mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Medicare & Mental Health Coverage

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

What's Changed?

- You can provide caregiver training, depression screening, and tobacco use cessation counseling services through telehealth (pages 5, 6, and 8)
- Added coverage information for:
  - Digital mental health treatment (DMHT) devices (page 6)
  - Safety planning intervention (SPI) and post-discharge phone follow-up contacts intervention (FCI) to reduce the risk of suicide (pages 7 and 10)
  - Opioid treatment programs (OTPs), including Brixadi® and Opvee® (page 32)
- Updated in-person telehealth requirements for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (page 11)
- Updated coverage requirements for marriage and family therapists (MFTs) and mental health counselors (MHCs) (pages 23 and 24)
- We allow the physician or non-physician practitioner (NPP) written order or referral to substitute for the signature on the initial plan of care (POC) certification for certain therapies (page 28)
- Added to the HCPCS/CPT code table, including clarifying which are eligible for telehealth (pages 35 and 36)

Substantive content changes are in dark red.

Table of Contents

Medicare-covered behavioral health services, typically known as mental health and substance use services, can affect a patient's overall well-being. It's important to understand Medicare's covered services and who can provide them.

Medicare-Covered Mental Health Services

We may cover these behavioral health and wellness services:

- Alcohol misuse screening and counseling for adults who use alcohol but aren't dependent. If you detect misuse, we cover up to 4 brief, face-to-face counseling sessions per year if the patient is competent and alert during counseling.
- Alcohol treatment, behavior modification using chemical aversion therapy, detoxification, outpatient hospital treatment, and rehabilitative services, including inpatient hospital stays.
- Annual wellness visit (AWV) to develop or update a personalized prevention plan, including social determinants of health (SDOH) risk assessment and depression screening.
  - If you detect cognitive impairment at an AWV or other routine visit, you may perform a more detailed cognitive assessment and develop a care plan during a separate visit
  - The AWV can be a community health integration (CHI) or principal illness navigation (PIN) initiating visit
- Advance care planning to discuss a patient's health care wishes if they can't make decisions about their care, as part of the AWV or a separate Medicare Part B service, including an advance directive.
- Behavioral health integration (BHI) by clinical staff to assess, monitor, and plan care, as well as psychiatric collaborative care services using BHI along with a psychiatric consultant to enhance primary care services.
- Caregiver-focused behavioral health risk assessment of their own behavior and health risks, which benefits the patient.
- Caregiver training services when a physician, non-physician practitioner (NPP), or therapist provides them as part of the patient's individualized treatment plan or therapy plan of care. You can provide these through telehealth.

Anyone experiencing a mental health crisis, including a substance use crisis or thoughts of suicide, can get confidential support 24/7 by calling 988 or visiting 988lifeline.org. Visit the SAMHSA 988 Partner Toolkit for information and resources.

- CHI services to help patients who have unmet social needs that affect the diagnosis and treatment of their medical problems identify and connect with appropriate clinical and social support resources.
  - Practitioners may provide CHI services monthly, as medically necessary, following an initiating Evaluation and Management (E/M) visit (CHI initiating visit) when the practitioner identifies SDOH needs that significantly limit their ability to diagnose or treat the patient problems addressed in the visit
  - Community health workers, care navigators, peer support specialists, and other auxiliary personnel may be employed by community-based organizations if the billing practitioner provides the required supervision
- Cognitive assessment and care planning (CPT code 99483), a comprehensive evaluation of a new or existing patient who exhibits cognitive impairment signs and symptoms, required to establish or confirm a diagnosis, etiology, and condition severity.
- Chronic care management (CCM) and complex CCM for patients with multiple chronic conditions placing them at high risk, including chronic pain management for patients with chronic pain.
- Depression screening, up to 15 minutes annually, when staff-assisted depression care supports can assure accurate diagnosis, effective treatment, and follow-up.
  - At minimum, screening by clinical staff in a primary care setting who can advise the physician of results and coordinate treatment referrals
  - You can provide these through telehealth
- Digital mental health treatment (DMHT) devices provided “incident to” professional behavioral health services used along with ongoing treatment under a behavioral health treatment plan or therapy plan of care.
  - The billing practitioner must prescribe or order the DMHT device that’s been cleared under section 510(k) of the Food, Drug, and Cosmetics Act
  - The patient can use the DMHT device at home or in an outpatient setting, if that’s how FDA classified the device for use under 21 CFR 882.5801
- Electroconvulsive therapy (ECT), which involves passing small electric currents through the brain to intentionally trigger a seizure to treat major depressive disorder and other clinical conditions.
- Health and behavioral assessment and intervention that identifies or treats psychological, behavioral, emotional, cognitive, and social factors important to prevent, treat, or manage physical health issues.
- Hypnotherapy.
- Initial preventive physical exam to review medical and social health history and provide preventive services education, counseling, and referral, as appropriate.
- Intensive outpatient program (IOP) services.
- Medication for opioid use disorder (MOUD) management when a patient agrees to a medication trial period treatment option and its effectiveness is monitored.

