



## Medicare Mental Health



CPT codes, descriptions and other data only are copyright 2021 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

# Table of Contents

<b>What’s Changed?</b> .....	<b>3</b>
<b>Medicare-Covered Services</b> .....	<b>4</b>
<b>Prescription Drug Coverage</b> .....	<b>7</b>
<b>Medicare Advantage Organizations</b> .....	<b>7</b>
<b>Non-Covered Services</b> .....	<b>7</b>
<b>Eligible Professionals</b> .....	<b>7</b>
<b>Provider Information</b> .....	<b>8</b>
Table 1. Psychiatrist .....	8
Table 2. Clinical Psychologist (CP) .....	9
Table 3. Clinical Social Worker (CSW).....	10
Table 4. Clinical Nurse Specialist (CNS).....	11
Table 5. Nurse Practitioner (NP) .....	12
Table 6. Physician Assistant (PA).....	13
Table 7. Certified Nurse-Midwife (CNM).....	16
Table 8. Independently Practicing Psychologist (IPP).....	17
Table 9. Certified Registered Nurse Anesthetist (CRNA).....	18
<b>Incident to Provision</b> .....	<b>19</b>
<b>Commonly Used CPT Codes</b> .....	<b>20</b>
Table 10. Eligible Professionals Commonly Used CPT Codes .....	20
<b>National Correct Coding Initiative</b> .....	<b>23</b>
<b>Outpatient Psychiatric Hospital Services</b> .....	<b>23</b>
Partial Hospitalization Program.....	25
Community Mental Health Center .....	26
Behavioral Health Integration Services .....	26
<b>Medical Records Checklist: Outpatient Psychiatric Services</b> .....	<b>27</b>
<b>Acute Care Hospital</b> .....	<b>30</b>
<b>Inpatient Psychiatric Facility Services</b> .....	<b>30</b>
Medical Records Requirements .....	30
<b>Medical Records Checklist: Inpatient Psychiatric Services</b> .....	<b>31</b>
Coverage Period .....	35
<b>Same Day Billing Guidelines</b> .....	<b>35</b>
<b>Resources</b> .....	<b>36</b>

## What's Changed?

- Interactive telecommunications systems can include interactive, real-time, 2-way audio-only diagnosis, evaluation, or mental health or substance use disorder telehealth services treatment technology when patient's in their home (page 6).
- Nurse Practitioners (NPs), Certified Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), and Physician Assistants (PAs) may provide services on assignment, but they can't charge a patient more than amounts permitted under [42 CFR 424.55](#). If a patient pays more than these limits, the practitioner must refund the patient-amount over the allowed charge (pages 11, 12, 13, 16).
- January 1, 2022, we pay PA professional services, including services and supplies provided incident to their services (page 13).
- January 1, 2022, we pay professional PA services in all rural and non-rural settings and areas; we pay them only if no facility or other provider bills them or we didn't pay other services they provided (page 13).
- January 1, 2022, PAs may reassign their service payment rights and incorporate as a practitioners' group, only in their specialty, and bill Medicare like NPs and CNSs (page 14).
- Starting January 1, 2022, PAs bill their services directly to the Medicare Program and get paid like NPs and CNSs (pages 14–15).
- January 1, 2022, PAs must use their NPI to bill services (page 15).
- Revised regulations to require an in-person visit within 6 months before furnishing telehealth mental health services and every 12 months while the patient gets telehealth services unless physician and patient agree risks and burdens outweigh an in-person visit benefits and it's documented in medical record (page 24).

