mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Medicare & Mental Health Coverage

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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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.

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

Medicare-Covered 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, detoxification, outpatient hospital treatment, and rehabilitative services, including inpatient hospital stays
- Annual wellness visit (AWV) to develop or update a personalized prevention plan, including health 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
  - Starting in 2024, we'll cover a Social Determinants of Health (SDOH) Risk Assessment at no cost to the patient when it's provided as an optional AWV element (as part of the same visit with the same date of service as the AWV)
  - The AWV can be a community health integration (CHI) or principal illness navigation (PIN) initiating visit when the practitioner identifies an unmet SDOH need that prevents the patient from carrying out the recommended personalized prevention plan
- Advance care planning (ACP) 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 Part B service, including an advance directive
- Behavioral health integration (BHI) by clinical staff to assess, monitor, and plan care
- Biofeedback therapy, where patients learn non-drug treatments to control bodily responses, like heart rate and muscle tension

- Bundled substance use disorder (SUD) payments (see HCPCS G2086, G2087, and G2088 billing codes) for:
  - SUD management and counseling
  - SUD services provided in an office setting, including:
    - Overall management
    - Care coordination
    - Individual and group psychotherapy
    - Substance use counseling

Opioid Treatment Programs

We now pay certified Opioid Treatment Programs (OTPs) through bundled opioid use disorder (OUD) Medicare Part B treatment services payments. Covered services include FDA-approved opioid agonist and antagonist medication (including methadone, buprenorphine, and naltrexone) and their administration (if applicable), substance use counseling, individual and group therapy, toxicology testing, intake activities, periodic assessments, take-home supplies of naloxone, and intensive outpatient program services.

Opioid Treatment Program Directory and OTPs Billing & Payment have more information.

- Caregiver-focused behavioral health risk assessment of their own behavior and health risks, which benefits the patient
  - We'll pay for 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
- Chemical and electrical aversion therapy to condition a person to avoid undesirable behavior by pairing the behavior with unwanted stimuli
- Community health integration (CHI) services 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) where the practitioner identifies the presence of 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 (CBOs) if the billing practitioner provides the required supervision for these services, similar to other care management services
- Cognitive assessment and care planning, 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
- Chronic pain management (CPM) 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; screening by clinical staff in a primary care setting who can advise the physician of results and coordinate treatment referrals
- Diagnostic psychological and neuropsychological tests
- Drug therapy or pharmacological management using medications to treat a disease
- Drug withdrawal treatment to monitor signs and symptoms after changes in regular drug dose
- Electroconvulsive therapy (ECT) treating depression and other mental illness that involves passing small electric currents through the brain, intentionally triggering a seizure
- Family psychotherapy with or without the patient present, as medically reasonable and necessary, with patient treatment as the primary purpose
- 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
- 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
- Individual activity therapy that's part of a partial hospitalization program (PHP), which may be cognitive, physical, social, and spiritual but not recreational or diversionary
  - PHP, a structured, intensive, outpatient psychiatric services program, is an alternative to inpatient psychiatric care provided during the day (doesn't require an overnight stay) through a hospital outpatient department or community mental health center (CMHC)
- Initial preventive physical exam (IPPE) to review medical and social health history and provide preventive services education, counseling, and referral, as appropriate
- Intensive outpatient program (IOP) services
- Interactive psychotherapy
- Interactive telecommunications, including 2-way, interactive audio-only technology to diagnose, evaluate, or treat certain mental health or SUDs using telehealth services if the patient is in their home
  - Hospital clinical staff must have the capability to provide 2-way, interactive, audio-video technology services but may use audio-only technology given an individual patient's technological limitations, abilities, or preferences
  - You can provide telehealth using 2-way, interactive, audio-only technology through December 31, 2024
  - Telehealth services provided to people in their homes will be paid at the non-facility PFS rate through December 31, 2024
- Marriage and family therapist (MFT) services (also available through telehealth)