- Medications for substance use disorders (SUDs), which includes medications for alcohol use disorder (MAUD) and MOUD when you use them with counseling and behavioral therapy to treat SUDs. We also pay for certain medications and services a certified opioid treatment program (OTP) provider uses to treat opioid use disorders (OUDs), including MOUD in the emergency department (ED) (see HCPCS code G2213).
- Narcosynthesis, used by a medical doctor (MD) or doctor of osteopathy (DO) only for administering sedative or tranquilizer drugs, usually intravenously, to relax the patient and remove inhibitions for discussion of subjects difficult for the patient to discuss freely in the fully conscious state.
- Partial Hospitalization Program (PHP), a structured, intensive, outpatient psychiatric services program, is an alternative to inpatient psychiatric care and provided during the day (doesn't require an overnight stay) through a hospital outpatient department or community mental health center (CMHC).
- OTPs provide medications and counselling for OUD, including methadone, buprenorphine, naltrexone, and nalmefene, for patients diagnosed with OUD. OTPs must be SAMHSA-certified and accredited by an independent, SAMHSA-approved accrediting body.
- PIN services, which help patients diagnosed with high-risk conditions (for example, mental health conditions, SUD, and cancer) identify and connect with appropriate clinical and social support resources. You can perform these after a psychiatric diagnostic evaluation or a health behavior assessment and intervention (HBAI), which can serve as the initiating visit.
- PIN-peer support services, which are like PIN services except they have more focus on services performed by peer support specialists under general supervision.
- Psychoanalysis that treats mental disorders by investigating the interaction of conscious and unconscious elements by people trained as psychoanalysts.
- Psychiatric evaluation to create a treatment plan based on a psychiatric disorder's causes, symptoms, course, and consequences.
- Psychological and neuropsychological testing.
- Psychotherapy.
  - Family psychotherapy with or without the patient present, as medically reasonable and necessary, with patient treatment as the primary purpose
  - Individual and group psychotherapy; individual therapy with 1 or more therapists or more than 1 person in a therapy session with 1 or more therapists
  - Interactive psychotherapy
  - Psychotherapy for crisis
- Safety planning intervention (SPI) and post-discharge phone follow-up contacts intervention (FCI).
- Screening, brief intervention, and referral to treatment (SBIRT) services are early interventions and treatment for people with SUDs, as well as those at risk of developing these disorders.

- SDOH risk assessment (see HCPCS code G0136). You may provide an SDOH risk assessment with an E/M visit, AWV (see MLN Matters® article MM13486), or behavioral health office visit, like psychiatric diagnostic evaluation and HBAI.
- SUD treatment, including for OUD, in:
  - An office setting for OUD management, counseling, and services (see HCPCS billing codes G2086, G2087, and G2088). It includes overall management, care coordination, and individual and group psychotherapy.
  - A patient's home (including an acceptable telehealth substance use treatment or a co-occurring mental health disorder service site).
- Telehealth, defined as 2-way, interactive, audio-video technology, to diagnose, evaluate, or treat certain mental health or SUDs if the patient is in their home. Practitioners must be able to provide 2-way, real-time, audio-video technology services but may use audio-only technology given an individual patient's technological limitations, abilities, or preferences. We cover telehealth for behavioral and mental health on a permanent basis.
- Therapeutic activities that can improve the patient's condition, like occupational therapy, recreational therapy, and milieu therapy.
- Tobacco use cessation counseling, 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year). You can provide these through telehealth.
- Transcranial magnetic stimulation for treating severe major depressive disorder.
- Transitional care management, within 30 days of an inpatient hospital setting discharge, interactive contact, certain non-face-to-face services, and face-to-face visits.

Patients can find more information in Roadmap to Behavioral Health to understand how to use their health coverage to improve their mental and physical health.

Non-Covered Mental Health Services

We don't cover these mental health services:

- 24-hour in-home care
- Adult day health programs, like structured therapeutic health services and supervised activities
- Biofeedback training
- Environmental intervention or modifications
- Experimental treatments, including hemodialysis specifically for treating schizophrenia
- Interpreting or explaining results or data
- Massage therapy
- Pastoral counseling
- Preparing reports
- Transportation to appointments or outpatient meals

Same Day Billing for Mental Health and Primary Care Services

Integrating mental health and SUD services addresses all patients' needs, whether they get care in a traditional primary care setting or a specialty mental or SUD health care setting. Services include:

- Primary health care services
- Mental health care services (including substance use treatment)
- Alcohol and substance use (other than tobacco) structured assessment and intervention services (SBIRT services) billed under HCPCS codes:

G2011	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention, 5–14 minutes	
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	
G0397	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	

Part B pays for reasonable and necessary integrated health care services provided on the same day, to the same patient, by the same or different professionals in the same or different locations.

The Eligible Professionals section lists Part B providers who may provide diagnostic and therapeutic mental, psychoneurotic, personality disorder, and SBIRT treatment services allowed under state law.

AUDIT: Alcohol Use Disorders Identification Test

DAST: Drug Abuse Screen Test

We cover medically reasonable and necessary services or supplies to treat the patient's overall diagnosis and condition or improve a malformed body part. Services must meet standards of good medical diagnosis, direct care, and patient medical treatment condition practice and must not be mainly for patient, provider, or supplier convenience.

Services must also meet specific National Coverage Determination and Local Coverage Determination medical necessity criteria.

Indicate the specific sign, symptom, or patient complaint for every service billed. Although a provider may consider a service or test good medical practice, we don't pay for services without patient symptoms, complaints, or specific documentation.

We also pay for multiple mental health services for the same patient on the same day. However, we don't pay for inappropriate or duplicate services on the same day. If you have questions about local or national policies that may prevent you from billing certain services, find your Medicare Administrative Contractor's website.

Substance Use Screenings & Treatment and SBIRT Services have more information on SUD services.

Safety Planning Intervention & Follow-Up Contacts Intervention

SPI involves a patient working with a clinician and developing a personalized list of coping and response strategies and sources of support. The patient can use this list if they experience thoughts of harming themselves or others. This isn't a suicide risk assessment, but an intervention for patients who you determine have an elevated risk for suicide, including risky substance use. You can use SPI to reduce the risk of overdose. The billing practitioner provides this service.

The basic components of a safety plan include:

- Recognizing warning signs of an impending suicidal crisis or actions that increase the risk of overdose
- Employing internal coping strategies
- Using social contacts and social settings as a means of distraction from suicidal thoughts or taking steps to reduce the risk of suicide
- Using family members, significant others, caregivers, and friends to help resolve the crisis
- Contacting mental health professionals, crisis services, or agencies
- Making the environment safe, including restricting access to lethal means, as applicable

Note: Use HCPCS code G0560.