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

This booklet reviews Medicare-covered behavioral health services, typically referred to as mental health and substance use services. These services affect a patient's overall well-being. It's important to understand these Medicare-covered services. This booklet explains:

- Covered and non-covered services
- Eligible professionals
- Medicare Advantage (MA) coverage
- Medicare drug plan (Part D) coverage
- Medical record documentation
- Coding

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

## 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 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 personalized prevention plan, including health risk assessment and depression screening
- [Advance Care Planning \(ACP\)](#) to discuss 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
- 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 Opioid Use Disorder (OUD) payments for:
  - OUD management and counseling
  - Billed in office setting, including:
    - Overall management
    - Care coordination
    - Individual and group psychotherapy
    - Substance use counseling (see HCPCS G2086–G2088 billing codes)

- 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 it with unwanted stimuli
- [Cognitive Assessment and Care Planning](#), a comprehensive evaluation of new or existing patient who exhibits cognitive impairment signs and symptoms, required to establish or confirm diagnosis, etiology, and condition severity
- [Chronic Care Management](#) (CCM) and complex CCM for patients with multiple chronic conditions placing them 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 primary care setting who can advise physician of results and coordinate treatment referrals
- Diagnostic psychological and neuropsychological tests
- Drug therapy or pharmacological management using medication(s) to treat disease; all Medicare drug plans have drug management programs for at-risk patients enrolled in Part D
- Drug withdrawal treatment to monitor signs and symptoms after changes in regular drug dose
- Electroconvulsive therapy (ECT) treating depression and other mental illness using electric current to the head
- Family psychotherapy with or without patient present, as medically reasonable and necessary, with patient treatment as the primary purpose
- Health and behavioral assessment and intervention identifying or treating 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 individual in 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

### Opioid Treatment Programs

We now pay certified Opioid Treatment Programs (OTPs) through bundled OUD Medicare Part B treatment services payments. 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.

[Opioid Treatment Program Directory](#) and [OTPs Medicare Billing & Payment](#) booklet have more information.

- [Initial Preventive Physical Exam](#) (IPPE) to review medical and social health history and preventive services education
- Interactive psychotherapy
- **Interactive telecommunications system, including interactive, real-time, 2-way audio-only technology to diagnose, evaluate, or treat certain mental health or Substance Use Disorders (SUDs) using telehealth services if patient is in their home**
- Medication management when a patient agrees to a medication trial period treatment option and effectiveness is monitored
- [Medication-Assisted Treatment](#) (MAT) uses medications with counseling and behavioral therapy to treat SUDs, including OUDs; since January 2020, when a certified OTP provider treats OUDs, we pay for certain medications and services
- Narcosynthesis, a form of narcoanalysis where patient recalls repressed memories under hypnosis
- Psychiatric collaborative care services using BHI to enhance primary care services and including 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, and course and consequences
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) services that are early interventions for individuals with non-dependent substance use to help them prevent more extensive or specialized treatment
- SUD treatment in a patient's home (now an acceptable telehealth substance use treatment or a co-occurring mental health disorder service site)
- [Tobacco use cessation counseling](#)
- Therapeutic activities which can improve the patient's condition, like occupational therapy, recreational therapy, and milieu therapies
- [Transitional care management](#), within 30 days of inpatient hospital setting discharge, interactive contact, certain non-face-to-face services, and face-to-face visits
- Urgently needed care to treat sudden illness or injury that doesn't need emergency medical attention to prevent disability or death

## Prescription Drug Coverage

Medicare drug plans cover 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 drug plan. MA enrollees can get Part A, Part B, and Part D benefits under a single 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

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.

## Non-Covered Services

We **don'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 service apps

## Eligible Professionals

We recognize that these Part B suppliers are eligible to furnish diagnostic and therapeutic mental health services, perform diagnostic tests, and provide [Behavioral Health Integration](#) (BHI) and [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)
- Certified Registered Nurse Anesthetists (CRNAs) (supervision of diagnostic psychological and neuropsychological tests)

## 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. Psychiatrist**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• MD or DO</li> <li>• Act within scope of your license</li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice medicine in the state where you furnish services</li> <li>• We don't statutorily preclude the services, and they're reasonable and necessary</li> <li>• Generally, you may supervise diagnostic psychological and neuropsychological tests</li> <li>• You may furnish services and supplies incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>• Paid at 100% under <a href="#">Medicare Physician Fee Schedule</a> (PFS)</li> </ul>





