



Medicare Mental Health



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What's Changed?

- Clarified NP coverage requirements in Table 5

You'll find substantive content updates in dark red font.

Introduction

This booklet offers a comprehensive review of Medicare covered behavioral health services. Behavioral health services, typically referred to as mental health services and includes substance abuse, affects a patient's overall well-being. It's important to understand Medicare coverage of these services. This booklet includes information on covered and non-covered services, eligible providers, Medicare Advantage and Medicare drug plan coverage, as well as medical record documentation and coding.

Covered Medicare Fee-for-Service Mental Health Services

Medicare may cover these services to support behavioral health and wellness:

- Alcohol misuse screening and counseling for adults who use alcohol but aren't dependent; if you detect misuse, Medicare covers up to 4 brief face-to-face counseling sessions per year if patient is alert and competent 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 a health risk assessment and a depression screening
- Advance care planning to discuss the patient's health care wishes if they aren't able to make decisions about their care, as part of the AWV, or as a separate Part B service
- Behavioral Health Integration (BHI) by clinical staff to assess, monitor, and plan care
- Biofeedback therapy, a non-drug treatment where patients learn to control bodily responses like heart rate and muscle tension
- Bundled Payments for Opioid Use Disorder (OUD) are payments for OUD management and counseling, billed in the office setting, including overall management, care coordination, individual and group psychotherapy, and substance use counseling; for billing codes, refer to HCPCS G2086–G2088



- Caregiver-focused behavioral health risk assessment of their own behavior and health risks, which benefits the patient
- Chemical and electrical aversion therapy to condition a person to avoid undesirable behavior by pairing the behavior with unwanted stimuli
- Cognitive Assessment and Care Planning, a comprehensive evaluation of a new or existing patient who exhibits signs and symptoms of cognitive impairment, required to establish or confirm a diagnosis, etiology, and condition severity
- [Chronic Care Management \(CCM\)](#) and Complex Chronic Care Management for patients with multiple chronic conditions which place the person at high risk
- Annual depression screening, up to 15 minutes, when staff-assisted depression care supports can assure accurate diagnosis, effective treatment, and follow-up; screening by clinical staff in the 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 medication(s) to treat disease; most Medicare Drug Plans have drug management programs for at-risk patients enrolled in Medicare Part D
- Drug withdrawal treatment to monitor the signs and symptoms from removal or a decrease in the regular drug dose
- Electroconvulsive therapy (ECT) treating depression and other mental illness using electric current to the head
- 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 identifying or treating the psychological, behavioral, emotional, cognitive, and social factors important to prevent, treat, or manage physical health issues
- Hypnotherapy
- Individual and group psychotherapy may be individual therapy with 1 or more therapists or more than 1 individual in a therapy session with 1 or more therapists
- Individual activity therapy as part of a Partial Hospitalization Program (PHP) and may be cognitive, physical, social, and spiritual and not recreational or diversionary
- [Initial Preventive Physical Examination \(IPPE\)](#) to review medical and social health history and preventive services education

Opioid Treatment Programs

Effective January 2020, CMS pays certified Opioid Treatment Programs (OTPs) through bundled payments for OUD treatment services under Medicare Part B. Covered services include FDA-approved opioid agonist and antagonist medication, assisted treatment medications and their administration (if applicable), substance use counseling, individual and group therapy, toxicology testing, intake, and periodic assessments.

Find more information in the [Opioid Treatment Program Directory](#).