FCI is specific for patients with suicide risk, including those who've experienced an overdose. It involves a series of phone contacts, up to 4 calls per calendar month, between a provider and patient in the weeks and sometimes months following any instance in which the patient has been discharged after a crisis encounter. This includes discharge from an ED or psychiatric inpatient care, or crisis stabilization.

These calls happen when the person is in the community, and they're designed to reduce the risk of subsequent adverse outcomes. FCI calls are typically 10–20 minutes and encourage use of the safety plan (as needed in a crisis) and updating it to optimize effectiveness, express psychosocial support, and encourage follow-up care and services.

Bill this service once per month, covering up to 4 calls. Because Part B cost-sharing applies, we require verbal or written patient consent; we allow consent during the first call when consent isn't obtained in advance. You may bill FCI incident to the services of the billing practitioner.

Note: Use HCPCS code G0544.

Prescription Drug Coverage

Medicare Part A and Part B generally don't cover prescription drugs. However, Part B covers certain medications that patients can't self-administer, like drugs that must be given by a health care provider. For broader prescription drug coverage, patients must enroll in Medicare drug plans (Part D).

Part D must cover certain protected drug classes, including antipsychotics, antidepressants, and anticonvulsants. Drug plans must cover most medications in these drug classes, with some exceptions.

Medicare Advantage Organizations

Medicare Advantage (MA) enrollees can get Part A, Part B, and Part D benefits under a single plan. MA plans provide Part B-covered mental health services and may offer certain benefits beyond what Part B pays (for example, telehealth services). They may also provide supplemental benefits that Parts A or B don't cover. For example, supplemental mental health benefits may address coping with life changes, conflict resolution, or grief counseling.

Telehealth

Starting October 1, 2025, in-person visit requirements will apply for mental health services provided by telehealth. This includes a required in-person visit within the 6 months before the initial telehealth treatment, as well as the required subsequent in-person visits at least every 12 months.

Telehealth also applies to mental health services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). For RHCs and FQHCs, we don't require the in-person visit for mental health services provided through telehealth to patients in their homes until January 1, 2026.

We'll continue to allow direct supervision to permit the immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.

The regulations at 42 CFR 410.78(b)(3)(xiv) describe 2 exceptions to the in-person requirements effective October 1, 2025:

- Patients who already get telehealth behavioral health services and have circumstances where in-person care may not be appropriate
- Groups with limited availability for in-person behavioral health visits have the flexibility to arrange for practitioners to provide in-person and telehealth visits with different practitioners, based on availability

Exceptions to the in-person visit requirement require a clear justification documented in the patient's medical record. Hospitals must also document that patients have a regular source of general medical care and can get any needed point-of-care testing, including vital sign monitoring and lab studies.

We created 3 Outpatient Prospective Payment System (OPPS)-specific HCPCS codes to describe that the patient must be in their home and that no associated professional service is billed under the Physician Fee Schedule (PFS). Hospital staff must be licensed to provide these services consistent with all applicable state scope of practice laws. We exempt these services from having staff physically located in the hospital or outpatient department when providing services remotely using communication technology.

Table 1. Telehealth HCPCS Codes

Description	HCPCS Code
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 15–29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	C7900
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 30–60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	C7901
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service (List separately in addition to code for primary service)	C7902

You can find more telehealth codes under Commonly Used HCPCS/CPT Codes with the * indicator. Telehealth & Remote Patient Monitoring has more information.

Eligible Professionals

The sections below list the required qualifications, coverage requirements, and the PFS payment amount that physicians and these practitioners are eligible to bill and be paid under Part B:

- Physicians (MDs and DOs), particularly psychiatrists
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Independently practicing psychologists
- Certified registered nurse anesthetists (CRNAs) (supervision of diagnostic psychological and neuropsychological tests)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs), including certified alcohol and drug counselors

Provider Information

These sections list individual provider-type required qualifications, coverage, and payment criteria. Each provider type must meet all qualifications and coverage requirements. See the Commonly Used HCPCS/CPT Codes section for specific billing codes.

Physician

Required Qualifications

- MD or DO
- Legally authorized to practice medicine in the state where you provide services
- Act within the scope of your license

Coverage Requirements

- We don't statutorily preclude the services, and they're reasonable and necessary
- Generally, in addition to performing tests, you may also supervise the performance of diagnostic psychological and neuropsychological tests
- You may have services and supplies provided incident to your personal professional services

Payment

Paid at 100% under the PFS

Clinical Psychologist

Required Qualifications

- Psychology doctoral degree
- Licensed or certified in the state where you practice at the independent level and directly provide diagnostic, assessment, preventive, and therapeutic patient services

Coverage Requirements

- Legally authorized to practice psychology in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- If the patient consents, attempt to consult their attending or primary care physician about provided services and either:
  - Document the date the patient consented or declined the consultation and the consultation dates in the patient's medical record
  - Document in the patient's medical record if consultations are unsuccessful with the date and the physician notification method (doesn't apply if the physician referred the patient to a CP)
- Generally, in addition to personally performing diagnostic psychological and neuropsychological tests, you may supervise the performance of those tests
- You may have services and supplies provided incident to your personal professional services

Payment

- We pay only on assignment
- Paid at 100% of assigned services under the PFS

Clinical Social Worker

Required Qualifications

- Social work master's or doctoral degree
- At least 2 years of supervised clinical social work
- Licensed or certified in the state where you provide services
- If you practice in a state that doesn't have licensure or certification, you completed at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in social work practice in an appropriate setting (for example, a hospital, skilled nursing facility (SNF), or clinic)