- Medication for Opioid Use Disorder (MOUD) management when a patient agrees to a medication trial period treatment option and its effectiveness is monitored
- Medication-Assisted Treatment (MAT) uses medications with counseling and behavioral therapy to treat SUDs, including OUDs; when a certified opioid treatment program (OTP) provider treats OUDs, we pay for certain medications and services
- Mental health counselor (MHC) services (also available 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
- Narcosynthesis, a form of narcoanalysis when a patient recalls repressed memories under hypnosis
- PIN services help patients who are diagnosed with high-risk conditions (for example, mental health conditions, substance use disorder, and cancer) identify and connect with appropriate clinical and social support resources
  - PIN services can be performed after a psychiatric evaluation, which can serve as the initiating visit
- Principal illness navigation-peer support (PIN-PS) services are similar to PIN services except they have more focus on services performed by peer support specialists under general supervision
- Psychiatric collaborative care services using BHI to enhance primary care services and include a psychiatric consultant
- Psychoanalysis that treats mental disorders by investigating the interaction of conscious and unconscious elements
- Psychiatric evaluation that systematically evaluates a psychiatric disorder's causes, symptoms, course, and consequences
- Screening, brief intervention, and referral to treatment (SBIRT) services that are early interventions for people with non-dependent substance use to help them prevent more extensive or specialized treatment
- SUD treatment in a patient's home (an acceptable telehealth substance use treatment or a co-occurring mental health disorder service site)
- Tobacco use cessation counseling
- Therapeutic activities that can improve the patient's condition, like occupational therapy, recreational therapy, and milieu therapies
- 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
- Urgent care to treat sudden illness or injury that doesn't need emergency medical attention to prevent disability or death

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

Non-Covered Services

We don't cover these mental health services:

- Environmental intervention or modifications
- Adult day health programs, like structured therapeutic health services and supervised activities
- Biofeedback training (any modality)
- Pastoral counseling
- Report preparation
- Results or data interpretation or explanation
- Hemodialysis specifically for treating schizophrenia (experimental)
- Transportation or outpatient meals
- Phone apps

Prescription Drug Coverage

Medicare Part A and Part B generally don't cover drugs, but Part B covers some medications patients can't self-administer. For other prescription coverage, patients must enroll in a separate Medicare drug plan.

Drug plans cover certain protected mental health treatment 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 (for example, telehealth) benefits beyond what Part B pays. They may also provide supplemental benefits Parts A or B don't cover. For example, supplemental mental health benefits may address coping with life changes, conflict resolution, or grief counseling, all offered as individual or group sessions.

Eligible Professionals

The tables below list the coverage requirements for behavioral health services and the Medicare Physician Fee Schedule (PFS) payment amount that physicians and these practitioners are eligible to bill and be paid under the Medicare Part B Program:

- Physicians (Medical Doctors (MDs) and Doctors of Osteopathy (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 (IPPs)
- Certified Registered Nurse Anesthetists (CRNAs) (supervision of diagnostic psychological and neuropsychological tests)
- Marriage and Family Therapists (MFTs)
- Mental Health Counselors (MHCs)

Provider Information

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

Table 1. Physician

Required Qualifications	Coverage Requirements	Payment
• MD or DO • Act within the scope of your license	• 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 • 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	• Paid at 100% under the Medicare PFS

Table 2. Clinical Psychologist (CP)

Required Qualifications	Coverage Requirements	Payment

• 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
	• 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, you must attempt to consult their attending or primary care physician about provided services and either:
	  ◦ Document the date the patient consented or declined consultation and the consultation dates in the patient's medical record
	  ◦ If consultations are unsuccessful, document that in the patient's medical record 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 diagnostic psychological and neuropsychological tests
	• You may have services and supplies provided incident to your personal professional services
		• We pay only on assignment
		• Paid at 100% of assigned services under the Medicare PFS

Table 3. Clinical Social Worker (CSW)

Required Qualifications	Coverage Requirements	Payment
• Social work master's or doctoral degree • At least 2 years of supervised clinical social work • Licensed or certified CSW by the state where you provide services	• 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 don't pay CSWs under the CSW benefit category for their hospital inpatient services • 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 under the CSW benefit category for CSW services to patients under a PHP or an IOP by a hospital outpatient department or CMHC • We don't pay under the CSW benefit category for CSW services to SNF inpatients and patients in Medicare-participating ESRD facilities if the services are under the respective provider's participation requirements	• We pay only on assignment

Table 3. Clinical Social Worker (CSW) (cont.)

