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Medicare Payments for Part B Mental Health Services

Note: This article was revised on November 14, 2008, to show that the "Reasonable Expectation of Improvement" discussion on page 9 only applies to mental health services furnished under partial hospitalization programs.

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for mental health services provided to Medicare beneficiaries.

Provider Action Needed

As recommended by the Office of Inspector General's (OIG's) April 2007 report, this special edition article is being provided to explain Medicare's guidelines for payment of Part B mental health services including: qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E&M) services involving a

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general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment. It is important that providers of mental health services to Medicare beneficiaries know the policies guiding the provision of and payment for such services. While instructions on these various topics related to mental health services furnished to Medicare beneficiaries have already been provided under several Medicare manuals, this special article consolidates and summarizes these manual instruction policy guidelines.

Background

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) as recommended by the Office of Inspector General's (OIGs) April 2007 Report titled: "Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation and Coding." You can review a copy of this report at <http://www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf> on the internet.

In that report the OIG's study found that forty-seven percent of the mental health services allowed by Medicare in 2003 did not meet program requirements, resulting in approximately \$718 million in improper payments. Medicare allowed approximately \$2.14 billion in 2003 for Part B mental health services; 47 percent of these services did not meet Medicare requirements. Miscoded and undocumented services accounted for 26 and 19 percent of all mental health services in 2003, respectively. Medically unnecessary services and services that violated the "incident to" rule each accounted for 4 percent of all mental health services in 2003. Psychiatrists typically billed for procedures involving evaluation and management (E&M) services, while psychologists and clinical social workers were more likely to bill for individual and group psychotherapy.

Eliminating error rates has been a goal of CMS. Each year, CMS measures Medicare's national fee-for-service paid claims error rates in addition to more specific error rates based on Medicare contractor jurisdictions, services, and provider specialties. A key part of the CMS effort for reducing/eliminating improper payments has been to increase the level of detail of the error rate information to highlight the areas in need of improvement in the case of mental health services, such as medical necessity, documentation, and coding.

This special edition article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for E&M services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

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Medicare Coverage for Part B Mental Health Services

General provisions of the Social Security Act (sometimes referred to as the Act) govern Medicare reimbursement of all services, including mental health services. The Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet) states that no payment may be made for services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” The Social Security Act (Section 1833(e); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the internet) requires that providers furnish “such information as may be necessary to determine the amounts due” to receive Medicare payment. Related regulations at 42 CFR §§ 411.15(k)(1) and 424.5(a)(6) implement these provisions of the Medicare law.

Medicare Part B covers physicians’ services, outpatient care, and other services not covered by Medicare’s Hospital Insurance (Part A). In general, beneficiaries are responsible for coinsurance of 20 percent of the approved amount for most Part B services; however, the Act limits payments to 62.5 percent of the expenses (Medicare-approved amount) for mental health services (Social Security Act, Section 1833(c); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the internet). Specifically, the law limits payments for incurred expenses in connection with the treatment of “mental, psychoneurotic, and personality disorders.”

The Social Security Act (Section 1848(a)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the internet) established the Medicare physician fee schedule (MPFS) as the basis for Medicare reimbursement for all physician services beginning in January 1992. The Social Security Act (Section 1848(c)(5); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the internet) required the Secretary of the Department of Health and Human Services to develop a uniform coding system for all physician services. The American Medical Association’s (AMA) “Current Procedural Terminology” (CPT) maintains a numeric coding system for physicians’ services, including mental health services. In 1983, the CMS adopted CPT as part of Medicare’s Healthcare Common Procedure Coding System (HCPCS) and mandated that providers use HCPCS to report physicians’ services to Medicare. This was reaffirmed in the Medicare Physician Fee Schedule Final Rule, dated November 25, 1991, Vol. 56, No. 227, p. 59527.

Qualification Requirements for Mental Health Providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the State in which the services are performed. Qualification requirements for mental health professionals are listed below.

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A qualified physician must:

- Be legally authorized to practice medicine and surgery by the State in which he/she performs his/her services; and
- Perform his/her services within the scope of his/her license as defined by State law.

Also, see the Medicare General Information, Eligibility and Entitlement Manual (Pub. 100-01), Chapter 5, Section 70 at

<http://www.cms.hhs.gov/manuals/downloads/qe101c05.pdf> on the CMS website for the definition of a physician, and see the Medicare Benefits Policy Manual, Chapter 15, Section 30 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a physician.