Coverage Requirements

- Legally authorized to practice clinical social work in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- You provide mental health services for diagnosing and treating a mental illness and you're legally authorized to perform them under state law
- We cover CSW hospital outpatient services and pay for CSW services under the CSW benefit category when hospitals bill under the CSW's NPI
- We don't pay you under the CSW benefit category for your:
  - Hospital inpatient services
  - Services to patients under a PHP or an IOP by a hospital outpatient department or CMHC
  - Services to SNF inpatients and patients in Medicare-participating ESRD facilities if the services are under the respective provider's participation requirements
- We may cover ancillary CSW services when provided as auxiliary personnel incident to the personal professional services of a physician, CP, CNS, NP, PA, or CNM
- We don't cover services provided incident to your personal professional services

Payment

- We pay only on assignment
- Paid at 80% of the lesser of the actual charge for the service or 75% of the CP's PFS

Clinical Nurse Specialist

Required Qualifications

- Be a registered nurse (RN) currently licensed in the state where you practice and authorized to provide CNS services according to state law
- Doctor of Nursing Practice or master's degree in a defined clinical nursing area from an accredited educational institution
- Certified as a CNS by a recognized national certifying body with established CNS standards

Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services while working in collaboration with a physician
- We may cover assistant-at-surgery services you provide
- You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under the CNS benefit
- We authorize you to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

Payment

- We pay only on assignment.
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under 42 CFR 424.55. If a patient paid for a service over these limits, refund their payment.
- We pay for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the PFS.
- We pay for assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the PFS.

Nurse Practitioner

Required Qualifications

- Be an RN licensed and authorized by the state where you provide NP services according to state law
- Be a registered professional nurse who's authorized by the state where you provide services to practice as an NP by December 31, 2000
- Got Medicare NP billing privileges for the first time since January 1, 2003, and:
  - Are NP-certified by a recognized national certifying body with established NP standards
  - Have a master's degree in nursing or a Doctor of Nursing Practice doctoral degree
- Got Medicare NP billing privileges for the first time before January 1, 2003, and meet certification requirements
- Got Medicare NP billing privileges for the first time before January 1, 2001

Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services while working in collaboration with a physician
- We may cover assistant-at-surgery services you provide
- You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under the NP benefit
- We authorize you to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

Payment

- We pay only on assignment.
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under 42 CFR 424.55. If a patient paid for a service over these limits, refund their payment.
- We pay for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the PFS.
- We pay for assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the PFS.

Physician Assistant

Required Qualifications

Licensed by the state where you practice and 1 of these criteria apply:

- Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation)
- Passed a national certification exam administered by the National Commission on Certification of Physician Assistants

Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if provided by an MD or a DO
- Someone who meets all PA qualifications provides the services
- You provide services under a physician's supervision
- We may cover assistant-at-surgery services you provide
- You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under the PA benefit category and as authorized by state law
- We authorize you to supervise the performance of diagnostic tests according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

Payment

- We pay only on assignment.
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under 42 CFR 424.55. If a patient paid for a service over these limits, refund their payment.
- We pay for:
  - Professional services, including services and supplies provided incident to your services
  - Professional services provided in all rural and non-rural settings and areas
  - Services at 80% of the lesser of the actual charge or at 85% of the amount a physician gets under the PFS
  - Assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the PFS
  - Services provided incident to a PA outside a hospital at 85% of the amount a physician gets under the PFS
- We pay only if no facility or other provider charges or we didn't pay any other service amount they provided.
- When you bill a hospital inpatient and outpatient service directly, we unbundle the payment and pay you directly.
- You can bill Medicare, and we pay for your services directly like we do NPs and CNSs.
- You may reassign your service payment rights and incorporate as a group of practitioners only in your specialty and bill Medicare like NPs and CNSs.
- Bill under your NPI.

Certified Nurse-Midwife

Required Qualifications

- RN legally authorized to practice as a nurse-midwife in the state where you provide services
- Successfully completed a nurse-midwives program of study and got clinical experience accredited by an accrediting body the U.S. Department of Education approves
- Certified as a Nurse-Midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council

Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- We consider the services physicians' services if they're provided by an MD or a DO
- You provide the services without physician supervision and without association with a physician or other health care provider, unless otherwise required under state law
- You may personally perform diagnostic psychological and neuropsychological tests without physician supervision or oversight as required under the CNM benefit category and as authorized under state law
- We authorize you to supervise diagnostic tests performed according to state law and scope of practice
- You may have services and supplies provided incident to your personal professional services

Payment

- We pay only on assignment.
- If you provide services on assignment, you can't charge a patient more than the amounts permitted under 42 CFR 424.55. If a patient paid for a service over these limits, refund their payment.
- We pay for services at 80% of the lesser of the actual charge, or 100% of the amount a physician gets under the PFS.

Independently Practicing Psychologist

Required Qualifications

- Psychologist who isn't a CP
- Meets 1 of these criteria:
  - Practices independent of an institution, agency, or physician's office and is licensed or certified to practice psychology in the state or jurisdiction where you provide the services
  - Practicing psychologist who provides services in a jurisdiction that doesn't issue licenses