- Interactive psychotherapy
- Medication management when a patient agrees to a medication treatment option for a trial period and is monitored for its effectiveness
- Medication-Assisted Treatment (MAT) uses medications with counseling and behavioral therapy to treat substance use disorders including OUDs; effective January 2020, when a certified OTP provider treats OUDs, Medicare pays for certain medications and services
- Narcosynthesis, a form of narcoanalysis where the patient recalls repressed memories under hypnosis
- PHP, a structured and intensive program of outpatient psychiatric services, is an alternative to inpatient psychiatric care provided during the day that doesn't require an overnight stay, through a hospital outpatient department or community mental health center
- Psychiatric collaborative care services uses BHI to enhance primary care services and includes a psychiatric consultant
- Psychoanalysis treats mental disorders by investigating the interaction of conscious and unconscious elements
- Psychiatric evaluation systematically evaluates the causes, symptoms, and course and consequences of a psychiatric disorder
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) services is early intervention for individuals with non-dependent substance use to help them prevent more extensive or specialized treatment
- Substance use disorder treatment in a patient's home is now an acceptable telehealth services site for substance use treatment or a co-occurring mental disorder
- Tobacco use cessation counseling
- Therapeutic activities which can improve the patient's condition, such as occupational therapy, recreational therapy, and milieu therapies
- Transitional care management, within 30 days of discharge from an inpatient hospital setting, interactive contact, certain non-face-to-face services, and face-to-face visits
- Urgently needed care to treat a sudden illness or injury that doesn't need emergency medical attention to prevent disability or death



Prescription Drug Coverage

Medicare Part D covers prescription drugs. 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. Medicare Advantage enrollees can get Part A, Part B, and Part D benefits under a single plan.

Medicare Drug Plans cover certain protected mental health treatment drug classes, including antipsychotics, antidepressants, and anticonvulsants. Medicare Drug Plans must cover most medications in these drug classes, with some exceptions.

Medicare Advantage Organizations

In addition to providing all Medicare Part B covered mental health services, Medicare Advantage plans may offer "additional telehealth benefits" (telehealth benefits beyond what Part B pays), as well as supplemental benefits that aren't covered under Medicare Parts A or B. For example, these mental health supplemental benefits may address areas like coping with life changes, conflict resolution, or grief counseling, all offered as individual or group sessions.

Non-Covered Medicare Fee-for-Service Mental Health Services

Medicare **doesn't** cover these mental health services:

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

Eligible Professionals

Medicare recognizes these Part B providers as eligible to provide diagnostic and BHI or SBIRT services, as permitted under state law:

- 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)

Provider Information

These tables list individual provider-type required qualifications, coverage, and payment criteria. Each provider type must meet all qualification and coverage requirements. For a list of specific billing codes, see the [Commonly Used CPT Codes](#) section.

Table 1. Psychiatrist

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • MD or DO • Act within scope of your license 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • Medicare doesn't statutorily preclude the services, and they're reasonable and necessary • You may provide the general supervision assigned to diagnostic psychological and neuropsychological tests • You may provide services and supplies incident to your professional services 	<ul style="list-style-type: none"> • Paid at 100% under Medicare Physician Fee Schedule (PFS)

Table 2. Clinical Psychologist (CP)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • Medicare doesn'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: <ul style="list-style-type: none"> ◦ Document consent or declination date to consultations and date of consultations in patient's medical record ◦ If consultations are unsuccessful, document the patient's medical chart with the date and physician notification method (doesn't apply if physician referred patient to CP) • You may generally supervise diagnostic psychological and neuropsychological tests • You may provide services and supplies incident to your professional services, except for hospital patient services 	<ul style="list-style-type: none"> • Paid only on assignment basis • Paid at 100% of assigned services under Medicare PFS

Table 3. Clinical Social Worker (CSW)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • Social Work Master’s or Doctoral degree • At least 2 years of supervised clinical social work • Licensed or certified as CSW by the state where you provide services • If you practice in a state that doesn’t have licensure or certification, and complete at least 2 years or 3,000 supervised social work practice clinical hours, post-Master’s degree in an appropriate setting (for example, a hospital, Skilled Nursing Facility [SNF], or clinic) 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • Medicare doesn’t statutorily preclude the services, and they’re reasonable and necessary • You provide services to diagnose and treat mental illnesses • Medicare doesn’t pay CSW services to hospitalized patients with no CSW services coverage • Medicare covers hospital outpatient CSW services and pays under the CSW benefit when billed by the hospital under CSW’s National Provider Identifier • Medicare doesn’t cover CSW services to patients under PHP by a hospital outpatient department or Community Mental Health Center • Medicare doesn’t cover CSW services to SNF inpatients and patients in Medicare-participating End-Stage Renal Disease facilities, or pay them under the CSW benefit if the services meet the respective participation requirements • Medicare may cover incident to services CSWs provide for physicians, CPs, CNSs, NPs, PAs, or CNMs • Medicare doesn’t cover services incident to your personal professional services 	<ul style="list-style-type: none"> • Paid only on assignment basis • Paid at 75% of CP’s Medicare PFS

