification requirements for CMHCs in the State where it is located; and
- Provide:
 - Outpatient services including specialized outpatient services for children, older adults, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;
 - Twenty-four-hour emergency care services that provide access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record;
 - Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services that provide structured day programs with treatment plans that vary in intensity of services and frequency and duration of services based on the needs of the patient;
 - At least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Social Security Act; and
 - Screening for patients who are being considered for admission to a State mental health facility to determine the appropriateness of such admission by an entity that has the appropriate clinical personnel and authorization under State law to perform all steps in the clinical evaluation process, with the exception of those that must be provided by a 24-hour facility. A CMHC that operates in a State that by law precludes it from providing these services may provide for such services by contract with an approved organization or entity (as determined by the Secretary of the Department of Health and Human Services) that, among other things, meets applicable licensure or certification requirements for CMHCs in the State where it is located.

The following services are not covered under a PHP:

- Services to hospital inpatients;
- Meals, self-administered medications, and transportation; and
- Vocational training.

Outpatient Mental Health Treatment Limitation

Effective January 1, 2014, Medicare pays outpatient mental health services at the same rate as other Part B services (that is, at 80 percent of the Medicare PFS).

When the outpatient mental health treatment limitation (the limitation) was in effect, it generally applied to all covered mental health therapeutic services performed in an outpatient setting. The limitation also applied to mental, psychoneurotic, and personality

disorder services that physicians, CPs, CNSs, NPs, PAs, and CNMs furnish to treat partial hospitalization patients because these individuals' services are paid separately from the program of services under a PHP. Psychological and neuropsychological testing services performed to evaluate a patient's progress during treatment were also subject to the limitation.

The following services were not subject to the limitation:

- Medical management of Alzheimer's Disease and related disorders (billed under Current Procedural Terminology code 90862 or any successor codes);
- Brief office visits for monitoring or to change drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders (billed under Healthcare Common Procedure Coding System [HCPCS] code M0064 or any successor codes);
- Diagnostic psychiatric evaluations and psychological and neuropsychological tests performed to establish or confirm the individual's diagnosis;
- Partial hospitalization services that are not directly provided by a physician or a NPP; and
- Partial hospitalization services billed by a CMHC, hospital outpatient department, or Critical Access Hospital.

Prior to 2010, Medicare patients were required to pay a 50 percent copayment for outpatient psychiatric services that were subject to the limitation. With enactment of the Medicare Improvements for Patients and Providers Act of 2008, the amount of the patient's copayment for services subject to the limitation was reduced as shown in the chart below.

Outpatient Mental Health Treatment Limitation

Year	Patient Copayment
On January 1, 2010	45%
On January 1, 2012	40%
On January 1, 2013	35%
On January 1, 2014 (the final copayment reduction)	20%

Incident to Provision

A physician, CP, CNS, NP, PA, or CNM may have outpatient psychiatric services and supplies furnished incident to his or her professional service. To be covered and paid under the Incident to Provision, the services and supplies must be furnished in compliance with State law and all of the following requirements must be met:

- The services and supplies must be an integral part of the patient's normal course of treatment during which the physician or other listed NPP has personally performed an initial service and remains actively involved in the course of treatment;
- The services and supplies are commonly furnished without charge (included in the physician's or other listed NPP's bill);
- The services and supplies are an expense to the physician or other listed NPP;
- The services and supplies are commonly furnished in the physician's or other listed NPP's office or clinic; and
- The physician or other listed NPP provides direct supervision, which means he or she is present in the office suite and immediately available if needed.

Services and supplies furnished by CPs, CSWs, CNSs, NPs, PAs, and CNMs may also be covered when furnished as an incident to the professional services of a physician or other specified NPP if they would have been covered when furnished incident to the services of a MD or a DO.

INPATIENT PSYCHIATRIC HOSPITAL SERVICES

The following requirements must be met for Medicare to pay for inpatient psychiatric hospital services under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) :

- IPFs must furnish:
 - The patient active psychiatric treatment that can be reasonably expected to improve his or her condition;
 - Services while the patient is receiving either active psychiatric treatment or admission and related services necessary for diagnostic treatment; and
- A physician must provide:
 - Certification at the time of admission or as soon thereafter as is reasonable and practicable that the patient needs, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel;
 - The first re-certification as of the 12th day of hospitalization; and
 - Subsequent re-certifications at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days that the patient continues to need, on a daily basis, active inpatient treatment furnished directly by, or requiring the supervision of, IPF personnel.