Coverage Requirements

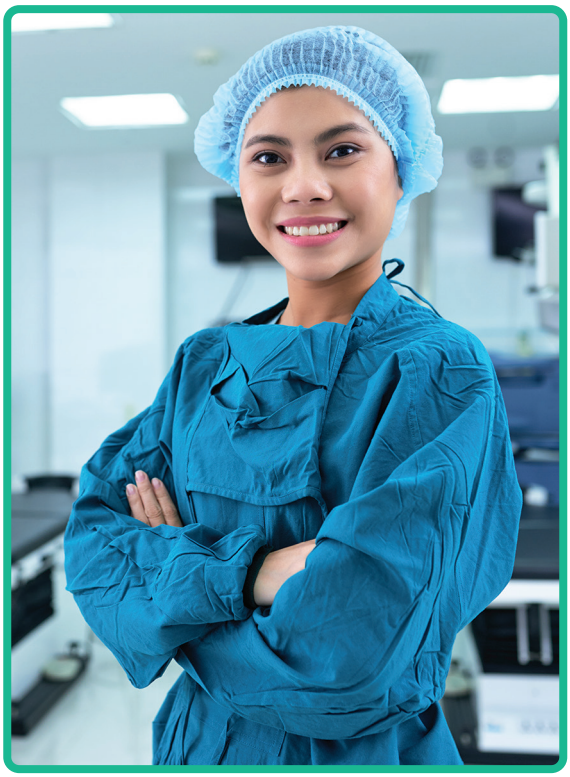
- We don't statutorily preclude the services, and they're reasonable and necessary
- Provide services on your own responsibility, free of administrative and professional control of an employer (for example, physician, institution, or agency)
- You treat your own patients
- When you practice in an office in an institution:
  - The office is confined to a separately identified part of the facility used solely as an office and not confused as extending throughout the entire institution
  - You operate a private practice (patients outside an institution and non-institutional patients)
- You may perform diagnostic psychological and neuropsychological tests when a physician or certain NPPs order them
- You can bill directly and collect and retain service fees

Payment

- We don't subject diagnostic psychological and neuropsychological tests to assignment; however, on the claim, include the name and address of the physician or NPP who orders the tests
- Paid at 100% under the PFS for diagnostic tests

Certified Registered Nurse Anesthetist

Required Qualifications



- Licensed as a registered professional nurse by the state where you practice
- Meet any licensure requirements the state imposes on non-physician anesthetists
- Graduated from a nurse anesthesia educational program that meets standards of the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) or other accreditation organization the HHS Secretary designates
- Passed a National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA) certification exam
- Graduated from a nurse anesthesia educational program that meets the COA Educational Program's standards and, within 24 months of graduation, passed a certification exam from NBCRNA or another certification organization the HHS Secretary designates

Coverage Requirements

- Legally authorized to practice medicine in the state where you provide services
- We don't statutorily preclude the services, and they're reasonable and necessary
- You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under the CRNA benefit category and as authorized by state law
- We authorize you to supervise the performance of diagnostic tests according to state law and scope of practice
- You can bill directly and collect and retain service fees

Payment

- Paid at 100% under the PFS as determined by the level of required supervision
- You may bill your services directly to Medicare and get paid directly, or have payment made to any person or entity (for example, hospital, critical access hospital, physician, group practice, or ambulatory surgical center) if you have an employment or contractor relationship that's paying you or them

Marriage & Family Therapist

Required Qualifications

- Master's or doctor's degree that qualifies for licensure or certification as an MFT according to the state law where you provide services
- Licensed or certified as an MFT in the state where you provide services
- After getting your degree, you complete at least 2 years or 3,000 hours of post-master's degree clinical supervised experience in marriage and family therapy in an appropriate setting (for example, a hospital, SNF, or clinic)

Coverage Requirements

- Legally authorized to practice as an MFT in the state where you provide services
- You may enroll in Medicare and bill Medicare independently starting January 1, 2024
- We may cover ancillary MFT services when provided as auxiliary personnel incident to the personal professional services of a physician, CP, CNS, NP, PA, or CNM
- We don't cover services provided incident to your personal professional services
- You can provide MFT services through an acceptable telehealth mental health disorder service site

Payment

- We pay only on assignment.
- We pay for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the PFS.
- We don't pay under the MFT benefit category for MFT services to patients under a PHP or an IOP by a hospital outpatient department or CMHC.
- We exclude MFT services provided to SNF residents from consolidated billing. Include the SNF's Medicare provider number when you bill for these Part B services.

Mental Health Counselor

Required Qualifications

- Master's or doctor's degree that qualifies for licensure or certification as an MHC according to the state law where you provide MHC services
- Licensed or certified in the state where you provide services as 1 of these:
  - An MHC
  - A clinical professional counselor
  - An addiction, alcohol, or drug counselor
  - A professional counselor in the state where you provide services
- After getting your degree, you complete at least 2 years or 3,000 hours of clinical supervised experience in mental health counseling

Coverage Requirements

- Legally authorized to practice as an MHC in the state where you provide services
- You may enroll in Medicare and bill Medicare independently starting January 1, 2024
- We may cover ancillary MHC services when provided as auxiliary personnel incident to the personal professional services of a physician, CP, CNS, NP, PA, or CNM
- We don't cover services provided incident to your personal professional services
- You can provide MHC services through an acceptable telehealth mental health disorder service site
- Addiction counselors or alcohol and drug counselors who meet the applicable MHC requirements can enroll in Medicare as MHCs

Payment

- We pay only on assignment.
- We pay for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the PFS.
- We don't pay under the MHC benefit category for MHC services to patients under a PHP or an IOP by a hospital outpatient department or CMHC.
- We exclude MHC services provided to SNF residents from consolidated billing. Include the SNF's Medicare provider number when you bill for these Part B services.

Incident to Provision

Physicians and certain NPPs have a provision under their benefit category that authorizes them to have ancillary services and supplies provided by auxiliary personnel "incident to" their own personal professional services.

Physicians and specifically CPs, NPs, CNSs, CNMs, and PAs can bill and be paid for these integral, although incidental, services and supplies provided by auxiliary personnel as if they provided the services themselves if all the incident to requirements are met:

- Services and supplies are integral to the patient's normal treatment course, and the physician or other listed NPP personally provided an initial service to which the auxiliary personnel's services are incidental. The physician or NPP must remain actively involved in treating the patient.
- The auxiliary personnel provide services and supplies without charge (included in the physician's or other listed NPP's bill).
- Services and supplies are an expense to the physician or other listed NPP.
- Services and supplies are commonly offered in the physician's or other listed NPP's office or clinic.
- The physician or other listed NPP provides direct supervision and is available if needed.

