



Medicare & Mental Health Coverage



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What's Changed?

- Added language for anyone experiencing a mental health crisis and where to get help (page 5)
- Added chronic pain management as a covered behavioral health and wellness service (page 6)
- Hospital clinical staff must have the capability to provide 2-way, interactive, audio-video technology services but may use audio-only technology given an individual patient's technological limitations, abilities, or preferences (page 7)
- Added language about providing telehealth services using 2-way, interactive, audio-only technology through December 31, 2024 (page 7)
- Added a behavioral health resource (page 8)
- Clarified nurse practitioner qualification requirements (page 15)
- Added language about the in-person visit requirements after the PHE ends (pages 27)
- We created 3 Outpatient Prospective Payment System-specific HCPCS codes to describe that the patient must be in their home and there's no associated professional service billed under the Medicare Physician Fee Schedule (page 27)
- We created a new general behavioral health integration code (page 29)
- Added HCPCS G2011 and description to reflect current coding available for screening, brief intervention, and referral to treatment services (page 38)

Substantive content changes are in dark red.

Medicare-covered behavioral health services, typically referred to as mental health and substance use services, can affect a patient's overall well-being. It's important to understand Medicare's covered services and who can provide them.

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

Medicare-Covered Services

We may cover these behavioral health and wellness services:

- [Alcohol misuse screening and counseling](#) for adults who use alcohol but aren't dependent; if you detect misuse, we cover up to 4 brief, face-to-face counseling sessions per year if the patient is competent and alert during counseling
- Alcohol treatment, detoxification, outpatient hospital treatment, and rehabilitative services, including inpatient hospital stays
- [Annual wellness visit](#) (AWV) to develop or update a personalized prevention plan, including health risk assessment and depression screening
- [Advance care planning](#) (ACP) to discuss a patient's health care wishes if they can't make decisions about their care, as part of the AWV or a separate Part B service, including an advance directive
- [Behavioral health integration](#) (BHI) by clinical staff to assess, monitor, and plan care
- Biofeedback therapy, where patients learn non-drug treatments to control bodily responses, like heart rate and muscle tension
- Bundled opioid use disorder (OUD) payments for:
 - OUD management and counseling
 - OUD services provided in an 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 the behavior with unwanted stimuli

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 (including methadone, buprenorphine, and naltrexone) and their administration (if applicable), substance use counseling, individual and group therapy, toxicology testing, intake activities, periodic assessments, and take-home supplies of naloxone.

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

- [Cognitive assessment and care planning](#), a comprehensive evaluation of a new or existing patient who exhibits cognitive impairment signs and symptoms, required to establish or confirm a diagnosis, etiology, and condition severity
- [Chronic care management](#) (CCM) and complex CCM for patients with multiple chronic conditions placing them at high risk
- **Chronic pain management (CPM) for patients with chronic pain**
- [Depression screening](#), up to 15 minutes annually, when staff-assisted depression care supports can assure accurate diagnosis, effective treatment, and follow-up; screening by clinical staff in a primary care setting who can advise the physician of results and coordinate treatment referrals
- Diagnostic psychological and neuropsychological tests
- Drug therapy or pharmacological management using medications to treat a disease
- Drug withdrawal treatment to monitor signs and symptoms after changes in regular drug dose
- Electroconvulsive therapy (ECT) treating depression and other mental illness that involves passing small electric currents through the brain, intentionally triggering a seizure
- Family psychotherapy with or without the patient present, as medically reasonable and necessary, with patient treatment as the primary purpose
- Health and behavioral assessment and intervention 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 person in a therapy session with 1 or more therapists
- Individual activity therapy that's part of a partial hospitalization program (PHP), which may be cognitive, physical, social, and spiritual but not recreational or diversionary
 - PHP, a structured, intensive, outpatient psychiatric services program, is an alternative to inpatient psychiatric care provided during the day (doesn't require an overnight stay) through a hospital outpatient department or community mental health center (CMHC)
- [Initial preventive physical exam](#) (IPPE) to review medical and social health history and provide preventive services education, counseling, and referral, as appropriate