Table 4. Clinical Nurse Specialist (CNS)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • Medicare doesn’t statutorily preclude the services, and they’re reasonable and necessary • Medicare considers the services physicians’ services if provided by an MD or DO • You provide the services with a physician • Medicare may cover assistant-at-surgery services you provide • You may personally provide diagnostic psychological and neuropsychological tests with a physician as required under CNS benefit and as permitted under state law • Medicare may cover incident to services and supplies 	<ul style="list-style-type: none"> • Paid only on assignment basis • Paid at 85% of amount physician gets under Medicare PFS • Medicare directly pays you for assistant-at-surgery services at 85% of 16% of the amount a physician gets under Medicare PFS

Table 5. Nurse Practitioner (NP)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> ● RN licensed and authorized by the state where you provide NP services according to state law: <ul style="list-style-type: none"> ○ Got Medicare NP billing privileges for first time since January 1, 2003, and: <ul style="list-style-type: none"> ▪ Are 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 first time before January 1, 2003, and meets the certification requirements ○ Got Medicare NP billing privileges for first time before January 1, 2001 	<ul style="list-style-type: none"> ● Legally authorized to practice medicine in the state where you provide services ● Medicare doesn’t statutorily preclude the services, and they’re reasonable and necessary ● Medicare considers the services physicians’ services if provided by an MD or DO ● You provide the services while working in collaboration with a physician ● Medicare may cover assistant-at-surgery services you provide ● You may personally provide diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform the tests in collaboration with a physician as required under the NP benefit; Also, NPs are authorized to supervise the performance of diagnostic tests in accordance with state law and scope of practice ● Medicare may cover incident to services and supplies 	<ul style="list-style-type: none"> ● Paid only on assignment basis ● Paid at 85% of amount physician gets under Medicare PFS ● Medicare directly pays you for assistant-at-surgery services at 85% of 16% of the amount a physician gets under Medicare PFS

Table 6. Physician Assistant (PA)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> ● Licensed by the state where you practice and 1 of these criteria: <ul style="list-style-type: none"> ○ Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs, and Committee on Allied Health Education and Accreditation) ○ Passed the national certification exam administered by the National Commission on Certification of Physician Assistants 	<ul style="list-style-type: none"> ● Legally authorized to practice medicine in the state where you provide services ● Medicare doesn't statutorily preclude the services, and they're reasonable and necessary ● Medicare considers the services physicians' services if provided by an MD or DO ● An individual who meets all PA qualifications provides the services ● You provide services under an MD or DO's general supervision ● The physician supervisor or designee doesn't need to be physically present during a service unless state law or regulations require otherwise ● Medicare may cover assistant-at-surgery services you provide ● You may personally provide diagnostic psychological and neuropsychological tests under the general supervision of a physician as required under the PA benefit and as permitted under state law ● Medicare may cover incident to services and supplies 	<ul style="list-style-type: none"> ● Paid only on assignment basis ● Paid only to your: <ul style="list-style-type: none"> ○ Qualified employer eligible to enroll in the Medicare Program under existing provider and supplier categories ○ Contractor ● Medicare pays 85% of amount physician gets under Medicare PFS ● Medicare pays your employer or contractor for assistant-at-surgery services at 85% of the amount a physician gets under Medicare PFS