Required Qualifications	Coverage Requirements	Payment
• If you practice in a state that doesn't have licensure or certification and 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, SNF, or clinic)	• We may cover ancillary CSW services when provided as auxiliary personnel incident to the personal professional services of a physician, a CP, a CNS, an NP, a PA, or a CNM • We don't cover services provided incident to your personal professional services	• Paid at 80% of the lesser of the actual charge for the service or 75% of the CP's Medicare PFS

Table 4. Clinical Nurse Specialist (CNS)

Required Qualifications	Coverage Requirements	Payment
• 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	• 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 CNSs 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	• 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, you must 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 Medicare PFS • We pay for assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS

Table 5. Nurse Practitioner (NP)

Required Qualifications	Coverage Requirements	Payment

• 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 they 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:
  ◦ NP certified by a recognized national certifying body with established NP standards
  ◦ 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 meets certification requirements
• Got Medicare NP billing privileges for the first time before January 1, 2001
	• 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 NPs 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
		• 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, you must 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 Medicare PFS
		• We pay for assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS

Table 6. Physician Assistant (PA)

Required Qualifications	Coverage Requirements	Payment

• 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, Commission on Accreditation of Allied Health Education Programs and Committee on Allied Health Education and Accreditation)
	• 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 an MD or a DO's supervision
	• We may cover assistant-at-surgery services you provide
		• 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, you must refund their payment
		• We pay for your professional services, including services and supplies provided incident to your services
		• We pay for your professional services provided in all rural and non-rural settings and areas

Table 6. Physician Assistant (PA) (cont.)

Required Qualifications	Coverage Requirements	Payment
• Passed a national certification exam administered by National Commission on Certification of Physician Assistants	• 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 PAs 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	• We pay only if no facility or other provider charges or we didn't pay any other service amount they provided • We pay for services at 80% of the lesser of the actual charge or at 85% of the amount a physician gets under the Medicare PFS • We pay for your assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS • We pay for services provided incident to a PA outside a hospital at 85% of the amount a physician gets under the Medicare PFS • 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 do • You must bill under your NPI

Table 7. Certified Nurse-Midwife (CNM)

Required Qualifications	Coverage Requirements	Payment
• 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 American College of Nurse-Midwives or American College of Nurse-Midwives Certification Council	• 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 CNMs 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	• 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, you must 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 Medicare PFS

Table 8. Independently Practicing Psychologist (IPP)

Required Qualifications	Coverage Requirements	Payment

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

Table 9. Certified Registered Nurse Anesthetist (CRNA)

Required Qualifications	Coverage Requirements	Payment
• 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 Council on Accreditation of Nurse Anesthesia Educational Programs (COA) or other accreditation organization the HHS Secretary designates • Passed a National Board of Certification & Recertification of 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	• 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 CRNAs 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	• Paid at 100% under the Medicare PFS • You may bill your services directly to Medicare, 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

Table 10. Marriage & Family Therapist (MFT)

Required Qualifications	Coverage Requirements	Payment
• 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)	• Legally authorized to practice as an MFT in the state where you provide services • You may enroll in Medicare and bill Medicare independently beginning January 1, 2024 • You may also still provide services and supplies as auxiliary personnel incident to a physician's or certain NPP's personal professional service	• 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 Medicare 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

Table 11. Mental Health Counselor (MHC)

Required Qualifications	Coverage Requirements	Payment
• 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 as an MCH; a clinical professional counselor; an addiction, alcohol, or drug counselor; or a professional counselor in the state where you provide services • After getting your degree and you complete at least 2 years or 3,000 hours of clinical supervised experience in mental health counseling	• Legally authorized to practice as an MHC in the state where you provide services • You may enroll in Medicare and bill Medicare independently beginning January 1, 2024 • You may also still provide services and supplies as auxiliary personnel incident to a physician's or certain NPP's personal professional service	• 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 Medicare 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

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 for these integral, although incidental, services and supplies provided by auxiliary personnel as if they furnished the services themselves and, are paid for these services as if they furnished them personally, if all the incident to requirements are met. However, there's no payment under the Medicare PFS to physicians or NPPs for incident to services in an institutional setting (hospital or SNF).

- Services and supplies are integral to the patient's normal treatment course and the physician or other listed NPP personally furnished 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.
- Typically, the incident to regulations require the physician or other listed NPP to furnish direct supervision; they're present in the office suite and immediately available if needed.

We offer an exception to the direct supervision requirement for incident to behavioral health services provided by auxiliary personnel. That is, 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 a provider furnishes for the diagnosis, evaluation, or treatment of a mental health disorder, including an 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.

Commonly Used CPT Codes

With thousands of CPT codes, using the correct CPT code to show the mental health services you provide to patients is essential for billing correctly.

