



ISSUE BRIEF
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Medicare Mental Health Coverage

ABOUT THIS BRIEF

Medicare generally covers less than half the cost of mental health-care services. In order for you to best help your clients with mental health-care needs, it is critical to understand Medicare's mental health benefits and gaps. In this brief, we present an overview of mental health coverage and payment policies, including consumers' costs and their rights to appeal denials of payment.

Special thanks to our guest authors this month, Amy Coviello and Kim Glaun of the Medicare Rights Center. We are also grateful to Leslie Fried of the American Bar Association and Diane Archer, Eleanor Bader, Andrea Kastin, Maya Katz, and Ruchel Ramos of the Medicare Rights Center for their input into this brief.

Coping with a mental illness can be stressful and difficult for people with Medicare and their loved ones. Depression is under-diagnosed, and many people struggle with mental illness for several years before it is detected. In addition, many people with Medicare are embarrassed to seek or obtain treatment because of perceived stigma associated with psychiatric care.

Dealing with a maze of insurance issues can easily overwhelm patients and families. Good information is critical to help clients and their caregivers understand more about mental health care and the benefits for which they are eligible.

Some things to know...

- Almost one-fifth of individuals age 55 and older experience mental disorders that are not part of the normal aging process.¹
- More than half of younger Americans with disabilities have problems with mental functioning—nearly three times the rate reported by seniors.²
- Only 50 percent of older adults who **acknowledge** having mental health issues get any treatment, and only a small number of them receive specialized mental health care.³

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When Does Medicare Pay for Mental Health Care, and What Is Covered?

Medicare covers a range of mental health services, including inpatient care under Medicare Part A and doctors', social workers' or therapists' services under Part B.

PART A

If your client needs inpatient care for the diagnosis or treatment of a mental illness, Medicare Part A will help pay for care either in a general hospital or a psychiatric hospital, a specialty hospital that only treats people who have mental health needs.

PART B

If your client needs diagnostic or treatment services for a mental illness but does not need to be in the hospital to get the care, Medicare Part B helps pay for outpatient services from these types of providers:

- Psychiatrists and other medical doctors
- Clinical psychologists
- Clinical social workers
- Clinical nurse specialists
- Nurse practitioners
- Physicians' assistants

Your clients can go to outpatient hospital departments, doctors' or therapists' offices, or clinics to get the following Medicare-covered services:

- Individual and group therapy
- Family counseling to explain the therapeutic process and involve family members in the person's treatment
- Tests to make sure the patient is getting the right treatment
- Individualized activity therapy
- Occupational therapy
- Training and education
- Laboratory tests
- Prescription drugs that cannot be self-administered, such as injections that must be given by a nurse or doctor

Sometimes your client might need more intensive care than a doctor or therapist can provide, but still may not need to be admitted into a hospital. If so, Medicare may pay for partial hospitalization services if the doctor/therapist certifies that your client needs it to avoid having to get more costly inpatient treatment at a hospital. Hospital outpatient departments or local community mental health centers can provide partial hospitalization services.

What Must People Pay for Medicare-Covered Mental Health Care?

PART A—INPATIENT HOSPITAL SERVICES

People with Medicare who need inpatient care, either in a general or psychiatric hospital, must pay the Part A hospital deductible (\$840 in 2003) once in a benefit period unless they have supplemental insurance (such as Medigap insurance, retiree insurance, employer insurance or Medicaid) to cover the cost. A benefit period starts when someone enters a hospital or skilled nursing facility and ends when he or she has been out of such a facility for 60 consecutive days.

After the deductible, Medicare pays fully for the first 60 days of a covered hospital stay. If more care is needed, your client will pay a coinsurance of \$210 a day (in 2003) for days 61 through 90 in a hospital. If an even longer stay is needed, your client will pay a coinsurance of \$420 a day (in 2003) for up to 60 "lifetime reserve" days (days 91-150). These 60 lifetime reserve days are only available once in a person's lifetime. Once your clients have exhausted these 60 days, they will be responsible for the full cost of care themselves unless they have supplemental insurance to pay for it.

There is no limit on the number of benefit periods that Medicare will cover in a general hospital. However, Medicare limits the number of days that it will cover in an inpatient psychiatric hospital. **In a person's lifetime, Medicare will pay for a total of 190 days in a psychiatric hospital.** After those 190 days, Medicare will only pay for more inpatient psychiatric care in a general hospital. Because psychiatric hospital coverage is so limited, most people with Medicare who need inpatient care receive treatment in the psychiatric ward of a general hospital.

Employer-sponsored health insurance, retiree plans, Medicaid or supplemental coverage through a private Medigap insurance policy that people with Medicare buy on their own may fill gaps in Medicare coverage. People with Medigap always have coverage for their hospital coinsurance and an additional 365 days of full hospital coverage in their lifetime. Most Medigap policies also cover the hospital deductible. But even with Medigap insurance, out-of-pocket costs can be high for people with mental health con-

ditions who may go in and out of the hospital frequently, thereby exhausting their Medicare and Medigap benefits relatively quickly.