- Interactive psychotherapy
- Interactive telecommunications, including 2-way, interactive audio-only technology to diagnose, evaluate, or treat certain mental health or substance use disorders (SUDs) using telehealth services if the patient is in their home
 - Hospital clinical staff must have the capability to provide 2-way, interactive, audio-video technology services but may use audio-only technology given an individual patient's technological limitations, abilities, or preferences
 - After the COVID-19 public health emergency (PHE) ended on May 11, 2023, the Consolidated Appropriations Act, 2023 extends the availability of telehealth services that you can provide using 2-way, interactive, audio-only technology through December 31, 2024
- Medication for Opioid Use Disorder (MOUD) management when a patient agrees to a medication trial period treatment option and its effectiveness is monitored
- [Medication-Assisted Treatment](#) (MAT) uses medications with counseling and behavioral therapy to treat SUDs, including OUDs; when a certified OTP provider treats OUDs, we pay for certain medications and services
- Narcosynthesis, a form of narcoanalysis where a patient recalls repressed memories under hypnosis
- Psychiatric collaborative care services using BHI to enhance primary care services and include a psychiatric consultant
- Psychoanalysis that treats mental disorders by investigating the interaction of conscious and unconscious elements
- Psychiatric evaluation that systematically evaluates a psychiatric disorder's causes, symptoms, and course and consequences
- [Screening, brief intervention, and referral to treatment](#) (SBIRT) services that are early interventions for people with non-dependent substance use to help them prevent more extensive or specialized treatment
- SUD treatment in a patient's home (an acceptable telehealth substance use treatment or a co-occurring mental health disorder service site)
- [Tobacco use cessation counseling](#)
- Therapeutic activities that can improve the patient's condition, like occupational therapy, recreational therapy, and milieu therapies
- [Transitional care management](#), within 30 days of an inpatient hospital setting discharge, interactive contact, certain non-face-to-face services, and face-to-face visits
- Urgent care needed to treat sudden illness or injury that doesn't need emergency medical attention to prevent disability or death

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

Non-Covered Services

We **don't** cover these mental health services:

- Environmental intervention or modifications
- Adult day health programs
- 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 applications (“apps”)

Prescription Drug Coverage

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

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

Medicare Advantage Organizations

Medicare Advantage (MA) enrollees can get Part A, Part B, and Part D benefits under a single plan. MA Plans provide Part B covered mental health services and may offer certain (for example, telehealth) benefits beyond what Part B pays. They may also provide supplemental benefits Parts A or B don't cover. For example, supplemental mental health benefits may address coping with life changes, conflict resolution, or grief counseling, all offered as individual or group sessions.

Eligible Professionals

We recognize these Part B suppliers as eligible to provide diagnostic and therapeutic mental health services, perform diagnostic tests, and provide 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"> • MD or DO • Act within the scope of your license 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • We don't statutorily preclude the services, and they're reasonable and necessary • Generally, you may supervise diagnostic psychological and neuropsychological tests • You may provide services and supplies incident to your personal professional services 	<ul style="list-style-type: none"> • Paid at 100% under the Medicare Physician Fee Schedule (PFS)



Table 2. Clinical Psychologist (CP)

Required Qualifications	Coverage Requirements	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 psychology in the state where you provide services • We don't statutorily preclude the services, and they're reasonable and necessary • If the patient consents, you must attempt to consult their attending or primary care physician about provided services and either: <ul style="list-style-type: none"> • Document the date the patient consented or declined consultation and the consultation dates in the patient's medical record • If consultations are unsuccessful, document that in the patient's medical record with the date and the physician notification method (doesn't apply if the physician referred patient to a CP) • Generally, you may supervise diagnostic psychological and neuropsychological tests • You may provide services and supplies incident to your personal professional services, except in a hospital setting 	<ul style="list-style-type: none"> • We pay only on assignment • Paid at 100% of assigned services under the Medicare PFS