**Table 2. Clinical Psychologist (CP)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• Psychology Doctoral degree</li> <li>• Licensed or certified in the state where you practice at the independent level and directly furnish diagnostic, assessment, preventive, and therapeutic patient services</li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice psychology in the state where you furnish services</li> <li>• We don't statutorily preclude the services, and they're reasonable and necessary</li> <li>• 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"> <li>◦ Document the date patient consented or declined consultation and consultation dates in patient's medical record</li> <li>◦ If consultations are unsuccessful, document that in the patient's medical record with the date and physician notification method (doesn't apply if physician referred patient to CP)</li> </ul> </li> <li>• Generally, you may supervise diagnostic psychological and neuropsychological tests</li> <li>• You may furnish services and supplies incident to your personal professional services, except in a hospital setting</li> </ul>	<ul style="list-style-type: none"> <li>• We pay only on assignment</li> <li>• Paid at 100% of assigned services under <a href="#">Medicare PFS</a></li> </ul>

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

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• Social Work Master’s or Doctoral degree</li> <li>• At least 2 years supervised clinical social work</li> <li>• Licensed or certified CSW by the state where you furnish services</li> <li>• If you practice in a state that doesn’t have licensure or certification, and you completed 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)</li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice clinical social work in the state where you furnish services</li> <li>• We don’t statutorily preclude the services, and they’re reasonable and necessary</li> <li>• You furnish mental health services for the diagnosis and treatment of mental illness and you’re legally authorized to perform them under state law</li> <li>• We don’t pay CSWs under CSW benefit category for their hospital inpatient services</li> <li>• We cover CSW hospital outpatient services and pay CSW services under CSW benefit category when hospitals bill under CSW’s National Provider Identifier (NPI)</li> <li>• We don’t pay under CSW benefit category for CSW services to patients under PHP by a hospital outpatient department or Community Mental Health Center (CMHC)</li> <li>• We don’t pay under 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</li> <li>• We may cover ancillary CSW services incident to personal physician, CP, CNS, NP, PA, or CNM professional services</li> <li>• We don’t cover services incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>• We pay only on assignment</li> <li>• Paid at 75% of CP’s <a href="#">Medicare PFS</a></li> </ul>

**Table 4. Clinical Nurse Specialist (CNS)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>Registered Nurse (RN) currently licensed in the state where you practice and authorized to furnish CNS services according to state law</li> <li>Doctor of Nursing Practice or Master’s degree in a defined clinical nursing area from an accredited educational institution</li> <li>Certified as a CNS by a recognized <a href="#">national certifying body</a> with established CNS standards</li> </ul>	<ul style="list-style-type: none"> <li>Legally authorized to practice medicine in the state where you furnish services</li> <li>We don’t statutorily preclude the services, and they’re reasonable and necessary</li> <li>We consider the services physicians’ services if furnished by MD or DO</li> <li>You furnish services while working in collaboration with a physician</li> <li>We may cover assistant-at-surgery services you furnish</li> <li>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 CNS benefit; we authorize CNSs to supervise diagnostic tests performance according to state law and scope of practice</li> <li>You may furnish services and supplies incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>We pay only on assignment</li> <li>If you furnish services on assignment, you can’t charge a patient more than amounts permitted under <a href="#">42 CFR 424.55</a> <ul style="list-style-type: none"> <li>If a patient paid a service over these limits, you must refund their payment</li> </ul> </li> <li>We pay services at 80% of the lesser of actual charge or 85% of amount a physician gets under <a href="#">Medicare PFS</a></li> <li>We pay assistant-at-surgery services directly at 85% of 16% of amount a physician gets under Medicare PFS</li> </ul>