Table 7. Certified Nurse-Midwife (CNM)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • 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 clinical experience accredited by an accrediting body approved by the U.S. Department of Education • Certified as a Nurse-Midwife by the American College of Nurse-Midwives or American College of Nurse-Midwives Certification Council 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • Medicare doesn't statutorily preclude the services, and they're reasonable and necessary • Medicare considers the services physicians' services if provided by an MD or DO • You provide services without physician supervision and without association with a physician or other health care provider, unless otherwise required under state law • You may personally provide diagnostic psychological and neuropsychological tests without physician supervision or oversight as authorized by the CNM benefit and permitted under state law • Medicare may cover incident to services and supplies 	<ul style="list-style-type: none"> • Paid only on assignment basis • Paid at 80% of the lesser of the actual charge or 100% of the amount physician gets under Medicare PFS

Table 8. Independently Practicing Psychologist (IPP)

Required Qualifications	Coverage	Payment
<ul style="list-style-type: none"> • Psychologist who isn't a CP • Meets 1 of these criteria: <ul style="list-style-type: none"> ◦ Practices independently of an institution, agency, or physician's office and 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 	<ul style="list-style-type: none"> • Medicare doesn'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, a physician, an institution, or an agency) • You treat your own patients • When you practice in an office that's in an institution: <ul style="list-style-type: none"> ◦ The office is confined to a separately identified part of facility used solely as an office and can't be confused as extending throughout the entire institution ◦ You operate a private practice (to patients outside the institution as well as institutional patients) • You may provide diagnostic psychological and neuropsychological tests when physician orders them • You can bill directly and collect and retain your service fees 	<ul style="list-style-type: none"> • Diagnostic psychological and neuropsychological tests aren't subject to assignment; however, you must include name and address of physician ordering tests on the claim • Paid at 100% for assigned services under Medicare PFS

Incident to Provision

A physician, CP, CNS, NP, PA, or CNM may provide outpatient psychiatric services and supplies incident to their professional services. Medicare pays under the “Incident to” provision when the services and supplies comply with state law and meet all these requirements:

- Services and supplies are integral to the patient’s normal course of treatment and the physician or other listed Non-Physician Practitioners (NPPs) personally provided an initial service and remains actively involved in treatment
- Practitioner commonly provides the services and supplies without charge (included in the physician’s or other listed NPP’s bill)
- Services and supplies are an expense to physician or other listed NPP
- Services and supplies are commonly offered in the physician’s or other listed NPP’s office or clinic
- Physician or other listed NPP provides direct supervision; they’re present in the office suite and immediately available if needed.

Medicare may cover CP, CSW, CNS, NP, PA, and CNM services and supplies as an incident to the professional services of a physician or other specified NPP, the same as an MD or DO.

Get more information on the incident to provision at [42 CFR Section 410.71](#).

Commonly Used CPT Codes

There are thousands of CPT codes. Using the correct CPT code shows the mental health service(s) you provide to patients and is essential to correct billing. The most used psychiatric and therapeutic codes include 90791, 90792, 90832, 90834, 90837, 90846, 90847, 90853, and 90839.

Table 9. Eligible Professionals Commonly Used CPT Codes

Description	CPT Code
Interactive complexity add-on (for psychotherapy codes) Code 90785 is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838, 99202–99255, 99304–99337, 99341–99350) and group psychotherapy (90853)	90785
Psychiatric diagnostic evaluation	90791

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Table 9. Eligible Professionals Commonly Used CPT Codes (cont.)

Description	CPT Code
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 add-on—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
Family psychotherapy, conjoint therapy (with the 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

* Mental Health code not approved for partial hospitalization program.

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Table 9. Eligible Professionals Commonly Used CPT Codes (cont.)

Description	CPT Code
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—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—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
Psychological testing evaluation services add-on—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—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

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Table 9. Eligible Professionals Commonly Used CPT Codes (cont.)