Table 3. Clinical Social Worker (CSW)

Required Qualifications	Coverage Requirements	Payment
<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 CSW by the state where you provide services 	<ul style="list-style-type: none"> • Legally authorized to practice clinical social work in the state where you provide services • We don’t statutorily preclude the services, and they’re reasonable and necessary • You provide mental health services for diagnosing and treating a mental illness and you’re legally authorized to perform them under state law • We don’t pay CSWs under the CSW benefit category for their hospital inpatient services • We cover CSW hospital outpatient services and pay CSW services under the CSW benefit category when hospitals bill under the CSW’s NPI • We don’t pay under the CSW benefit category for CSW services to patients under a PHP by a hospital outpatient department or CMHC 	<ul style="list-style-type: none"> • We pay only on assignment

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

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> If you practice in a state that doesn't have licensure or certification and you completed at least 2 years or 3,000 supervised clinical hours of social work practice, post-master's degree in an appropriate setting (for example, a hospital, skilled nursing facility (SNF), or clinic) 	<ul style="list-style-type: none"> We don't pay under the CSW benefit category for CSW services to SNF inpatients and patients in Medicare-participating ESRD facilities if the services are under the respective provider's participation requirements We may cover ancillary CSW services incident to personal physician, CP, CNS, NP, PA, or CNM professional services We don't cover services incident to your personal professional services 	<ul style="list-style-type: none"> Paid at 75% of the CP's Medicare PFS



Table 4. Clinical Nurse Specialist (CNS)

Required Qualifications	Coverage Requirements	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 • We don’t statutorily preclude the services, and they’re reasonable and necessary • We consider the services physicians’ services if they’re provided by MD or DO • You provide the services while working in collaboration with a physician • We may cover assistant-at-surgery services you provide • You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under CNS benefit; we authorize CNSs to supervise diagnostic tests performance according to state law and scope of practice • You may provide services and supplies incident to your personal professional services 	<ul style="list-style-type: none"> • We pay only on assignment • If you provide services on assignment, you can’t charge a patient more than the amounts permitted under 42 CFR 424.55 <ul style="list-style-type: none"> • If a patient paid a service over these limits, you must refund their payment • We pay services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the Medicare PFS • We pay assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS

Table 5. Nurse Practitioner (NP)

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> • RN licensed and authorized by the state where you provide NP services according to state law • Be a registered professional nurse who’s authorized by the state where they provide services to practice as a NP by December 31, 2000 • Got Medicare NP billing privileges for first time since January 1, 2003, and: <ul style="list-style-type: none"> • 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 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 • We don’t statutorily preclude the services, and they’re reasonable and necessary • We consider the services physician services if they’re provided by an MD or a DO • You provide the services while working in collaboration with a physician • We may cover assistant-at-surgery services you provide • You may personally perform diagnostic psychological and neuropsychological tests to the extent authorized by state law to perform tests in collaboration with a physician as required under the NP benefit; we authorize NPs to supervise diagnostic tests performance according to state law and scope of practice • You may provide services and supplies incident to your personal professional services 	<ul style="list-style-type: none"> • We pay only on assignment • If you provide services on assignment, you can’t charge a patient more than the amounts permitted under 42 CFR 424.55 <ul style="list-style-type: none"> • If a patient paid a service over these limits, you must refund their payment • We pay services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the Medicare PFS • We pay assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS

Table 6. Physician Assistant (PA)

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> • Licensed by the state where you practice and 1 of these criteria apply: <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, Commission on Accreditation of Allied Health Education Programs, and Committee on Allied Health Education and Accreditation) 	<ul style="list-style-type: none"> • Legally authorized to practice medicine in the state where you provide services • We don't statutorily preclude the services, and they're reasonable and necessary • We consider the services physicians' services if provided by an MD or a DO • Someone who meets all PA qualifications provides the services • You provide services under an MD or DO's supervision • We may cover assistant-at-surgery services you provide 	<ul style="list-style-type: none"> • We pay only on assignment • If you provide services on assignment, you can't charge a patient more than the amounts permitted under 42 CFR 424.55 <ul style="list-style-type: none"> • If a patient paid a service over these limits, you must refund their payment • We pay your professional services, including services and supplies provided incident to your services • We pay your professional services provided in all rural and non-rural settings and areas