**Table 5. Nurse Practitioner (NP)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• RN licensed and authorized by the state where you furnish NP services according to state law</li> <li>• Got Medicare NP billing privileges for first time since January 1, 2003, and:                             <ul style="list-style-type: none"> <li>◦ NP certified by recognized <a href="#">national certifying body</a> with established NP standards</li> <li>◦ Master’s degree in nursing or a Doctor of Nursing Practice Doctoral degree</li> </ul> </li> <li>• Got Medicare NP billing privileges for first time before January 1, 2003, and meets certification requirements</li> <li>• Got Medicare NP billing privileges for first time before January 1, 2001</li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice medicine in state where you furnish services</li> <li>• We don’t statutorily preclude the services, and they’re reasonable and necessary</li> <li>• We consider the services physicians’ services if furnished by MD or DO</li> <li>• You furnish services while working in collaboration with a physician</li> <li>• We may cover assistant-at-surgery services you furnish</li> <li>• 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 NP benefit; we authorize NPs to supervise diagnostic tests performance according to state law and scope of practice</li> <li>• You may furnish services and supplies incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>• We pay only on assignment</li> <li>• <b>If you furnish services on assignment, you can’t charge a patient more than amounts permitted under <a href="#">42 CFR 424.55</a></b> <ul style="list-style-type: none"> <li>◦ <b>If a patient paid a service over these limits, you must refund their payment</b></li> </ul> </li> <li>• We pay services at 80% of the lesser of actual charge or 85% of amount a physician gets under <a href="#">Medicare PFS</a></li> <li>• We pay assistant-at-surgery services directly at 85% of 16% of amount a physician gets under Medicare PFS</li> </ul>

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

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• Licensed by the state where you practice and 1 of these criteria:                             <ul style="list-style-type: none"> <li>◦ Graduated from a PA educational program accredited by <a href="#">Accreditation Review Commission on Education for the Physician Assistant</a> (or its predecessor agencies, Commission on Accreditation of Allied Health Education Programs, and Committee on Allied Health Education and Accreditation)</li> <li>◦ Passed the national certification exam administered by <a href="#">National Commission on Certification of Physician Assistants</a></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice medicine in the state where you furnish services</li> <li>• We don't statutorily preclude the services, and they're reasonable and necessary</li> <li>• We consider the services physicians' services if furnished by MD or DO</li> <li>• An individual who meets all PA qualifications furnishes the services</li> <li>• You furnish services under an MD or DO's supervision</li> <li>• We may cover assistant-at-surgery services you furnish</li> <li>• You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under PA benefit category and as authorized by state law; we authorize PAs to supervise diagnostic tests performance according to state law and scope of practice</li> <li>• You may furnish services and supplies incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>• We pay only on assignment</li> <li>• <b>If you furnish services on assignment, you can't charge a patient more than amounts permitted under <a href="#">42 CFR 424.55</a></b> <ul style="list-style-type: none"> <li>◦ <b>If a patient paid a service over these limits, you must refund their payment</b></li> </ul> </li> <li>• <b>As of January 1, 2022, we make your professional services payments, including services and supplies payments furnished incident to your services</b></li> <li>• <b>As of January 1, 2022, we pay your professional services furnished in all rural and non-rural settings and areas</b> <ul style="list-style-type: none"> <li>◦ <b>We pay only if no facility or other provider charges or we didn't pay any other service amount they furnished</b></li> </ul> </li> <li>• We pay services at 80% of lesser of actual charge or at 85% of amount a physician gets under <a href="#">Medicare PFS</a></li> <li>• We pay your assistant-at-surgery services directly at 85% of 16% of amount a physician gets under Medicare PFS</li> </ul>

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

Required Qualifications	Coverage Requirements	Payment
(continued from previous page)	(continued from previous page)	<ul style="list-style-type: none"> <li>• We pay services furnished incident to a PA outside a hospital at 85% of amount a physician gets under Medicare PFS</li> <li>• When you bill hospital inpatient and outpatient services directly, we unbundle the payment and we pay you directly</li> <li>• Before January 1, 2022, we paid your employer whether you furnished services under a W-2, employer-employee relationship, or were an independent contractor who got a 1099 reflecting the relationship                         <ul style="list-style-type: none"> <li>◦ As of January 1, 2022, you can bill us and we pay your services directly like we do NPs and CNSs</li> </ul> </li> <li>• Before January 1, 2022, you couldn't reassign your service payments and your employer or contractor couldn't bill reassigned services                         <ul style="list-style-type: none"> <li>◦ As of January 1, 2022, you may reassign your service payment rights and incorporate as a group of practitioners only in your specialty and bill us like NPs and CNSs do</li> </ul> </li> </ul>