Description	CPT Code
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional add-on—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 add-on—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—Each additional 15 minutes (List separately in addition to code for primary service)	96159
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	96164
Health behavior intervention, group—Each additional 15 minutes (List separately in addition to code for primary services)	96165
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96167
Health behavior intervention, family (with the patient present)—Each additional 15 minutes (List separately in addition to code for primary services)	96168
Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	96170
Health behavior intervention, family (without the patient present)—Each additional 15 minutes (List separately in addition to code for primary services)	96171

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National Correct Coding Initiative (NCCI)

The NCCI promotes national correct coding methods and offers national guidance on code pair edits that prevent billing certain services on the same day. Find more information about the NCCI on the [National Correct Coding Initiative Edits](#) webpage.

Outpatient Psychiatric Hospital Services

Outpatient psychiatric hospital services and supplies are:

- Medically necessary for diagnostic study or 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:
 - Type, amount, frequency, and duration of services
 - Diagnosis
 - Expected goals (except when you only provide a few brief services)
- Supervised and periodically evaluated by physician who:
 - Prescribes the services
 - Determines extent patient reached their treatment goals and whether POC should change
 - Provided supervision and direction to therapists involved in patient's treatment
 - Documents their involvement in patient's medical record
- For diagnostic study or, at a minimum, designed to reduce or control the patient's psychiatric symptoms to prevent a relapse or hospitalization and improve or maintain their level of functioning

Generally, Medicare covers these outpatient hospital psychiatric treatment services:

- Medically necessary diagnostic services for individuals when extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and prepare 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, as part of a PHP, that:
 - Require qualified occupational therapist skills
 - Are provided by, or under the supervision of, a qualified occupational therapist
 - Are included in patient's POC

- Activity therapies, as part of PHP, that are:
 - Individualized and essential for treating patient's diagnosed condition and progressing toward treatment goals
 - Clearly supported in POC and show each therapy's need (Not primarily recreational or diversionary)
- Family counseling services while treating the individual's condition
- Patient training and education when they're closely and clearly related to the care and treatment of individual's diagnosed psychiatric condition
- Drugs and biologicals for therapeutic purposes the 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 both physical and behavioral health issues, such as depression)

Generally, Medicare doesn't cover these outpatient hospital services:

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

Partial Hospitalization Program (PHP)

PHPs are distinct and structured programs that provide intensive outpatient psychiatric care through active treatment by combining clinically recognized items and services. Medicare covers PHP in hospital outpatient departments and Community Mental Health Centers (CMHCs).

The patient may pay a percentage of the Medicare-approved amount for each service from doctors or other qualified mental health professionals, if that health care professional accepts assignment. The patient may also pay [coinsurance](#) for each day of PHP services in a hospital outpatient setting or CMHC.

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

- Discharged from inpatient hospital treatment and the PHP replaces continued inpatient treatment
- At reasonable risk of needing inpatient hospitalization without partial hospitalization

The PHP must meet these program and patient criteria ([42 CFR Section 410.43](#)) guidelines:

- Active treatment that includes an individual POC with coordinated services designed for the patient's needs
- POC treatment includes a multi-disciplinary team care approach directed by a physician who certifies the patient's need for partial hospitalization and a minimum of 20 hours per week of therapeutic services

- Treatment goals should be:
 - Measurable
 - Functional
 - Time-framed
 - Medically necessary
 - Directly related to the admission reason
- The patient requires comprehensive, highly structured, and scheduled multi-modal treatment that requires medical supervision and coordination under an individualized POC because of a mental disorder that severely interferes with multiple areas of daily life (social, vocational, Activities of Daily Living [ADL]/instrumental ADLs, and educational functioning)
- The patient can cognitively and emotionally participate in the active treatment process and tolerate its intensity

Medicare **doesn't** cover under PHP services:

- Hospital inpatient services
- Meals, self-administered medications, transportation
- Support groups for people to talk and socialize (different than group psychotherapy, which Medicare covers)
- Testing or training for job skills not part of the mental health treatment



Community Mental Health Center (CMHC)

CMHCs provide partial hospitalization services under Medicare Part B and are subject to the Outpatient Prospective Payment System (OPPS). Medicare-authorized CMHCs must meet program and patient criteria ([42 CFR Section 485.900](#)) guidelines:

- Meet appropriate state CMHC licensing or certification where located
- Provide:
 - Outpatient services including specialized services for children, older adults, chronically mentally ill individuals, and residents of its mental health service area discharged from inpatient treatment at a mental health facility
 - 24-hour emergency care services with access to a clinician 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 that vary in intensity, frequency, and duration based on the patient's needs
 - Provide at least 40% of its services to individuals who are ineligible for benefits under [SSA Title XVIII](#)
 - Clinically evaluate candidates for admission to a state mental health facility 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 approved entity (as determined by the HHS Secretary)

A CMHC is an originating site for telehealth services. Find more information about telehealth services and important coding information in the [Telehealth Services](#) booklet.

Behavioral Health Integration (BHI) Services

Integrating behavioral health care with primary care is an effective strategy for improving outcomes for those with mental or behavioral health conditions. Medicare separately pays physicians and NPPs providing BHI services to patients over a calendar month. Find more information on BHI, including psychiatric collaborative care services and important coding information, in the [Behavioral Health Integration Services](#) booklet.

The following outpatient psychiatric services medical records checklist reminds clinicians and staff of required documentation, and you can print it.

[Print Checklist](#)

Medical Records Checklist: Outpatient Psychiatric Services

Partial Hospitalization Program (PHP) Services & Community Mental Health Centers (CMHCs)

Medical Record Content (Check if Yes)

- Patient identification data.
- Diagnosis including intercurrent disease diagnosis and psychiatric diagnosis.
- Indicate significant illnesses and medical conditions on the problem list.
- Prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

CMHC & PHP Standard Initial Evaluation (Check if Yes)

- Completed within 24 hours of admission
- Include admitting diagnosis, and other diagnoses
- Source of referral
- Reason for admission as stated by patient or other individual significantly involved
- Identify patient's immediate clinical care needs related to the psychiatric diagnosis
- List of current prescriptions and over-the-counter medications and other substances the patient takes
- For **PHP only**, an explanation of why patient is at risk for hospitalization if PHP isn't provided
- Identify appropriate members of patient's interdisciplinary team

CMHC & PHP Standard Comprehensive Assessment (Check if Yes)

- Completed timely by interdisciplinary treatment team consistent with patient's needs, but no later than 4 working days after admission
- Identifies the physical, psychological, psychosocial, emotional, and therapeutic needs related to the patient's psychiatric illness and ensures active treatment plan is consistent with findings
- Includes:
 - Reason for admission
 - A psychiatric evaluation containing medical history and severity of symptoms
 - Information about previous and current mental status
 - Onset of symptoms of the illness and circumstances leading to admission
 - Description of attitudes and behaviors affecting the treatment plan
 - Assessment of intellectual and memory functioning and orientation
 - Complications of risk factors affecting care planning
 - Functional status including whether patient can participate in their own care, and patient's strengths and goals
 - Factors affecting patient safety or safety of others and suicide risk factors
 - Drug profile of all patient's prescription and over-the-counter medications
 - Need for referrals and further evaluation by other health care professionals
 - Factors to consider for discharge planning
 - Identify patient's current social and health care support systems
 - For pediatric clients, assess social service needs and make referral as needed
- Make updates with interdisciplinary team when changes occur in the patient's status, response to treatment, or patient meets goals
- Upon discharge or transfer of patient to another entity, within 2 working days, the CMHC must forward:
 - Discharge summary
 - Clinic record if requested

CMHC & PHP Standard Comprehensive Assessment (cont.) (Check if Yes)

- If a patient refuses the services of a CMHC, or is non-compliant with treatment plan, the CMHC must forward to the primary health care provider:
 - Copy of the CMHC discharge summary
 - Client record if requested
- Discharge summary includes patient:
 - Current active treatment plan
 - Most recent physician orders
 - Any documentation to help in post-discharge continuity of care

Acute Care Hospital

When a physician admits a patient to the hospital for mental health services, Medicare covers the services if the patient needs active treatment with an intensity only appropriately provided in an inpatient setting. The facility must be a general hospital with a distinct psychiatric unit or a psychiatric hospital that only cares for people with mental health conditions.