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

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> Passed a national certification exam administered by National Commission on Certification of Physician Assistants 	<ul style="list-style-type: none"> You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under the PA benefit category and as authorized by state law; we authorize PAs to supervise diagnostic tests performed according to state law and scope of practice You may provide services and supplies incident to your personal professional services 	<ul style="list-style-type: none"> We pay only if no facility or other provider charges or we didn't pay any other service amount they provided We pay services at 80% of the lesser of the actual charge or at 85% of the amount a physician gets under the Medicare PFS We pay your assistant-at-surgery services directly at 85% of 16% of the amount a physician gets under the Medicare PFS We pay services provided incident to a PA outside a hospital at 85% of the amount a physician gets under the Medicare PFS When you bill a hospital inpatient and outpatient service directly, we unbundle the payment and pay you directly You can bill Medicare and we pay your services directly like we do NPs and CNSs You may reassign your service payment rights and incorporate as a group of practitioners only in your specialty and bill Medicare like NPs and CNSs do You must bill under your NPI

Table 7. Certified Nurse-Midwife (CNM)

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

Table 8. Independently Practicing Psychologist (IPP)

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

Table 9. Certified Registered Nurse Anesthetist (CRNA)

Required Qualifications	Coverage Requirements	Payment
<ul style="list-style-type: none"> Licensed as a registered professional nurse by the state where you practice Meet any licensure requirements the state imposes on non-physician anesthetists Graduated from a nurse anesthesia educational program that meets standards of Council on Accreditation of Nurse Anesthesia Educational Programs (COA) or other accreditation organization the HHS Secretary designates Passed a National Board of Certification & Recertification of Nurse Anesthetists (NBCRNA) certification exam Graduated from a nurse anesthesia educational program that meets the COA Educational Program’s standards and, within 24 months of graduation, passed a certification exam from NBCRNA or another certification organization the HHS Secretary designates 	<ul style="list-style-type: none"> Legally authorized to practice medicine in the state where you provide services We don’t statutorily preclude the services, and they’re reasonable and necessary You may personally perform diagnostic psychological and neuropsychological tests under physician supervision as required under the CRNA benefit category and as authorized by state law; we authorize CRNAs to supervise diagnostic tests performed according to state law and scope of practice You can bill directly and collect and retain service fees 	<ul style="list-style-type: none"> Paid at 100% under the Medicare PFS You may bill your services directly to Medicare, get paid directly, or have payment made to any person or entity (for example, hospital, critical access hospital, physician, group practice, or ambulatory surgical center) if you have an employment or contractor relationship that’s paying you or them

Incident to Provision

While we authorize a physician, a CP, a CSW, an NP, a CNS, a CNM, and a PA to personally provide outpatient psychiatric services and supplies as their professional services, auxiliary personnel can provide them 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 are integral to the patient's normal treatment course and the physician or other listed NPP personally provided an initial service and remain actively involved in treatment
- The 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 the physician or other listed NPP
- Services and supplies are commonly offered in the physician's or other listed NPP's office or clinic
- The 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 a DO.

[42 CFR 410.26](#) and [42 CFR 410.27](#) have more information.



Commonly Used CPT Codes

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

Table 10. Commonly Used Mental Health-Related CPT Codes

Description	CPT Code
Interactive complexity (List separately in addition to the code for primary procedure) (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90833, 90834, 90836, 90837, 90838], and group psychotherapy [90853]) (Use 90785 in conjunction with 90853 for the specified patient when group psychotherapy includes interactive complexity)	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services (Use 90785 in conjunction with 90791, 90792 when the diagnostic evaluation includes interactive complexity services)	90792
Psychotherapy, 30 minutes with patient	90832
Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90833
Psychotherapy, 45 minutes with patient	90834
Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90836
Psychotherapy, 60 minutes with patient	90837
Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90838
Psychotherapy for crisis; first 60 minutes	90839*
Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	90840
Psychoanalysis	90845
Family psychotherapy (without the patient present), 50 minutes	90846
Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	90847

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Table 10. Commonly Used Mental Health-Related CPT Codes (cont.)