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

Required Qualifications	Coverage Requirements	Payment
(continued from previous page)	(continued from previous page)	<ul style="list-style-type: none"> <li>• Before January 1, 2022, we required a supervising physician to bill under their NPI for services you furnished incident to physician’s professional services</li> <li>• Before January 1, 2022, we required your employer or contractor to bill under your NPI for services furnished incident to your professional services                             <ul style="list-style-type: none"> <li>◦ As of January 1, 2022, you must bill under your NPI</li> </ul> </li> </ul>



**Table 7. Certified Nurse-Midwife (CNM)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• RN legally authorized to practice as nurse-midwife in the state where you furnish services</li> <li>• Successfully completed nurse-midwives program of study and clinical experience accredited by accrediting body the U.S. Department of Education approved</li> <li>• Certified as a Nurse-Midwife by <a href="#">American College of Nurse-Midwives</a> or <a href="#">American College of Nurse-Midwives Certification Council</a></li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice medicine in the state where you furnish services</li> <li>• We don't statutorily preclude the services, and they're reasonable and necessary</li> <li>• We consider the services physicians' services if furnished by MD or DO</li> <li>• You furnish services without physician supervision and without association with a physician or other health care provider, unless otherwise required under state law</li> <li>• You may personally perform diagnostic psychological and neuropsychological tests without physician supervision or oversight as required under CNM benefit category and as authorized under state law; we authorize CNMs to supervise diagnostic tests performance according to state law and scope of practice</li> <li>• You may furnish services and supplies incident to your personal professional services</li> </ul>	<ul style="list-style-type: none"> <li>• We pay only on assignment</li> <li>• <b>If you furnish services on assignment, you can't charge a patient more than amounts permitted under <a href="#">42 CFR 424.55</a></b> <ul style="list-style-type: none"> <li>◦ <b>If a patient paid a service over these limits, you must refund their payment</b></li> </ul> </li> <li>• We pay services at 80% of lesser of actual charge or 100% of amount a physician gets under <a href="#">Medicare PFS</a></li> </ul>



**Table 8. Independently Practicing Psychologist (IPP)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>● Psychologist who isn't a CP</li> <li>● Meets 1 of these criteria:                             <ul style="list-style-type: none"> <li>○ Practices independent of an institution, agency, or physician's office and licensed or certified to practice psychology in the state or jurisdiction where you furnish the services</li> <li>○ Practicing psychologist who furnishes services in jurisdiction that doesn't issue licenses</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● We don't statutorily preclude the services, and they're reasonable and necessary</li> <li>● Provide services on your own responsibility, free of administrative and professional control of an employer (for example, physician, institution, or agency)</li> <li>● You treat your own patients</li> <li>● When you practice in an office in an institution:                             <ul style="list-style-type: none"> <li>○ Office is confined to a separately identified part of facility used solely as an office and not confused as extending throughout entire institution</li> <li>○ You operate a private practice (patients outside institution and institutional patients)</li> </ul> </li> <li>● You may perform diagnostic psychological and neuropsychological tests when physician or certain Non-Physician Practitioners (NPPs) order them</li> <li>● You can bill directly and collect and retain service fees</li> </ul>	<ul style="list-style-type: none"> <li>● We don't subject diagnostic psychological and neuropsychological tests to assignment; however, you must include physician name and address or NPP who orders tests on claim</li> <li>● Paid at 100% of assigned services under <a href="#">Medicare PFS</a></li> </ul>