Patients who are treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve and for 190 days of care in freestanding psychiatric hospitals.

Under the IPF PPS, Federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services and are determined based on:

- Geographic factors;
- Patient characteristics; and
- Facility characteristics.

Additional payments are provided for:

- Patients treated in IPFs that have a qualifying emergency department;
- The number of ECT treatments furnished; and
- Outlier payments for cases with extraordinarily high costs.

SAME DAY BILLING GUIDELINES

Integration of the services listed below is an approach to health care that can better address the needs of all individuals, including those with mental health and substance use disorder, regardless of whether a patient is receiving care in a traditional primary care setting or a specialty mental or substance use disorder health care setting:

- Mental health care services (which, under the Medicare Program, includes treatment for substance use disorder);
- Alcohol and/or substance (other than tobacco) abuse structured assessment, and intervention services (SBIRT services) billed under HCPCS codes G0396 and G0397; and
- Primary health care services.

Medicare Part B pays for reasonable and necessary integrated health care services when they are furnished on the same day, to the same patient, by the same professional or a different professional. This is regardless of whether the professionals are in the same or different locations.

The Eligible Professionals section on page 4 provides a list of the suppliers who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders as well as Medicare SBIRT services, to the extent permitted under State law.

In general, Medicare-covered services are those services considered medically reasonable and necessary to the overall diagnosis or treatment of the patient's condition or to improve the functioning of a malformed body member. Services or supplies are considered medically necessary if they meet the standards of good medical practice and are:

- Proper and needed for the diagnosis or treatment of the patient's medical condition;
- Furnished for the diagnosis, direct care, and treatment of the patient's medical condition; and
- Not mainly for the convenience of the patient, provider, or supplier.

Services must also meet specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations. For more information about the Medicare coverage determination process, visit <http://www.cms.gov/Medicare/Coverage/DeterminationProcess> on CMS website. For every service billed, you must indicate the specific sign, symptom, or patient complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without patient symptoms or complaints or specific documentation.

Medicare also pays for multiple mental health services furnished to the same patient on the same day. However, the Medicare Program prohibits inappropriate and/or duplicate payment for services furnished on the same day. In general, you should consult with your local Medicare Administrative Contractor (MAC) to determine if local or national policies may prevent you from billing for certain services on the same day. To find MAC contact information, refer to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> on the CMS website.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The NCCI was implemented to promote national correct coding methodologies and to provide national guidance on code pair edits that prevent certain services from being billed together on the same day. For more information about the NCCI, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd> and refer to the Medicare Learning Network® (MLN) publication titled "How to Use the National Correct Coding Initiative (NCCI) Tools" located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf> on the CMS website.

RESOURCES

The chart below provides mental health services resource information.

Mental Health Services Resources

For More Information About...	Resource
Mental Health and Screening, Brief Intervention, and Referral to Treatment Services	<p>Chapters 2, 6, and 15 of the “Medicare Benefit Policy Manual” (Publication 100-02) and Chapters 3 and 4 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website</p> <p>MLN publication titled “Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf on the CMS website</p> <p>MLN Matters Article® titled “Screening for Depression in Adults” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7637.pdf on the CMS website</p>
Inpatient Psychiatric Facility Prospective Payment System	<p>http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS on the CMS website</p> <p>MLN publication titled “Inpatient Psychiatric Facility Prospective Payment System” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/InpatientPsychFac.pdf on the CMS website</p>
Mental Health Services in Federally Qualified Health Centers and Rural Health Clinics	<p>Chapter 13 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf on the CMS website</p>
Compilation of Social Security Laws	<p>http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website</p>
All Available Medicare Learning Network® (MLN) Products	<p>“MLN Catalog” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website</p>

For More Information About...	Resource
Provider-Specific Medicare Information	MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	http://www.medicare.gov on the CMS website



This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a service to the public and is not intended to grant rights or impose obligations. This booklet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://go.cms.gov/MLNProducts> and in the left-hand menu click on the link called ‘MLN Opinion Page’ and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

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