Table 12. Commonly Used Mental Health-Related CPT Codes

Description	CPT Code
Interactive complexity (List separately in addition to the code for primary procedure) (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90833, 90834, 90836, 90837, 90838), and group psychotherapy [90853]) (Use 90785 in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)	90792
Psychotherapy, 30 minutes with patient	90832
Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90833
Psychotherapy, 45 minutes with patient	90834
Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90836
Psychotherapy, 60 minutes with patient	90837
Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90838
Psychotherapy for crisis; first 60 minutes	90839*
Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	90840
Psychoanalysis	90845
Family psychotherapy (without the patient present), 50 minutes	90846

*Mental health code not approved for partial hospitalization program.

Table 12. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	90847
Multiple-family group psychotherapy	90849*
Group psychotherapy (other than of a multiple-family group)	90853*
Electroconvulsive therapy (includes necessary monitoring)	90870
Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	96105
Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	96112
Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	96113
Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	96116
Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	96121
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	96130

*Mental health code not approved for partial hospitalization program.

Table 12. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	96131
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	96132
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	96133
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	96136
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	96137
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	96138
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	96139
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146
Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	96156**
Health behavior intervention, individual, face-to-face; initial 30 minutes	96158**
Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96159**

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

Table 12. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	96164**
Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96165**
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96167**
Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96168**
Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	96170**
Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96171**
Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes	G0017
Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service)	G0018

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

HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes), not provided more often than every 6 months, can also be provided with CPT code 90791 (Psychiatric diagnostic evaluation) and the health behavior assessment and intervention (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.

Outpatient Psychiatric Hospital 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 Guidelines section for more information)
- Provided under an individualized, written plan of care (POC) that states the:
  - Type, amount, frequency, and services duration
  - Diagnosis
  - Expected goals (except when you only provide a few brief services)
- 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

Generally, we cover these outpatient hospital psychiatric treatment services:

- 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
- Social workers, psychiatric nurses, and other staff trained to work with psychiatric patients

- 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
- 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
- Patient training and education when they're closely and clearly related to care and treating an individual's diagnosed psychiatric condition
- Therapeutic drugs and biologicals a patient can't self-administer
- CCM to patients with multiple chronic conditions (for example, patients with dementia typically have multiple chronic conditions that could involve physical and behavioral health issues, like depression)

Telehealth

Beginning in 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.

We'll continue to define direct supervision to permit the immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.

The regulations at 42 CFR 410.78(b)(3)(xiv) describe 2 exceptions to the in-person requirements that take effect on January 1, 2025:

1. Patients who already get telehealth behavioral health services and have circumstances where in-person care may not be appropriate
2. 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

The telehealth policies described above also apply to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

Beginning January 1, 2024, MHCs and MFTs can provide and bill Medicare telehealth services.

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 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 13. Telehealth HCPCS Codes

Description	HCPCS Code
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 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, initial 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
Administration of a standardized, evidence based social determinants of health risk assessment tool, 5-15 minutes	G0136

We assigned HCPCS codes C7900 and C7901 to ambulatory payment classifications (APCs) based on the PFS facility payment rates for CPT codes 96158 and 96159. C7902 is an add-on code; payment is packaged, and the code isn't assigned to an APC.

Generally, we don't cover these outpatient hospital services:

- 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

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

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.

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

- Discharged from an inpatient hospital treatment 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 admission reason
- The patient requires a comprehensive, highly structured, scheduled, multi-modal individualized POC requiring medical supervision and coordination because their mental disorder 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

Partial hospitalization services don't include:

- Hospital inpatient services
- Meals, self-administered medications, transportation
- Support groups where people talk and socialize (different than group psychotherapy, which we cover)
- Job skills training or testing skills not part of mental health treatment

Intensive Outpatient Program

Intensive outpatient services are provided under an IOP.

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

IOP services may also be provided in OTPs for treating an OUD.

Physicians prescribe IOP for an individual 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 established and periodically reviewed by the physician (in consultation with appropriate staff participating in such program). This determines the physician's diagnosis, 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 (the primary purpose of which is treatment of the individual's condition)
- Patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment)
- Diagnostic services
- Other items and services (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, can be reasonably expected to improve or maintain the individual's condition and functional level, and to prevent relapse or hospitalization

Intensive outpatient services must include a physician certification and POC. However, although PHP requires the physician to certify that the services are instead 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 furnished in the OTP setting: NPs, PAs, CPs, CSWs, MHCs, MFTs, and 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.

Community Mental Health Centers

We cover Part B partial hospitalization services that community mental health centers (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, 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 is 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 behavioral health integration (BHI) services over a calendar month.

CPs, CSWs, MFTs, and MHCs can bill the general BHI code HCPCS 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.

Medical Records Checklist: Outpatient Psychiatric Services

This outpatient psychiatric medical records services checklist reminds clinicians and staff of required documentation.

