Medicare Learning Network
MLN Matters®
CMS CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Flu Season is upon us! CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (*Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.*) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to ***http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*** on the CMS website.

MLN Matters® Number: MM6686

Related Change Request (CR) #: 6686

Related CR Release Date: October 30, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R51GI, R114BP, and R1843CP

Implementation Date: January 4, 2010

Outpatient Mental Health Treatment Limitation

Provider Types Affected

This article is of special interest to physicians, clinical psychologists (CPs), clinical social workers (CSWs), nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) who submit claims to Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), or carriers, for mental health services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 6686 alerts providers that the Centers for Medicare & Medicaid Services (CMS) is phasing out the outpatient mental health treatment limitation (the limitation) over a 5-year period, from 2010-2014. Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, that is, at 80 percent of the physician fee schedule.

Background

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase out the outpatient mental health treatment limitation over a 5-year period, from 2010-2014. The limitation has resulted in Medicare paying only 50 percent of the approved amount under the physician fee schedule for outpatient mental health treatment rather than 80 percent that is paid for most other services.

Key Points of CR 6686

Section 102 of MIPPA requires that the current 62.5% outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

- **January 1, 2010 – December 31, 2011**, the limitation percentage is 68.75% (of which Medicare pays 55% and the patient pays 45%);
- **January 1, 2012 – December 31, 2012**, the limitation percentage is 75% (of which Medicare pays 60% and the patient pays 40%);
- **January 1, 2013 – December 31, 2013**, the limitation percentage is 81.25% (of which Medicare pays 65% and the patient pays 35%); and,
- **January 1, 2014 – onward**, the limitation percentage is 100%, at which time Medicare pays 80% and the patient pays 20%.

For Rural Health Clinics and Federally Qualified Health Centers, the amount the patient pays may differ from the percentages shown above if the charges are not equal to the encounter rate for the clinic.

Services Not Subject to the Limitation

- Medicare will not apply the limitation on type of bill (TOB) 75x. Since Comprehensive Outpatient Rehabilitation Facilities (CORFs) do not provide mental health therapeutic services, the limitation does not apply to CORF services. Note that CPT code 96152 is the only CPT code allowed for behavioral health services provided in a CORF, and this service is not subject to the limitation.
- **Diagnosis of Alzheimer's disease or Related Disorder** - When the primary diagnosis reported for a particular service is Alzheimer's disease or as an Alzheimer's related disorder, your Medicare contractor will look to the nature of the service that has been rendered in determining whether it is subject to the limitation.
    - Alzheimer's disease is coded 331.0 in the "International Classification of Diseases, 9th Revision", which is outside the diagnosis code range 290-319 that represents mental, psychoneurotic and personality disorders that are potentially subject to the limitation.

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- Additionally, Alzheimer's related disorders are identified by Medicare contractors under ICD-9 codes that are outside the 290-319 diagnosis code range. Typically, treatment provided to a patient with a diagnosis of Alzheimer's disease or a related disorder represents medical management of the patient's condition (**such as described under CPT code 90862 or any successor code) and is not subject to the limitation**. CPT code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
- However, when the **primary** treatment rendered to a patient with a diagnosis of Alzheimer's disease or a related disorder is **solely psychotherapy, it is subject to the limitation**.

Additional Information

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

The official instruction, CR6686, was issued via three transmittals to your Medicare FI, carrier, or A/B MAC regarding this change. The first transmittal, available at ***http://www.cms.hhs.gov/Transmittals/downloads/R60GI.pdf***, revises the Medicare General Information, Eligibility and Entitlement Manual. The second transmittal, available at ***http://www.cms.hhs.gov/Transmittals/downloads/R114BP.pdf***, revises the Medicare Benefit Policy Manual. The third transmittal, available at ***http://www.cms.hhs.gov/Transmittals/downloads/R1843CP.pdf***, revises the Medicare Claims Processing Manual.

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