Note: Under the PFS, we don't pay physicians or NPPs for incident to services in an institutional setting (hospital or SNF).

We offer an exception to the direct supervision requirement for incident to behavioral health services provided by auxiliary personnel. In other words, incident to behavioral health services can be provided under the general supervision of a physician or an NPP instead of direct supervision. Under general supervision, the physician or NPP may be contacted by phone, if necessary, as the physician's or NPP's presence isn't required during a procedure.

We don't define behavioral health services by HCPCS codes; however, we generally understand a behavioral health service to be any service provided for the diagnosis, evaluation, or treatment of a mental health disorder, including SUD.

Physicians, NPPs, and practitioners can also serve as auxiliary personnel and provide services and supplies incident to the personal professional services of another physician or NPP. Appropriate payment can be made to the other supervising physician, or NPP in this case, if you meet all the incident to requirements.

42 CFR 410.26 and 42 CFR 410.27 have more information.

Outpatient Psychiatric Hospital Services

There's a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs and from intensive treatment programs to those that provide primarily supportive services.

Outpatient psychiatric hospital services and supplies are:

- Medically necessary for diagnostic study or if the patient's condition is reasonably expected to improve (see the Same Day Billing for Mental Health and Primary Care Services section for more information)
- Provided under an individualized, written plan of care (POC)* that states the:
  - Type, amount, frequency, and duration of services
  - Diagnosis
  - Expected goals
- Supervised and periodically evaluated by a physician who:
  - Prescribes the services
  - Determines the extent the patient reached treatment goals and if the POC should change
  - Provides supervision and direction to therapists treating the patient
  - Documents their involvement in the patient's medical record
- For diagnostic study or, at a minimum, designed to reduce or control a patient's psychiatric symptoms to prevent a relapse or hospitalization and improve or maintain their level of functioning

* We don't require a POC when you provide only a few brief services.

Covered Outpatient Services

Generally, we cover these outpatient hospital psychiatric treatment services, which may include a PHP and IOP:

- Medically necessary diagnostic services for patients when extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and prepare a POC
- Individual and group psychotherapy with physicians, CPs, CSWs, or other eligible providers authorized or licensed by the state where they provide services (for example, MFTs and certified alcohol and drug counselors)

- Occupational therapy services, when part of a PHP or an IOP, that:
  - Require qualified occupational therapist skills
  - Are provided by, or under supervision of, a qualified occupational therapist
  - Are included in a patient's POC
    - Starting January 1, 2025, the physician's or NPP's signature on the order or referral counts as a signature on the POC if that physician or NPP hasn't signed and returned the patient's POC to the occupational therapist within 30 days of the initial evaluation.
    - This applies only when the patient's physician or NPP signs and dates the written order or referral and indicates the type of therapy needed. Include that written order or referral in the patient's medical record.
- Activity therapies, when part of a PHP or an IOP, that:
  - Are individualized and essential for treating a patient's diagnosed condition and progressing toward treatment goals
  - Have a POC that clearly supports and shows each therapy's need (not primarily recreational or diversionary)
- Family counseling services while treating a person's condition, including counseling services for caregivers
- Patient training and education when they're closely and clearly related to care and treating a person's diagnosed psychiatric condition; these include caregiver training services provided for the benefit of the patient
- Therapeutic drugs and biologicals a patient can't self-administer

Non-Covered Outpatient Services

Generally, we don't cover these outpatient hospital services, which may include PHP and IOP:

- Meals and transportation
- Activity therapies, group activities, or other primarily recreational or diversionary services and programs
- Outpatient psychosocial programs (we cover outpatient psychosocial components not primarily for social or recreational purposes)
- Vocational training related only to specific employment opportunities

Partial Hospitalization Program

PHPs are distinct and structured programs that provide intensive outpatient psychiatric care, including SUD services, through active treatment by combining clinically recognized items and services. We cover PHP in hospital outpatient departments and CMHCs.

PHPs offer psychiatric treatment less than 24 hours a day to patients:

- Discharged from an inpatient hospital treatment program and a PHP replaces continued inpatient treatment
- At reasonable inpatient hospitalization risk without partial hospitalization

PHPs must meet these program and patient criteria:

- Active treatment includes an individual POC with coordinated services designed for the patient's needs
- The POC treatment includes a physician-directed multi-disciplinary team care approach certifying the patient's need for partial hospitalization therapeutic services a minimum of 20 hours per week, and this determination must occur no less frequently than monthly
- Treatment goals should be:
  - Measurable
  - Functional
  - Time framed
  - Medically necessary
  - Directly related to the admission reason
- The patient requires a comprehensive, highly structured, scheduled, and multi-modal individualized POC requiring medical supervision and coordination because their mental disorder or SUD severely interferes with multiple areas of daily life (social, vocational, activities of daily living (ADLs) or instrumental ADLs, and educational functioning)
- The patient can cognitively and emotionally participate in the active treatment process and tolerate its intensity

Patients may pay a percentage of each doctor's or other qualified mental health professional's approved service amount if they accept assignment. Patients may also pay each day's PHP services coinsurance in a hospital outpatient setting or CMHC.

Intensive Outpatient Program

Intensive outpatient services are provided under an IOP.

Outpatients may get IOP services from their hospital, or through a critical access hospital (CAH), a CMHC, an FQHC, an RHC, or an OTP as a distinct and organized intensive ambulatory treatment service, offering less than 24-hour daily care, in a location other than a person's home or inpatient or residential setting.