Community Mental Health Center & Partial Hospitalization Program

Medical Record Content

- ☐ Patient identification data
- ☐ Diagnosis, including intercurrent disease diagnosis and psychiatric diagnosis
- ☐ Indicate significant illnesses and medical conditions on a problem list
- ☐ Prominently note medication allergies and adverse reactions in the record; note in the record if the patient has no known allergies or adverse history of reactions

Standard Initial Evaluation

- ☐ Complete within 24 hours of patient admission
- ☐ Include admitting diagnosis and other diagnoses
- ☐ Referral source
- ☐ Admission reason as stated by the patient or other person significantly involved
- ☐ Identify the patient's immediate clinical care needs for their psychiatric diagnosis
- ☐ Current patient prescriptions list, including over-the-counter medications and other substances they take
- ☐ For **PHPs only,** an explanation of the patient's hospitalization risk if a PHP isn't provided
- ☐ Identify the patient's appropriate interdisciplinary team members

Standard Comprehensive Assessment

- ☐ Interdisciplinary treatment team completed a timely assessment consistent with the patient's needs, but no later than 4 working days after the patient's admission
- ☐ Identifies the patient's psychiatric illness and ensures the physical, psychological, psychosocial, emotional, and therapeutic active treatment plan needs are consistent with your findings
- ☐ Includes the patient's:
  - ☐ Admission reason
  - ☐ Psychiatric evaluation containing medical history and symptoms severity
  - ☐ Previous and current mental health status information
  - ☐ Onset of illness symptoms and admission circumstances
  - ☐ Description of attitudes and behaviors affecting their treatment plan
  - ☐ Intellectual, memory functioning, and orientation assessment

Standard Comprehensive Assessment (cont.)

- Care planning risk factor complications
- Functional status, including whether they can participate in their own care and their strengths and goals
- Factors affecting their or others' safety, including suicide risk factors
- Prescription drug profile, including over-the-counter medications
- Referral needs and further health care professional evaluation
- Considered discharge planning factors
- Current social and health care support systems
- For pediatric clients, assess social service needs and make needed referrals

- Make interdisciplinary team updates when the patient's status or treatment response changes occur or when they meet goals
- Upon patient discharge or transfer to another entity, within 2 working days the CMHC must forward the patient's:
  - Discharge summary
  - Clinic record, if requested
- If the patient refuses CMHC services or is non-compliant with the treatment plan, the CMHC must forward to their primary health care provider:
  - CMHC discharge summary copy
  - Client record, if requested
- Discharge summary includes the patient's:
  - Current active treatment plan
  - Most recent physician orders
  - Documentation to help in post-discharge continuity of care

Acute Care Hospital

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 inpatient psychiatric facilities (IPFs) and distinct psychiatric units in acute care hospitals and critical access hospitals (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 Coverage Period section 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.

Inpatient Psychiatric Facility Services

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 Inpatient Psychiatric Facility Prospective Payment System (IPF 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 short-term acute-care, rehabilitation, psychiatric, children's, cancer, and CAHs.

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

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.

Medical Records Checklist: Inpatient Psychiatric Services

This inpatient psychiatric services medical records checklist reminds clinicians and staff of required documentation.

Medical Record Content

- ☐ Patient identification data, including inpatient legal status
- ☐ Incoming patient history findings and treatment plan
- ☐ Patient provisional or admitting diagnosis, including intercurrent disease diagnosis and psychiatric diagnosis
- ☐ Staff or others significantly involved clearly document inpatient admission reasons
- ☐ Social service records must include:
  - ☐ Inpatient, family members, and others' interviews
  - ☐ Home plans assessment
  - ☐ Family attitudes
  - ☐ Community resources
  - ☐ Contacts
  - ☐ Social history
  - ☐ If indicated, a completed and recorded neurological exam during the admission physical

Psychiatric Evaluation

- ☐ Completed within 60 hours of patient admission
- ☐ Medical history
- ☐ Mental status record
- ☐ Admission illness onset and circumstances noted
- ☐ Attitudes and behavior described
- ☐ Estimated intellectual and memory functioning and orientation
- ☐ Inpatient assets inventory, descriptive and not interpretive

Comprehensive Written Treatment Plan

- ☐ Individual plan based on inpatient strengths and disabilities
- ☐ Substantiated diagnosis
- ☐ Short- and long-term goals
- ☐ Specific treatment modalities used
- ☐ Each treatment team member's responsibilities
- ☐ Adequate documentation justifying diagnosis, treatment, and completed rehabilitation activities
- ☐ All active therapeutic inpatient treatment efforts documented