A clinical psychologist (CP) must:

- Hold a doctoral degree in psychology; and
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Effective July 1, 1990, the diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished.

Clinical Psychologist Services that may be covered are:

- Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and/or regulation.

Medicare Carriers and MACs pay all qualified CPs based on the MPFS for the diagnostic and therapeutic services. (Psychological tests by practitioners who do not meet the requirements for a CP may be covered under the provisions for diagnostic psychological and neuropsychological tests as described in the Medicare Benefits Policy Manual, Chapter 15, Section 80.2 (see <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website).

Services and supplies furnished incident to a CP's services are covered in the same manner and under the same requirements that apply to services incident to a physician's services, as described in the Medicare Benefits Policy Manual, Chapter 15, Section 60. These services must be:

- Mental health services that are commonly furnished in CPs' offices;
- An integral, although incidental, part of professional services performed by the CP;

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- Performed under the direct personal supervision of the CP; i.e., the CP must be physically present and immediately available;
- Furnished without charge or included in the CP's bill; and
- Furnished by an employee of the CP (or an employee of the legal entity that employs or contracts with the supervising CP).

The services of CPs are not covered if the service is otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by State law to perform them. For example, the Social Security Act (Section 1862(a)(1)(A)); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet) excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though the services are authorized by State law, the services of a CP that are determined to be not reasonable and necessary are not covered. **Additionally, any therapeutic services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are not covered.**

Refer to the Medicare Benefits Policy Manual, Chapter 15, Section 170 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a clinical psychologist.

A clinical social worker (CSW) must:

- Possess a master's or doctor's degree in social work;
- Have performed at least two years of supervised clinical social work; and
- Be licensed or certified as a clinical social worker by the State in which the services are performed; or
- In the case of an individual in a State that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and the CSW must have completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, SNF, or clinic.

The Social Security Act (Section 1861(hh)(2); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the internet) defines "clinical social worker services" as those services that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a SNF that the SNF is required to provide as a requirement for participation are not included. Services furnished to patients of partial hospitalization programs are also not included. The services that are

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covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service.

Refer the Medicare Benefits Policy Manual, Chapter 15, Section 170 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a clinical social worker. Also see the Social Security Act (Section 1861(hh)) at http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the internet.

A nurse practitioner (NP) must:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must meet the requirements as follows:

- Possess a master's degree in nursing;
- Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners..

Refer to the Medicare Benefits Policy Manual, Chapter 15, Section 200 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a nurse practitioner.

A clinical nurse specialist (CNS) must:

- Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;

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- Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and
- Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for a CNS.

Refer to the Medicare Benefits Policy Manual, Chapter 15, Section 210 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a clinical nurse specialist.

A physician assistant (PA) must:

- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA); or
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and
- Be licensed by the State to practice as a physician assistant.

Refer to the Medicare Benefits Policy Manual, Chapter 15, Section 190 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website for the covered services of a physician assistant.

Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for these services. The limitation is called the outpatient mental health treatment limitation.

Expenses for diagnostic services (e.g., psychological and neuropsychological testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to diagnostic psychological and neuropsychological tests performed to evaluate the progress of a course of treatment for a diagnosed condition.

Incident to Services

Incident to a physician's professional services for outpatient services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services and supplies commonly furnished in physicians' offices are

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covered under the incident to provision. Charges for such services and supplies must be included in the physicians' bills. Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct supervision by a physician or those nonphysician practitioners who may bill for incident to services.

There are statutory exceptions to the requirement that services follow the rules of their own benefit category when one exists. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists have specific benefits enumerated under the Social Security Act. Those physicians/NPPs are allowed to: 1) bill directly for services they personally perform, or 2) have their services billed incident to the services of another physician/NPP, or 3) bill for the services of staff provided incident to their own services. The services provided as professional services incident to the services of another physician/NPP must represent the service covered under their statutory benefit and also comply with all the requirements for services incident to the services of a physician/NPP. Where the policies of the two benefit categories conflict and are not resolved in Medicare manuals, Medicare contractors will apply the policies that, in the judgment of the contractor, best serve the beneficiary.

The benefit differs for therapists and clinical social workers. Due to statutory provisions, physical therapists, occupational therapists, and clinical social workers may 1) bill directly for services they personally perform, or, 2) have their services billed incident to the services of a physician/NPP. However, the benefit for their services does not allow them to bill for the services of staff furnished as an incident to the services that they personally provide.