People with both Medicare and Medicaid generally have few if any out-of-pocket expenses for their hospital stays so long as they use providers who accept both Medicare and Medicaid. Retiree coverage varies considerably but may cover more of your clients' out-of-pocket costs.

PART B—OUTPATIENT SERVICES

Unless they have supplemental coverage, your clients will pay coinsurance of 50 percent of the cost of most mental health-care services under Part B (as opposed to the 20 percent coinsurance people with Medicare pay for most other medical services). The 50 percent coinsurance applies to outpatient services furnished in connection with treatment of a mental or psychoneurotic condition or personality disorder by practitioners such as clinical psychologists, social workers or psychiatrists, as well as services provided by a comprehensive outpatient rehabilitation facility (CORF).⁴ **However, all Medigap policies pay the full 50 percent coinsurance for mental health services covered under Medicare Part B.**

Part B covers the following services at 80 percent of the Medicare-approved amount:

- Medical services furnished to a hospital inpatient.
- Brief office visits to monitor or change prescriptions for the treatment of mental, psychoneurotic or personality disorders.
- Partial hospitalization care provided by a social worker, psychiatric nurse or other staff trained to work with psychiatric patients.
- Diagnostic services, such as initial evaluations and psychological testing performed to establish a diagnosis (follow-up diagnostic services to evaluate the progress of treatment are subject to the 50 percent limitation).
- Medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.⁵

HOW TO REDUCE HEALTH-CARE COSTS

To save money on mental health services and to avoid having to pay doctors in advance, your clients should use psychiatrists or other medical doctors who take Medicare "assignment." Doctors who take assignment cannot charge more than Medicare's approved amount for a service and must wait to receive payment directly from Medicare. Clinical psychologists and social workers are required to take assignment for people with Medicare who need psychiatric care.

Here's an example. An individual goes to a doctor for an office visit related to mental health needs, and the doctor charges \$175 for the visit. If the doctor agrees to take assignment, and Medicare approves \$120 for the service, then Medicare will pay 50 percent, or \$60. The patient or the patient's supplemental insurer must pay the remaining 50 percent coinsurance, or \$60. Doctors who take assignment cannot ask their Medicare patients for the balance of \$55 (\$175 less \$120) they could otherwise charge.

Doctors who don't take assignment are also limited in what they can charge. But they can charge their patients as much as 15 percent above the usual 50 percent coinsurance, and they can ask for payment in advance. For example, if a doctor charges \$175 for an office visit, she will bill Medicare but can ask her patients to pay her directly. Medicare will reimburse her patients. If Medicare only allows \$120 for the visit, then Medicare will pay 50 percent, or \$60, and the patients must pay the 50 percent coinsurance, or \$60, plus up to an additional 15 percent above Medicare's approved amount (some states have stricter limits). In this case, the patients must pay an additional \$18 (15 percent of \$120). Thus, patients without supplemental coverage will end up paying \$78 out-of-pocket for the doctor's visit. For a list of doctors who always take assignment, sometimes called "participating providers," call 1-800-MEDICARE (1-800-633-4227).

DOCTORS WHO HAVE "OPTED OUT" OF MEDICARE

All doctors who treat people with Medicare must bill Medicare for their services and have limits on what they can charge, unless they "opted out" of the program. If your clients see a doctor who has "opted out" of Medicare, they are responsible for paying the full cost of the care, and the doctor can charge what-

ever he or she pleases. Medicare will not pay for care from doctors who have “opted out” of Medicare, but these doctors must tell their patients in advance and have them sign a contract agreeing to pay the full cost.

DUAL ELIGIBLES AND MENTAL HEALTH COVERAGE

Dual eligibles are persons enrolled in both Medicare and Medicaid. People with Medicaid who have very low incomes and assets can qualify for full Medicaid benefits, which will pay for Medicare premiums, deductibles, and coinsurance and for some things that Medicare does not cover, such as prescription drugs and long-term care. Individuals with slightly higher incomes or assets may not be eligible for full Medicaid benefits in their state. Persons with incomes at or below the poverty line may qualify for the Qualified Medicare Beneficiary (QMB) program, a limited Medicaid benefit that pays Medicare premiums, deductibles and coinsurance only.⁶

Dual eligibles generally have lower expenses for mental health care than people who only have Medicare. If your dual eligible client sees a provider who accepts both Medicare and Medicaid, Medicaid must cover the Medicare coinsurance, up to the maximum rate determined by the state Medicaid program. Mental health providers must accept the combined Medicare and Medicaid reimbursements as payment in full. They cannot bill their patients for any part of the coinsurance.