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

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Table 10. Commonly Used Mental Health-Related CPT Codes (cont.)

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

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Table 10. Commonly Used Mental Health-Related CPT Codes (cont.)

Description	CPT Code
Health behavior intervention, individual, face-to-face; 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 (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96165
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96167
Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96168
Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	96170
Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	96171

*Mental health code not approved for partial hospitalization program.

National Correct Coding Initiative

The [National Correct Coding Initiative](#) (NCCI) promotes national correct coding methods and offers national guidance on code pair edits preventing billing certain services on the same day.

Outpatient Psychiatric Hospital Services

Outpatient psychiatric hospital services and supplies are:

- Medically necessary for diagnostic study or if the patient's condition is reasonably expected to improve (see the [Same Day Billing Guidelines](#) section for more information)
- Provided under an individualized, written plan of care (POC) that states the:
 - Type, amount, frequency, and services duration
 - Diagnosis
 - Expected goals (except when you only provide a few brief services)

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- Supervised and periodically evaluated by a physician who:
 - Prescribes the services
 - Determines the extent the patient reached treatment goals and if the POC should change
 - Provides supervision and direction to therapists involved in the patient's treatment
 - Documents their involvement in the patient's medical record
- For diagnostic study or, at a minimum, designed to reduce or control a patient's psychiatric symptoms to prevent a relapse or hospitalization and improve or maintain their level of functioning

Generally, we cover these outpatient hospital psychiatric treatment services:

- Medically necessary diagnostic services for patients when extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and prepare a POC
- Individual and group psychotherapy with physicians, CPs, CSWs, or other eligible providers authorized or licensed by the state where they provide services
- Social workers, psychiatric nurses, and other staff trained to work with psychiatric patients
- Occupational therapy services, when part of a PHP, that:
 - Require qualified occupational therapist skills
 - Are provided by, or under supervision of, a qualified occupational therapist
 - Are included in a patient's POC
- Activity therapies, when part of a PHP, that:
 - Are individualized and essential for treating a patient's diagnosed condition and progressing toward treatment goals
 - Have a POC that clearly supports and shows each therapy's need (not primarily recreational or diversionary)
- Family counseling services while treating a person's condition
- Patient training and education when they're closely and clearly related to care and treating an individual's diagnosed psychiatric condition
- Therapeutic drugs and biologicals a patient can't self-administer
- CCM to patients with multiple chronic conditions (for example, patients with dementia typically have multiple chronic conditions that could involve physical and behavioral health issues, like depression)

[42 CFR 405.2463\(b\)\(3\)](#) says there must be an in-person visit 6 months before providing telehealth mental health services and there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service unless the physician and patient agree the risks and burdens outweigh in-person visit benefits and it's documented in the medical record.

Patients who began getting mental health telehealth services in their homes during the COVID-19 public health emergency (PHE) or the 151-day period after the PHE’s end, before the in-person visit requirements take effect, don’t need to have an in-person, non-telehealth service within 6 months before getting mental health service in their homes. Instead, the requirement to get an in-person visit within 12 months of each remote mental health telehealth service applies.

Exceptions to the in-person visit requirement require a clear justification documented in the patient’s medical record. Hospitals must also document that patients have a regular source of general medical care and can get any needed point-of-care testing, including vital sign monitoring and lab studies.

We created 3 Outpatient Prospective Payment System (OPPS)-specific HCPCS codes to describe that the patient must be in their home and that no associated professional service is billed under the PFS. Hospital staff performing these services must be licensed to provide these services consistent with all applicable state scope of practice laws. We exempt these services from having staff be physically located in the hospital or outpatient department when providing services remotely using communication technology.