Recorded Progress

- ☐ All physicians, psychologists, or other licensed independent practitioners record patient progress
- ☐ Others significantly involved in active treatment modalities, when appropriate
- ☐ Determine the patient's progress note frequency by condition; less than weekly during the first 2 months and at least once per month thereafter
- ☐ Progress notes must include treatment plan revision recommendations, when necessary
- ☐ Progress notes must include a precise patient treatment plan progress assessment

Discharge Plan

- ☐ Discharge summary
- ☐ Patient's hospital stay recap
- ☐ Recommended patient follow-up and aftercare
- ☐ Patient discharge condition summary

*Discharge Planning Evaluation, Plan, and Summary

- ☐ Does the hospital have a discharge planning process that applies to all hospital patients?
- ☐ Early in the patient's hospitalization, did you identify if they're likely to suffer adverse health consequences if discharged without adequate discharge planning?
  - ☐ If **yes**, did you complete a discharge planning evaluation or was it requested by the patient, their representative, or the physician?
- ☐ Did an RN, a social worker, or another appropriately qualified staff member develop or supervise the plan?
- ☐ Did the evaluation include the patient's post-hospital services need and their self-care capacity or the possibility of returning to their pre-hospital environment?
- ☐ Was the planning evaluation timely to allow appropriate post-hospital arrangements?
- ☐ Does the patient's medical record document the interaction of relaying discharge planning evaluation results to them or their representative?

*Identifies the newest discharge planning conditions of participation.

*Standard Discharge Plan

- ☐ Did an RN, a social worker, or another appropriately qualified staff member develop or supervise discharge plan development if indicated in the evaluation?
- ☐ If the evaluation showed no discharge plan finding, did the patient's physician request it?
- ☐ Did the hospital re-assess the patient's discharge plan if factors affecting the patient's continuing care needs develop?
- ☐ Did the hospital arrange to implement the patient's discharge plan?
- ☐ Did the patient, family, and interested persons get counseling to prepare them for post-hospital care?
- ☐ Did the hospital include a Medicare home health agencies (HHAs) discharge plan list (HHAs must request that hospital list when available) and skilled nursing facilities (SNFs) serving that geographic area where the patient lives or, in the SNF's case, in the requested geographic area?
  - ☐ Did you present that list to the patient only if they needed home health or post-hospital extended care services indicated in the discharge planning evaluation?
  - ☐ If the patient was enrolled in a managed care organization, did the hospital indicate those contracted managed care organization services?
  - ☐ Did you document in the medical record that you presented the HHA list to the patient?
- ☐ Did the hospital inform the patient and family of their freedom to choose among participating providers' post-hospital care services and respect the patient's and family's preference (the hospital must not specify or limit available, qualified providers)?
- ☐ Did the hospital disclose any HHA or SNF financial interest it may have with them?

*Transfer or Referral

- ☐ If you transferred or referred a patient, did you provide follow-up or ancillary care medical information to appropriate facilities, agencies, or outpatient services?

*Identifies the newest discharge planning conditions of participation.

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 further 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 emergency department
- The number of ECT treatments provided
- Outlier cases (cases with extraordinarily high costs)

The Medicare Benefit Policy Manual, Chapter 2 has more information on how Medicare covers IPFs.

Same Day Billing Guidelines

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:

- Mental health care services (we include 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
- Primary health care services

AUDIT: Alcohol Use Disorders Identification Test

DAST: Drug Abuse Screen Test

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 eligible Part B providers that may provide diagnostic and therapeutic mental, psychoneurotic, personality disorder, and SBIRT treatment services allowed under state law.

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 (NCD) and Local Coverage Determination (LCD) medical necessity criteria.

Every service billed must indicate the specific sign, symptom, or patient complaint requiring the service. 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 MAC's website.

Resources

- CMS Behavioral Health Strategy
- CMS Blog: Important New Changes to Improve Access to Behavioral Health in Medicare
- CMS Opioid Treatment Programs
- Marriage and Family Therapist & Mental Health Counselors
- Medicare Benefit Policy Manual, Chapters 2, 6, and 15
- Medicare Claims Processing Manual, Chapters 3 and 4
- MLN Matters®: Provider Enrollment Changes to the Medicare Program Integrity Manual (MM13331)
- Notices and Forms
- Quality Improvement Organizations
- SAMHSA: What is Mental Health?