Physicians prescribe an IOP for a person determined (not less frequently than once every other month) to need these services for a minimum of 9 hours per week. They're provided under the physician's supervision pursuant to an individualized, written treatment plan or therapy plan of care established and periodically reviewed by the physician (in consultation with appropriate staff participating in such a program). This determines the physician's diagnosis, and the type, amount, frequency, and duration of the items and services provided under the plan and the treatment goals.

Intensive outpatient services include:

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law)
- Occupational therapy requiring the skills of a qualified occupational therapist
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
- Drugs and biologicals provided for therapeutic purposes (which can't be self-administered)
- Individualized activity therapies that aren't primarily recreational or diversionary
- Family counseling (for the primary purpose of treating the person's condition)
- Patient training and education (to the extent that training and educational activities are closely and clearly related to the person's care and treatment)
- Diagnostic services
- Other items and services (excluding meals and transportation) that:
  - Are reasonable and necessary for diagnosing or actively treating the person's condition
  - Can be reasonably expected to improve or maintain the person's condition and functional level
  - Help prevent relapse or hospitalization

When a hospital provides non-intensive outpatient program mental health services to an IOP patient, all intensive outpatient services and non-intensive outpatient mental health services should be reported on the same hospital claim with condition code 92.

Intensive outpatient services must include a physician certification and POC. However, although PHP requires the physician to certify that the services are in place of inpatient hospitalization, IOP services aren't intended for those who otherwise need an inpatient level of care.

In addition to physicians, the following NPPs may perform the required certification and POC requirements for IOP services provided in the OTP setting:

- NPs
- PAs
- CPs
- CSWs
- MHCs
- MFTs
- Any other NPPs defined in section 1842(b)(18)(C) of the Social Security Act, as permitted by state law and consistent with scope of practice requirements

For IOP services, non-excepted off-campus provider-based departments of a hospital are required to report modifier PN on each claim line for non-excepted items and services. Excepted off-campus provider-based departments of a hospital must continue to report modifier PO for all excepted items and services provided.

When a hospital provides non-intensive outpatient program mental health services to an IOP patient, all intensive outpatient services and non-intensive outpatient mental health services should be reported on the same hospital claim with condition code 92 in form locators 18–28 to indicate the claim is for IOP services.

Note: Certain IOP services aren't payable as RHC or FQHC services. For example, group therapy is considered an IOP service and payable via the IOP payment amount but wouldn't be paid if billed as an RHC or FQHC service.

Community Mental Health Centers

We cover Part B partial hospitalization services that CMHCs provide, subject to the OPPS. Medicare-authorized CMHCs must meet these program and patient criteria:

- Have appropriate state and local CMHC licensing or certification
- Provide:
  - Outpatient services, including specialized services for children, older adults, chronically mentally ill patients, and residents of its service area discharged from an inpatient mental health treatment facility
  - 24-hour emergency care services with clinician access and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record
  - Day treatment, partial hospitalization services, intensive outpatient services, or psychosocial rehabilitation services with structured daily treatment plans varying in intensity, frequency, and duration based on the patient's needs
  - At least 40% of its services to patients who are ineligible for Social Security Act, Title XVIII benefits
  - Clinically evaluated state mental health facility candidate admissions by clinical personnel and authorized under state law, except those provided by a 24-hour facility; a CMHC operating in a state that, by law, prevents it from providing these services may contract with an entity the HHS Secretary approves

A CMHC is an originating telehealth services site.

Behavioral Health Integration Services

Integrating behavioral health and primary care helps improve patient mental and behavioral health condition outcomes. We separately pay physicians and NPPs providing BHI services over a calendar month.

CPs, CSWs, MFTs, and MHCs can bill the general BHI HCPCS code G0323 when they're personally performing services to account for monthly care integration, and those services are the focal point of care integration. We allow general supervision for G0323.

Behavioral Health Integration Services has more information.

Opioid Treatment Programs

We now pay certified Opioid Treatment Programs (OTPs) through bundled opioid use disorder (OUD) Part B treatment services payments based on weekly episodes of care. We cover treatment for OUD for as long as reasonable and necessary.

Covered services include:

- FDA-approved opioid agonist and antagonist MOUD:
  - Methadone, including initiating treatment with methadone provided through 2-way interactive audio-video technology
  - Buprenorphine, including extended-release buprenorphine injection (under the brand name Brixadi®)
  - Naltrexone
  - Nalmefene hydrochloride nasal spray (under the brand name Opvee®)
- Dispensing and administering MOUD, if applicable
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities and periodic assessments, including SDOH risk assessment
- Take-home supplies of methadone, oral buprenorphine, naloxone, and nalmefene
- Intensive outpatient program services
- Coordinated care and referral services
- Patient navigational services
- Peer recovery support services

Opioid Treatment Program Directory and OTPs Billing & Payment have more information, including HCPCS codes and billing for OTPs.

Audio-Video Telehealth

You can provide these services through 2-way audio-video interaction:

- Substance use counseling and individual and group therapy services included in the bundled payment
- The add-on code for additional counseling and therapy
- Intake activities and periodic assessments
- Initiation of treatment with buprenorphine

Note: You can also provide these services through **audio-only** interaction (for example, phone calls) when audio-video communication isn't available to the patient. This includes circumstances where the patient isn't capable of, or doesn't consent to, using devices that permit a 2-way audio-video interaction, provided the OTP meets all other applicable requirements.

HCPCS Code G2076

OTPs can use the intake add-on HCPCS billing code G2076 when they start methadone treatment with audio-only devices. We allow this if the patient is with a licensed practitioner who can prescribe and dispense controlled medications and if audio-video technology isn't available or practical. This licensed practitioner must be in the same room as the patient to do the visual part of the exam.

Inpatient Psychiatric Facility Services

Inpatient psychiatric facilities (IPFs) include freestanding, certified psychiatric hospitals, and psychiatric units in acute care hospitals or CAHs, providing routine hospital and psychiatric services to diagnose and treat patients' mental disorders.