Medicare certifies Inpatient Psychiatric Facilities (IPFs) and distinct psychiatric units in acute care hospitals and Critical Access Hospitals (CAHs).

Medicare covers:

- Semi-private rooms
- Meals
- General nursing
- Drugs (including methadone to treat an opioid use disorder)
- Other hospital services and supplies as part of inpatient treatment

[Deductible and coinsurance](#) apply. See the [Coverage Period](#) section for more information.

Inpatient Psychiatric Facility (IPF) Services

IPFs include freestanding, certified psychiatric hospitals and psychiatric units in acute care hospitals or CAHs. IPFs provide routine hospital and psychiatric services to diagnose and treat patients with mental disorders.

Medicare pays for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) when it certifies the institution and the institution meets [Inpatient Psychiatric Hospital Services Regulations](#).

Medicare requires updated hospital inpatient rights and discharge planning conditions of participations for short-term acute-care, rehabilitation, psychiatric, children's, cancer, and CAHs.

Get more information about the current discharge planning conditions of participation requirements at [42 CFR Section 482.43](#).

Medical Records Requirements

The IPF medical records must show treatment level and intensity for each patient a physician or NPP admits to the hospital, among other requirements detailed at [42 CFR Section 482.61](#).

Patients can access their medical records when requested verbally or in writing, and the hospital must quickly seek to meet the patient's request, detailed at [42 CFR Section 482.13](#).

The following inpatient psychiatric services medical records checklist reminds clinicians and staff of required documentation, and you can print it.

[Print Checklist](#)

Medical Records Checklist: Inpatient Psychiatric Services

Medical Records Content (Check if Yes)

- Patient identification data including inpatient legal status
- History of findings and a treatment plan for the incoming patient
- Provisional or admitting diagnosis for every inpatient including intercurrent disease diagnoses and psychiatric diagnoses
- Admission reasons clearly documented by inpatient staff or others significantly involved
- 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, completed during the admission physical

Psychiatric Evaluation (Check if Yes)

- Completed within 60 hours of admission
- Medical history
- Record of mental status
- Illness onset noted and circumstances leading to admission
- Attitudes and behavior described
- Estimated intellectual and memory functioning and orientation
- Inpatient inventory of assets are descriptive and not interpretive

Comprehensive Written Treatment Plan (Check if Yes)

- An Individual plan based on inpatient strengths and disabilities
- A substantiated diagnosis
- Short- and long-term goals
- Specific treatment modalities used
- Responsibilities of each treatment team member
- Adequate documentation justifying the diagnosis, treatment, and rehabilitation activities completed
- Documented inpatient treatment to assure inclusion of all active therapeutic efforts

Recorded Progress (Check if Yes)

- By the physician(s), psychologist(s), or other licensed independent practitioner(s)
- Others significantly involved in active treatment modalities, when appropriate
- Determine progress note frequency by the inpatient's condition less than weekly during the first 2 months and at least once per month thereafter
- Progress notes must have revision recommendations in the treatment plan, when necessary
- Progress notes must include a precise patient assessment of treatment plan progress

Discharge Plan (Check if Yes)

- Discharge Summary
- Recap of patient's hospital stay
- Recommended patient follow-up and aftercare
- Patient condition summary at discharge

***Discharge Planning Evaluation, Plan, and Summary (Check if Yes)**

- Does the hospital have a discharge planning process that applies to all hospital patients?
- Did you identify, early in the patient's hospitalization, whether they're likely to suffer adverse health consequences if discharged without adequate discharge planning?
 - If **yes**, did you complete a discharge planning evaluation for them or was 1 requested by the patient, representative, or physician?
- Was the plan developed or supervised by an RN, social worker, or other appropriately qualified staff member?
- Did the evaluation include patient's need for post-hospital services and their capacity for self-care or the possibility of returning to their pre-hospital environment?
- Was the planning evaluation timely to allow appropriate post-hospital arrangements?
- Does the discharge planning evaluation in the patient's medical record document the interaction relaying the results of the evaluation to the patient or their representative?

