

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2166	Date: February 25, 2011
	Change Request 7307

SUBJECT: Clarification to CR 6686 - Outpatient Mental Health Treatment Limitation

I. SUMMARY OF CHANGES: One sentence in this manual instruction has been amended to clarify a previous, inadvertent policy change. Accordingly, this CR is intended to clarify guidance to contractors about how to determine the ICD-9 diagnosis codes that are considered as Alzheimer’s related disorders.

EFFECTIVE DATE: March 25, 2011

IMPLEMENTATION DATE: March 25, 2011

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	12/210/210.1 D/Outpatient Mental Health Treatment Limitation

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):

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

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

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SUBJECT: Clarification to CR 6686 - Outpatient Mental Health Treatment Limitation

Effective Date: March 25, 2011

Implementation: March 25, 2011

I. GENERAL INFORMATION

We are amending one sentence under this manual instruction to clarify policy regarding application of the outpatient mental health treatment limitation (the limitation) to ICD-9 diagnosis codes for Alzheimer’s related disorders. This sentence was changed inadvertently in a prior manual update.

A. Background: This manual instruction was revised initially under CR #6686 (issued 10-3-09) to implement section 102 of the Medicare Improvements for Patients and Providers Act. The Medicare Improvements for Patients and Providers Act legislation authorized a reduction in the coinsurance percentage that Medicare patients are required to pay for certain outpatient mental health treatment services. In addition to including the changed coinsurance percentages for 2010-2014, changes were made to this instruction to clarify the diagnoses/services to which the limitation does and does not apply.

B. Policy: For claims reported with a primary diagnosis of an Alzheimer’s related disorder, contractors should look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Alzheimer’s related disorders are identified by contractors under ICD-9 codes that are within the 290-319 code range (290.XX or others as contractors determine appropriate) or outside the 290-319 code range as determined appropriate by contractors.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M A A C	F I I E R	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
7307.1	Contractors shall identify Alzheimer’s related disorders by ICD-9 codes that are within the 290-319 code range (290.XX or others as contractors determine appropriate) or outside the 290-319 code range as determined appropriate by contractors.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				F I S S	M C S	V M S	C W F	
7307.2	<p>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.</p> <p>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.</p>	X		X	X						

IV. SUPPORTING INFORMATION

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

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.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

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.

210 - Outpatient Mental Health Treatment Limitation

(Rev.2166, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

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.2166, Issued: 02-25-11, Effective: 03-25-11, Implementation: 03-25-11)

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 testing 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 *within the 290-319 code range (290.XX or others as contractors determine appropriate) or outside the 290-319 code range as determined appropriate by contractors*. When 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, typically, 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

Example #2: 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

Example #3: 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
- Beneficiary liability (line 2 minus line 6).....\$258.00