We pay for inpatient psychiatric services under the IPF Prospective Payment System (PPS) when the facility is certified and meets inpatient psychiatric hospital services regulations.

We require updated hospital inpatient rights and discharge planning conditions of participation for these hospital types:

- Short-term acute care
- Rehabilitation
- Psychiatric
- Children's
- Cancer
- CAHs

42 CFR 482.43 outlines current discharge planning conditions of participation requirements.

IPF Medical Records Requirements

IPF medical records must show the physician or NPP treatment level and intensity for each patient they admit to the hospital, among other requirements detailed at 42 CFR 482.61.

Patients must be able to access their medical records when requested verbally or in writing, and the hospital must quickly meet the patient's request, detailed at 42 CFR 482.13.

Inpatient Hospital Services

When a physician admits a patient to the hospital for inpatient psychiatric facility services, we cover the services only if the patient needs intensive, appropriate, and active treatment in this type of setting. The psychiatric facility must be a general hospital with a distinct psychiatric unit or a psychiatric hospital that cares only for people with mental health conditions.

We certify IPFs and distinct psychiatric units in acute care hospitals and CAHs.

We cover:

- Semi-private rooms
- Meals
- General nursing
- Drugs (including methadone to treat OUD)
- Other inpatient hospital treatment services and supplies

Deductible and coinsurance apply. See the IPF Coverage Period section below for more information.

If appropriate, physicians can admit patients to a general acute care hospital that doesn't have a distinct psychiatric unit to get mental health and SUD services. These inpatient services are covered like other inpatient services in a general acute care hospital.

IPF Coverage Period

We cover IPF patient services in specialty facilities for 90 days per illness with a 60-day lifetime reserve and 190 days of care in freestanding psychiatric hospitals (this 190-day limit doesn't apply to certified psychiatric units).

The patient gets no more benefits after using 190 days of psychiatric hospital care.

Under the IPF PPS, federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services). We determine them by:

- Geographic factors
- Patient characteristics
- Facility characteristics

IPFs get additional payments for:

- Patients treated in IPFs with a qualifying ED
- The number of ECT treatments provided
- Outlier cases (cases with extraordinarily high costs)

Medicare Benefit Policy Manual, Chapter 2 has more information on how we cover IPFs.

Commonly Used HCPCS/CPT Codes

Using the correct HCPCS or CPT code to show the mental health services you provide to patients is essential for billing correctly.

Note: Only certain codes are billable as part of a PHP or an IOP. View the Medicare Claims Processing Manual, Chapter 4, sections 260 and 261 for more information.

Table 2. Commonly Used Mental Health-Related HCPCS/CPT Codes

Code Category	HCPCS/CPT Code
Cognitive assessment and care planning*	99483
Interactive complexity*	90785
Psychiatric diagnostic evaluation*	90791, 90792
Psychotherapy with patient*	90832, 90833, 90834, 90836, 90837, 90838
Psychotherapy for crisis* †	90839, 90840
Psychotherapy for crisis in an applicable site of service†	G0017, G0018
Psychoanalysis*	90845
Family psychotherapy*	90846, 90847
Multiple-family group psychotherapy	90849
Group psychotherapy (other than of a multiple-family group)*	90853
Electroconvulsive therapy (ECT)	90870
Hypnotherapy	90880
Preparation of report of patient's psychiatric status, history, treatment, or progress	90889
Neurobehavioral status exam*	96116, 96121
Psychological testing evaluation services*	96130, 96131
Neuropsychological testing evaluation services*	96132, 96133
Psychological or neuropsychological test administration*	96136, 96137, 96138, 96139
Psychological or neuropsychological test administration, with automated results	96146
Health behavior assessment or re-assessment* †	96156
Health behavior intervention* †	96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171

Table 2. Commonly Used Mental Health-Related HCPCS/CPT Codes (cont.)

Code Category	HCPCS/CPT Code
Administration of caregiver-focused health risk assessment instrument*	96161
Multiple-family group behavior management/modification training*	96202, 96203
Behavior identification assessment*	97151
Behavior identification-supporting assessment*	97152
Adaptive behavior treatment by protocol*	97153, 97154
Adaptive behavior treatment with protocol modification*	97155, 97158
Adaptive behavior treatment guidance*	97156, 97157
Caregiver training*	97550, 97551, 97552, G0539, G0540, G0541, G0542, G0543
Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month	G0544
Interprofessional telephone/internet/electronic health record assessment and management service	G0546, G0547, G0548, G0549, G0550
Interprofessional telephone/internet/electronic health record referral services	G0551
Supply of digital mental health treatment device and initial education and onboarding	G0552
Monthly treatment management of patient's therapeutic use of digital mental health treatment (DMHT) device	G0553, G0554
Assessment of SDOH* †	G0136
Safety planning interventions* †	G0560
Initiation of medication for the treatment of opioid use disorder in the emergency department setting	G2213

* Current telehealth codes.

† CPs, CSWs, MFTs, and MHCs can bill these codes.

HCPCS code G0136 can also be provided with CPT code 90791 (Psychiatric diagnostic evaluation) and the HBAI services, described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168. We allow the HBAI services described by the above CPT codes, and any successor codes, to be billed by CPs, CSWs, MFTs, and MHCs.

National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) promotes national correct coding methods and offers national guidance on code pair edits preventing billing certain services on the same day for the same patient.

Resources

- CMS Behavioral Health Strategy
- CMS Opioid Treatment Programs
- Medicare Benefit Policy Manual, Chapters 2, 6, and 15
- Medicare Claims Processing Manual, Chapters 3 and 4
- Notices and Forms
- Quality Improvement Organizations
- SAMHSA: What is Mental Health?