* Identifies the newest discharge planning conditions of participation.

***Standard Discharge Plan (Check if Yes)**

- Did an RN, social worker, or other appropriately qualified staff member develop or supervise the development of the discharge plan if indicated in the evaluation?
- If the evaluation showed no finding for a discharge plan, 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 developed?
- 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 discharge plan list of Medicare Program Home Health Agencies (HHAs) (HHAs must request that the hospital list their service when available) and Skilled Nursing Facilities (SNFs) serving that geographic area where the patient lives or in the case of a SNF, in the requested geographic area?
 - Did you only present the list to the patient if they needed home health or post-hospital extended care services as indicated in the discharge planning evaluation?
 - If the patient was enrolled in a managed care organization, did the hospital indicate those services contracted with the managed care organizations?
 - Did you document in the medical record that the list was presented to the patient?
- Did the hospital inform the patient and family of their freedom to choose among participating Medicare providers' post-hospital care services and respect the patient's and family's preference (the hospital must not specify or limit qualified providers available)?
- Did the hospital disclose any financial interest it may have in the HHA or SNF?

***Transfer or Referral (Check if Yes)**

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

* Identifies the newest discharge planning conditions of participation.

Coverage Period

Medicare covers IPF patients for psychiatric conditions in specialty facilities for 90 days per illness with a 60-day lifetime reserve, and for 190 days of care in freestanding psychiatric hospitals (this 190-day limit doesn't apply to certified psychiatric units). There are no further benefits once a patient uses 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). CMS determines them by:

- Geographic factors
- Patient characteristics
- Facility characteristics

IPFs get additional payments for:

- Patients treated in IPFs with qualifying emergency department
- Number of ECT treatments provided
- Outlier cases (cases with extraordinarily high costs)

Find more information on how Medicare covers IPFs in [Medicare Benefit Policy Manual, Chapter 2](#).

Same Day Billing Guidelines

Integrating mental health and substance use disorder services addresses the needs of all patients, whether they get care in a traditional primary care setting or a specialty mental or substance use disorder health care setting. Services include:

- Mental health care services (Medicare includes substance abuse treatment)
- Alcohol and substance abuse (other than tobacco) structured assessment, and intervention services (SBIRT services) billed under HCPCS codes:
 - G0396 (Alcohol and/or substance [other than tobacco] abuse structured assessment [e.g., audit, dast], and brief intervention 15 to 30 minutes)
 - G0397 (Alcohol and/or substance [other than tobacco] abuse structured assessment [e.g., audit, dast], and intervention, greater than 30 minutes)
- Primary health care services

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

The [Eligible Professionals](#) section lists the providers eligible under Part B to provide diagnostic and therapeutic treatment for mental, psychoneurotic, and personality disorders and Medicare SBIRT services allowed under state law.

Medicare covers 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 the standards of good medical practice for diagnosis, direct care, and treatment of the patient's medical condition, and not mainly the convenience of the patient, provider, or supplier.

Services must also meet specific medical necessity criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Find more information on the [Medicare Coverage Determination Process](#) webpage.

For every service billed, indicate the specific sign, symptom, or patient complaint showing the service need. Although a provider may consider a service or test good medical practice, Medicare doesn't pay for services without patient symptoms, complaints, or specific documentation.

Medicare also pays for multiple mental health services to the same patient on the same day. However, Medicare doesn'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 for certain services, [contact your MAC](#).

Resources

- [CMS Opioid Treatment Programs \(OTPs\)](#)
- [FY 2021 Inpatient Psychiatric Facilities Prospective Payment System \(IPF PPS\) and Special Requirements for Psychiatric Hospitals](#)
- [Inpatient Psychiatric Facility Prospective Payment System](#)
- [Medicare Benefit Policy Manual, Chapters 2, 6, and 15](#)
- [Medicare Claims Processing Manual, Chapters 3 and 4](#)
- [Notices and Forms](#)
- [Quality Improvement Organizations](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)

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