Table 11. Telehealth HCPCS Codes

Description	HCPCS Code
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	C7900
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	C7901
Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service (list separately in addition to code for primary service)	C7902

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

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

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

Partial Hospitalization Program

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

Patients may pay a percentage of each doctor's or other qualified mental health professional's approved service amount if they accept assignment. Patients may also pay each day's PHP services [coinsurance](#) in a hospital outpatient setting or CMHC.

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

- Discharged from an inpatient hospital treatment and a PHP replaces continued inpatient treatment
- At reasonable inpatient hospitalization risk without partial hospitalization

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

- Active treatment includes an individual POC with coordinated services designed for the patient's needs
- The POC treatment includes a physician-directed multi-disciplinary team care approach certifying the patient's need for partial hospitalization therapeutic services a minimum of 20 hours per week
- Treatment goals should be:
 - Measurable
 - Functional
 - Time framed
 - Medically necessary
 - Directly related to admission reason
- The patient requires a comprehensive, highly structured, scheduled, multi-modal individualized POC requiring medical supervision and coordination because their mental disorder severely interferes with multiple areas of daily life (social, vocational, activities of daily living (ADLs) or instrumental ADLs, and educational functioning)
- The patient can cognitively and emotionally participate in the active treatment process and tolerate its intensity

Partial hospitalization services **don't** include:

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

Community Mental Health Centers

We cover Part B partial hospitalization services community mental health centers (CMHCs) provide, subject to the OPPS. Medicare-authorized CMHCs must meet these [program and patient criteria](#):

- Have appropriate state and local CMHC licensing or certification
- Provide:
 - Outpatient services, including specialized services for children, older adults, chronically mentally ill patients, and residents of its service area discharged from an inpatient mental health treatment facility
 - 24-hour emergency care services with clinician access and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record
 - Day treatment, partial hospitalization services, or psychosocial rehabilitation services with structured daily treatment plans varying in intensity, frequency, and duration based on the patient's needs
 - At least 40% of its services is to patients 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.

In 2023, we created a [new general BHI code \(HCPCS G0323\)](#), which CPs and CSWs can bill when they're personally performing services to account for monthly care integration, and those services are the focal point of care integration. We allow general supervision for G0323.

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

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 a problem list
- Prominently note medication allergies and adverse reactions in the record; note in the record if the patient has no known allergies or adverse history of reactions

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

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

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

- Interdisciplinary treatment team completed a timely assessment consistent with the patient's needs, but no later than 4 working days after the patient's admission
- Identifies the patient's psychiatric illness and ensures the physical, psychological, psychosocial, emotional, and therapeutic active treatment plan needs are consistent with your findings
- Includes the patient's:
 - Admission reason
 - Psychiatric evaluation containing medical history and symptoms severity
 - Previous and current mental health status information
 - Onset of illness symptoms and admission circumstances
 - Description of attitudes and behaviors affecting their treatment plan
 - Intellectual, memory functioning, and orientation assessment
 - Care planning risk factor complications
 - Functional status, including whether they can participate in their own care and their strengths and goals
 - Factors affecting their or others' safety, including suicide risk factors
 - Prescription drug profile, including over-the-counter medications
 - Referral needs and further health care professional evaluation
 - Considered discharge planning factors
 - Current social and health care support systems
 - For pediatric clients, assess social service needs and make needed referrals

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

Acute Care Hospital

When a physician admits a patient to the hospital for inpatient psychiatric facility services, we cover the services only if the patient needs intensive, appropriate, and active treatment in this type of setting. The psychiatric facility must be a general hospital with a distinct psychiatric unit or a psychiatric hospital that cares only for people with mental health conditions.

We certify inpatient psychiatric facilities (IPFs) and distinct psychiatric units in acute care hospitals and critical access hospitals (CAHs).