Many state Medicaid programs cover treatments for mental illnesses that Medicare does not cover, including outpatient prescription drugs and community-based services such as psychosocial rehabilitation and targeted case-management treatment. Dual eligibles with full Medicaid will receive coverage for these additional treatments as long as they see a provider who accepts Medicaid.

Because Medicaid works differently in every state, you or your clients should check with your State Health Insurance Assistance Program (SHIP) or state Medicaid office for more specific information about mental health coverage for dual eligibles in your area.

PEOPLE WITH DEMENTIA

People with dementia can receive Medicare coverage for mental health services, such as psychotherapy, as long as their doctor determines that they will benefit from it.⁷

What to Do if Medicare Denies Payment

Your clients should closely review the statements they get after a psychologist or other mental health-care provider files a claim with Medicare. These are called Medicare Summary Notices (MSN). Claims for mental health care may be denied or reimbursed at a lower rate (i.e., at 50 percent versus 80 percent) because of incomplete information or errors. These mistakes can be corrected if the provider resubmits the bill.

Always look carefully at the MSN to see whether a denial is based on a local medical review determination or local coverage policy. Denials based on local policies that are at odds with current medical practice or research, or that restrict coverage arbitrarily, should be appealed.

Your clients can appeal a denial by following the instructions on the MSN. All they have to do is sign the MSN, make a photocopy to keep for their records, and send the original to the address of the Medicare carrier—the agency that contracts with Medicare to process Medicare claims—listed on the MSN. Your clients should include any supportive documentation, such as a letter from the doctor stating the medical need for the particular psychiatric care. They have 120 days from the date on the MSN to do this.

If the denial is upheld and there is at least \$100 in dispute, people have six months to file a written request for a Part B hearing. At this hearing, which can be done in person or over the telephone, your clients can present information to support the need for care. They can appoint you or another advocate to represent them at this hearing, if they prefer.

Further levels of appeal are available if the denial is upheld at the Part B hearing. If your clients do not agree with the decision and more than \$100 is in dispute, they can request a hearing before an Administrative Law Judge. The request must be made in

writing within 60 days of receiving the Part B hearing decision. If your clients are still not satisfied, the next level is the Departmental Appeals Board review, and the appeal deadline is 60 days after the Administrative Law Judge's decision. The final level is a review by the federal district court. The monetary threshold for federal district court review is a minimum of \$1,000, and the request must be made within 60 days after the Departmental Appeals Board decision.

For free help or more information about appeals, you or your clients can contact the Medicare intermediary or carrier whose telephone number should be included on the MSN. You can also contact your client's local SHIP. Call 1-800-MEDICARE (1-800-633-4227) for the number of the SHIP in your area or visit www.medicare.gov and click on "Helpful Contacts."

¹ The Henry J. Kaiser Family Foundation. *The Faces of Medicare: Medicare and the Under-65 Disabled*, 1999.

² The Henry J. Kaiser Family Foundation. *The Faces of Medicare: Medicare and the Under-65 Disabled*, 1999.

³ Administration on Aging 2001 Report. *Older Adults and Mental Health: Issues and Opportunities*, 2001.

⁴ 42 CFR §410.155(b)(1).

⁵ 42 CFR §410.155(b)(1).

⁶ The QMB program is one of the Medicare Savings Programs. The other Medicare Savings Programs include the Specified Low Income Beneficiary and Qualifying Individual Programs, which pay the Part B premiums for persons with incomes between 100-120 percent and 120-135 percent of the Federal Poverty Level, respectively.

⁷ For more information, visit www.alz.org/PhysCare/Insurance.htm. The CMS memorandum on medical review of services for people with dementia is available at www.cms.hhs.gov/manuals/pm_trans/AB01135.pdf.

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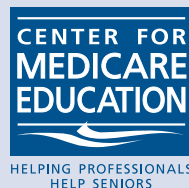
Send via mail, fax, or e-mail. Contact information listed below.

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Amy Coviello is a consultant for and former deputy director of education at the Medicare Rights Center (MRC). She worked on health-care issues affecting older adults and people with disabilities for over six years and holds a master's in public administration in health policy and management from New York University's Wagner Graduate School of Public Service. Her undergraduate work was completed at Georgetown University.

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Founded in 1989, MRC is a national not-for-profit organization that helps ensure that older adults and people with disabilities get good, affordable health care. MRC's education department works to teach people with Medicare and the individuals who counsel the health-care providers, social service workers, family members and others about health-care benefits, rights and options. MRC also provides direct services to individuals who need answers to Medicare questions or help securing coverage and getting the health care they need. Through public policy and communications efforts, MRC brings the consumer voice to the national debate on the future of Medicare, and it works closely with local and national media outlets to ensure public awareness and understanding of health-care issues facing older and disabled Americans. Visit MRC's Web site at www.medicarerights.org for more information and to sign up for free weekly education e-mails about health-care topics.



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