Speech-language pathologists may have their services billed incident to the services of a physician/NPP, but the benefit for their services does not allow them to bill for the services of staff as incident to the services they personally provide.

All of the requirements for services incident to must be followed before payment is appropriate. For more details on "incident to" services, see the Medicare Benefit Policy Manual, Chapter 15, Section 60 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS website..

Auxiliary personnel as it relates to "incident to" services means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

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Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide when the service(s) is (are) performed. However, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the time the aide is performing service(s).

Reasonable and Necessary Services

The Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet) states that all Medicare Part B services, including mental health services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable Expectation of Improvement for Mental Health Services Furnished under Partial Hospitalization Programs

Services furnished under partial hospitalization programs must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. The overall intent of the partial hospitalization program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g. intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

General Principles of Medical Record Documentation for Individual Mental Health Services

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;

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- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
 - Reason for encounter and relevant history;
 - Physical examination findings and prior diagnostic test results;
 - Assessment, clinical impression, and diagnosis;
 - Plan for care; and
 - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported on the health insurance claim should be supported by documentation in the medical record.

According to section 424.24(e) of the Code of Federal Regulations, additional medical record documentation requirements exist for partial hospitalization programs. (See <http://edocket.access.gpo.gov/cfr/2007/octqtr/pdf/42cfr424.24.pdf> on the Internet.)

Coding errors can occur from 'upcoding', 'downcoding', or miscoding. Upcoded services are billed at a level higher than the actual level of the service performed. For example, a 20- to 30-minute individual psychotherapy service billed as a 45- to 50-minute service is an upcoded service. Conversely, a downcoded service is billed at a lower level than the actual level of the service performed.

The OIG's report found that the majority of miscoded individual psychotherapy claims lacked documentation to justify the time billed. Individual psychotherapy can be billed as one of three time periods: 20 to 30 minutes, 45 to 50 minutes, or 75 to 80 minutes. Because reimbursement of psychotherapy services is based on face-to-face time spent with the patient, practitioners are required to document in the medical record the time spent with the patient. Providers must note that Section 1833(e) of the Act requires that providers furnish "such information as may be necessary to determine the amounts due" to receive Medicare payment."

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One of the principal causes of miscoded services occurs because no time is documented. When this happens, the services should be billed at the lowest possible time period. Miscoding for psychotherapy services also occurs when documentation in the medical record indicates that the actual services were not psychotherapy but totally different services, such as E&M services, medication management, psychological evaluation, and group psychotherapy. Medication management may be billed under one of two codes: 90862 (psychiatric pharmacologic management) or M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders).

Evaluation & Management (E&M) Services – Coding and Documentation Guidelines

Practitioners who provide E&M services in conjunction with psychotherapy need to document the E&M services and psychotherapy in the medical record. If only psychotherapy is documented, the practitioners should use codes for services solely for psychotherapy. Providers should thoroughly familiarize themselves with documentation guidelines for E&M services. These guidelines are available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage on the CMS website.

Miscoding for E&M services can occur when the E&M services are billed at a higher level than the medical record documentation supports. E&M services levels vary based on:

- The extent of the patient history obtained,
- The extent of the examination performed, and
- The complexity of the medical decisionmaking.

Additional causes of E&M coding errors reported in the OIG report included billing E&M services:

- For an initial visit when the services were rendered during a subsequent visit. Reimbursement rates for subsequent E&M visits are typically less than those for initial visits.
- When the services should have been billed as psychiatric diagnostic interview examinations, consultations, or psychotherapy, which are reimbursed at a lower rate.
- Where the place of service (e.g., inpatient) does not match the place of service indicated in the medical record (e.g., outpatient).

Psychiatric Therapeutic Procedures, Central Nervous System Assessment, and Health and Behavior Assessment

Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801 – 90802, 90804 – 90899 under the Psychiatry Section), overview and definitions for central nervous system assessment (CPT codes 96100 – 96117), and health and behavior

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assessment (CPT codes 96150 – 96155) as described in the Physicians' Current Procedural Terminology, which is an annual publication developed by the American Medical Association (AMA) and available from the AMA at <http://www.ama-assn.org/ama/pub/category/3113.html> on the internet..

Additional Information

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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