We cover:

- Semi-private rooms
- Meals
- General nursing
- Drugs (including methadone to treat OUD)
- Other inpatient hospital treatment services and supplies

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

If appropriate, physicians can admit patients to a general acute care hospital that doesn't have a distinct psychiatric unit to get mental health and SUD services. These inpatient services are covered the same as other [inpatient services in a general acute care hospital](#).

Inpatient Psychiatric Facility Services

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

We pay inpatient psychiatric services under the [Inpatient Psychiatric Facility Prospective Payment System \(IPF PPS\)](#) when the facility is certified and meets [inpatient psychiatric hospital services regulations](#).

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

[42 CFR 482.43](#) outlines current discharge planning conditions of participation requirements.

Medical Records Requirements

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

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

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

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 diagnosis and psychiatric diagnosis
- Staff or others significantly involved clearly document inpatient admission reasons
- Social service records must include:
 - Inpatient, family members, and others' interviews
 - Home plans assessment
 - Family attitudes
 - Community resources
 - Contacts
 - Social history
 - If indicated, a completed and recorded neurological exam during the admission physical

Psychiatric Evaluation (Check if Yes)

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

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

Discharge Plan (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, their representative, or the physician?
- Did an RN, social worker, or other appropriately qualified staff member develop or supervise the plan?
- Did the evaluation include the patient's post-hospital services need and their self-care capacity or the possibility of returning to their pre-hospital environment?
- Was the planning evaluation timely to allow appropriate post-hospital arrangements?
- Does the patient's medical record document the interaction of relaying discharge planning evaluation results to them or their representative?

*Standard Discharge Plan (Check if Yes)

- Did an RN, a 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 develop?
- Did the hospital arrange to implement the patient's discharge plan?
- Did the patient, family, and interested persons get counseling to prepare them for post-hospital care?
- Did the hospital include a Medicare home health agencies (HHAs) discharge plan list (HHAs must request that hospital list when available) and skilled nursing facilities (SNFs) serving that geographic area where the patient lives or, in the SNF's case, in the requested geographic area?
 - Did you present that list to the patient only if they needed home health or post-hospital extended care services indicated in the discharge planning evaluation?
 - If the patient was enrolled in a managed care organization, did the hospital indicate those contracted managed care organization services?
 - Did you document in the medical record that you presented the HHA list to the patient?
- Did the hospital inform the patient and family of their freedom to choose among participating providers' post-hospital care services and respect the patient's and family's preference (the hospital must not specify or limit available, qualified providers)?
- Did the hospital disclose any HHA or SNF financial interest it may have with them?

*Transfer or Referral (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). The patient gets no further benefits after using 190 days of psychiatric hospital care.

Under the IPF PPS, federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services). We determine them by:

- Geographic factors
- Patient characteristics
- Facility characteristics

IPFs get additional payments for:

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

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

Same Day Billing Guidelines

Integrating mental health and SUD services 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:
 - **G2011:** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
 - **G0396:** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes
 - **G0397:** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes
- Primary health care services

AUDIT: Alcohol Use Disorders Identification Test

DAST: Drug Abuse Screen Test

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

The [Eligible Professionals](#) section lists eligible Part B providers that may provide diagnostic and therapeutic mental, psychoneurotic, personality disorder, and SBIRT treatment services allowed under state law.

We cover medically reasonable and necessary services or supplies to treat the patient's overall diagnosis and condition or improve a malformed body part. Services must meet standards of good medical diagnosis, direct care, and patient medical treatment condition practice and must not be mainly for patient, provider, or supplier convenience.

Services must also meet specific [National Coverage Determination \(NCD\) and Local Coverage Determination \(LCD\)](#) medical necessity criteria.

Every service billed must indicate the specific sign, symptom, or patient complaint requiring the service 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](#)
- [Medicare Benefit Policy Manual, Chapters 2, 6, and 15](#)
- [Medicare Claims Processing Manual, Chapters 3 and 4](#)
- [Notices and Forms](#)
- [Quality Improvement Organizations](#)
- [SAMHSA: What is Mental Health?](#)

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