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Psychiatry Coding & Reimbursement Alert

Reader Question: Understand Patient Co-payment Subject to Outpatient Mental Health Treatment Limitation

Question: I am new to psychiatry coding having taken over the work at our psychiatrist's office from a friend. I have heard of the outpatient mental health treatment limitation for services provided in an outpatient setting. What is this limitation, and how does it impact coding and reimbursement for services?

Dallas Subscriber

Answer: The Outpatient Mental Health Treatment Limitation restricts Medicare payment for outpatient mental health services to a percent of covered expenses incurred in any calendar year in connection with the treatment of a mental, psychoneurotic, or personality disorder for an individual who is not a hospital inpatient at the time the expenses are incurred. The limitation is typically triggered by the primary diagnosis on the claim, and it essentially changes the usual percentage of coinsurance that the patient is required to pay for the outpatient mental health treatments covered by Medicare. Prior to 2010, the limitation essentially required Medicare patients to cover 50 percent of the Medicare allowed amount, rather than the 20 percent applied to most other services.

However, the Medicare Improvement for Patients and Providers Act of 2008 introduced a gradual reduction in the coinsurance percentage under the limitation. Thus, in 2012, the percent that Medicare covered was 60 percent, and the patient had to bear 40 percent. After Jan.1, 2013, Medicare covers 65 percent, and the patient's coinsurance is 35 percent. The final revision will take place for services on or after Jan.1, 2014, when Medicare will pay 80 percent and the patient will pay 20 percent of the allowed amount for outpatient mental health treatment services, consistent with Medicare's approach to other services not historically subject to the limitation.

The outpatient mental health limitation applies to all covered mental health treatment services provided in an outpatient setting for specific psychiatric conditions that are generally described in the International Classification of Diseases, Ninth Revision, Clinical Modification, under the code range 290-319. It includes the mental health services provided by physicians, CPs, CNSs, NPs, PAs, and CNMs.

However, the limitation does not typically apply to:

diagnostic services such as a diagnostic psychiatric evaluation (90791, Psychiatric diagnostic evaluation and 90792, Psychiatric diagnostic evaluationwith medical services), psychological tests (96101-96103), and neuropsychological tests (96118-96120)

brief office visits for monitoring or changing drug prescriptions (M0064, Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders); new code +90863 (Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services [List separately in addition to the code for primary procedure]) may also fall into this category.

For more information and additional references, see the MedLearn Matters article number MM6686 on this subject online at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6686.pdf.

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