**Table 9. Certified Registered Nurse Anesthetist (CRNA)**

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> <li>• Licensed as a registered professional nurse by the state where you practice</li> <li>• Meet any licensure requirements the state imposes on non-physician anesthetists</li> <li>• Graduated from nurse anesthesia educational program that meets standards of <a href="#">Council on Accreditation of Nurse Anesthesia Educational Programs</a> (COA) or other accreditation organization the HHS Secretary designates</li> <li>• Passed a <a href="#">National Board of Certification &amp; Recertification of Nurse Anesthetists</a> (NBCRNA) certification exam</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Legally authorized to practice medicine in the state where you furnish services</li> <li>• We don’t statutorily preclude the services, and they’re reasonable and necessary</li> <li>• You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under CRNA benefit category and as authorized by state law; we authorize CRNAs to supervise diagnostic tests performance according to state law and scope of practice</li> <li>• You can bill directly and collect and retain service fees</li> </ul>	<ul style="list-style-type: none"> <li>• Paid at 100% under <a href="#">Medicare PFS</a></li> <li>• You may bill your services directly to us, get paid directly, or have payment made to any individual 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</li> </ul>

## Incident to Provision

While we authorize a physician, CP, CSW, NP, CNS, CNM, and PA to personally provide outpatient psychiatric services and supplies as their professional services, they can be auxiliary personnel under the incident to benefit category and provide outpatient psychiatric services incident to personal professional physician (MD or DO), CP, NP, CNS, CNM, and PA services when their ancillary services and supplies provided incident to comply with state law and meet all these requirements:

- Services and supplies integral to the patient's normal treatment course and physician or other listed NPPs personally provided an initial service and remains actively involved in treatment
- Practitioner commonly provides 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

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

[42 CFR 410.26](#) has more information.



## 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 10. 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
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*

\* Mental health code not approved for partial hospitalization program.

CPT only copyright 2021 American Medical Association. All rights reserved.

**Table 10. Eligible Professionals Commonly Used CPT Codes (cont.)**

Description	CPT Code
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—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

CPT only copyright 2021 American Medical Association. All rights reserved.

**Table 10. 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

CPT only copyright 2021 American Medical Association. All rights reserved.

## 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. [National Correct Coding Initiative Edits](#) webpage has more information.

## 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 services duration
  - 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 treatment goals and if POC should change
  - Provides 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 patient's psychiatric symptoms to prevent 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 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, when part of a PHP, that:
  - Require qualified occupational therapist skills
  - Are provided by, or under supervision of, a qualified occupational therapist
  - Are included in patient's POC

- Activity therapies, when part of PHP, that are:
  - Individualized and essential for treating a patient's diagnosed condition and progressing toward treatment goals
  - POC clearly supports and shows each therapy's need (not primarily recreational or diversionary)
- Family counseling services while treating individual's condition
- Patient training and education when they're closely and clearly related to care and treatment of individual's diagnosed psychiatric condition
- Therapeutic drugs and biologicals 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)
- [42 CFR 405.2463\(b\)\(3\)](#) says there must be an in-person visit within 6 months before furnishing telehealth mental health services and every 12 months while patient gets them unless physician and patient agree risks and burdens outweigh in-person visit benefits and it's documented in the medical record

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. They 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 inpatient hospital treatment and PHP replaces continued inpatient treatment
- At reasonable inpatient hospitalization risk without partial hospitalization

PHP must meet these [program and patient criteria](#):

- Active treatment includes individual POC with coordinated services designed for patient's needs
- POC treatment includes physician-directed multi-disciplinary team care approach certifying patient's partial hospitalization therapeutic services minimum need of 20 hours per week
- Treatment goals should be:
  - Measurable
  - Functional
  - Time framed
  - Medically necessary
  - Directly related to admission reason
- Patient requires comprehensive, highly structured, scheduled, multi-modal individualized POC requiring medical supervision and coordination because mental disorder severely interferes with multiple areas of daily life (social, vocational, Activities of Daily Living [ADL]/instrumental ADLs, and educational functioning)
- 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

## Community Mental Health Center

We cover Part B partial hospitalization services that Community Mental Health Centers (CMHCs) provide, subject to the Outpatient Prospective Payment System (OPPS). Medicare-authorized CMHCs must meet these [program and patient criteria](#):

- Appropriate state and local CMHC licensing or certification
- Provide:
  - Outpatient services, including specialized services for children, older adults, chronically mentally ill individuals, and mental health residents of its service area discharged from inpatient mental health treatment facility
  - 24-hour emergency care services with clinician access and appropriate disposition with follow-up documentation of the emergency in 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 patient's needs
  - At least 40% of its services is to individuals 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. [Behavioral Health Integration Services](#) booklet has more information, including psychiatric collaborative care services and important coding information.

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

[Print Checklist](#)

## Medical Records Checklist: Outpatient Psychiatric Services

### Partial Hospitalization Program Services & Community Mental Health Centers

#### Medical Record Content (Check if Yes)

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

#### Community Mental Health Center & Partial Hospitalization Program Standard Initial Evaluation (Check if Yes)

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

## Community Mental Health Center & Partial Hospitalization Program Standard Comprehensive Assessment (Check if Yes)

- Interdisciplinary treatment team completed timely assessment consistent with patient's needs, but no later than 4 working days after admission
- Identifies patient's psychiatric illness and ensures physical, psychological, psychosocial, emotional, and therapeutic active treatment plan needs consistent with findings
- Includes:
  - 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 treatment plan
  - Intellectual, memory functioning, and orientation assessment
  - Care planning risk factor complications
  - Functional status, including whether patient can participate in own care and their strengths and goals
  - Factors affecting patient or others' safety and suicide risk factors
  - Patient's prescription drug profile, including over-the-counter medications
  - Referral needs and further health care professional evaluation
  - Considered discharge planning factors
  - Identify patient's current social and health care support systems
  - For pediatric clients, assess social service needs and make needed referrals
- Make interdisciplinary team updates when patient status or treatment response changes occur, or patient meets goals

## Community Mental Health Center & Partial Hospitalization Program Standard Comprehensive Assessment (cont.) (Check if Yes)

- Upon patient discharge or transfer to another entity, within 2 working days the CMHC must forward:
  - Discharge summary
  - Clinic record, if requested
- If patient refuses CMHC services, or is non-compliant with treatment plan, the CMHC must forward to primary health care provider:
  - CMHC discharge summary copy
  - 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, we cover the services only if the patient needs intensive, appropriate, and active treatment in an inpatient setting. The 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.

## Inpatient Psychiatric Facility 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' mental disorders.

We pay 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 physician or NPP patient treatment level and intensity for each patient they admit to the hospital, among other requirements detailed at [42 CFR 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 482.13](#).

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

[Print Checklist](#)

## Medical Records Checklist: Inpatient Psychiatric Services

### Medical Records Content (Check if Yes)

- Patient identification data, including inpatient legal status
- Incoming patient history findings and treatment plan
- Patient provisional or admitting diagnosis, including intercurrent disease diagnoses and psychiatric diagnoses
- 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 (Check if Yes)

- Completed within 60 hours of 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 (Check if Yes)**

- 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 (Check if Yes)**

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

**Discharge Plan (Check if Yes)**

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



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

- 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, representative, or physician?
- Did an RN, social worker, or other appropriately qualified staff member develop or supervise the plan?
- Did the evaluation include 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 patient's medical record document interaction relaying discharge planning evaluation results to 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 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 developed?
- Did the hospital arrange to implement 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 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 patient was enrolled in a managed care organization, did the hospital indicate those contracted managed care organizations services?
  - Did you document in the medical record 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 (Check if Yes)**

- 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). 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). We determine 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)

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

## Same Day Billing Guidelines

Integrating mental health and SUD services address 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:
  - **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

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 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 aren't mainly for patient, provider, or supplier convenience.

Services must also meet specific National Coverage Determination (NCD) and Local Coverage Determination (LCD) medical necessity criteria. [Medicare Coverage Determination Process](#) webpage has more information.

Every service billed must indicate the specific sign, symptom, or patient complaint showing the service need. 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 Opioid Treatment Programs](#)
- [Calendar Year 2022 Payment Policies Under the Physician Fee Schedule and other Changes to Part B Payment Policies](#)
- [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 \(SAMHSA\)](#)

[Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).