

# **CMS Update – Reimbursement for Mental Health Services**

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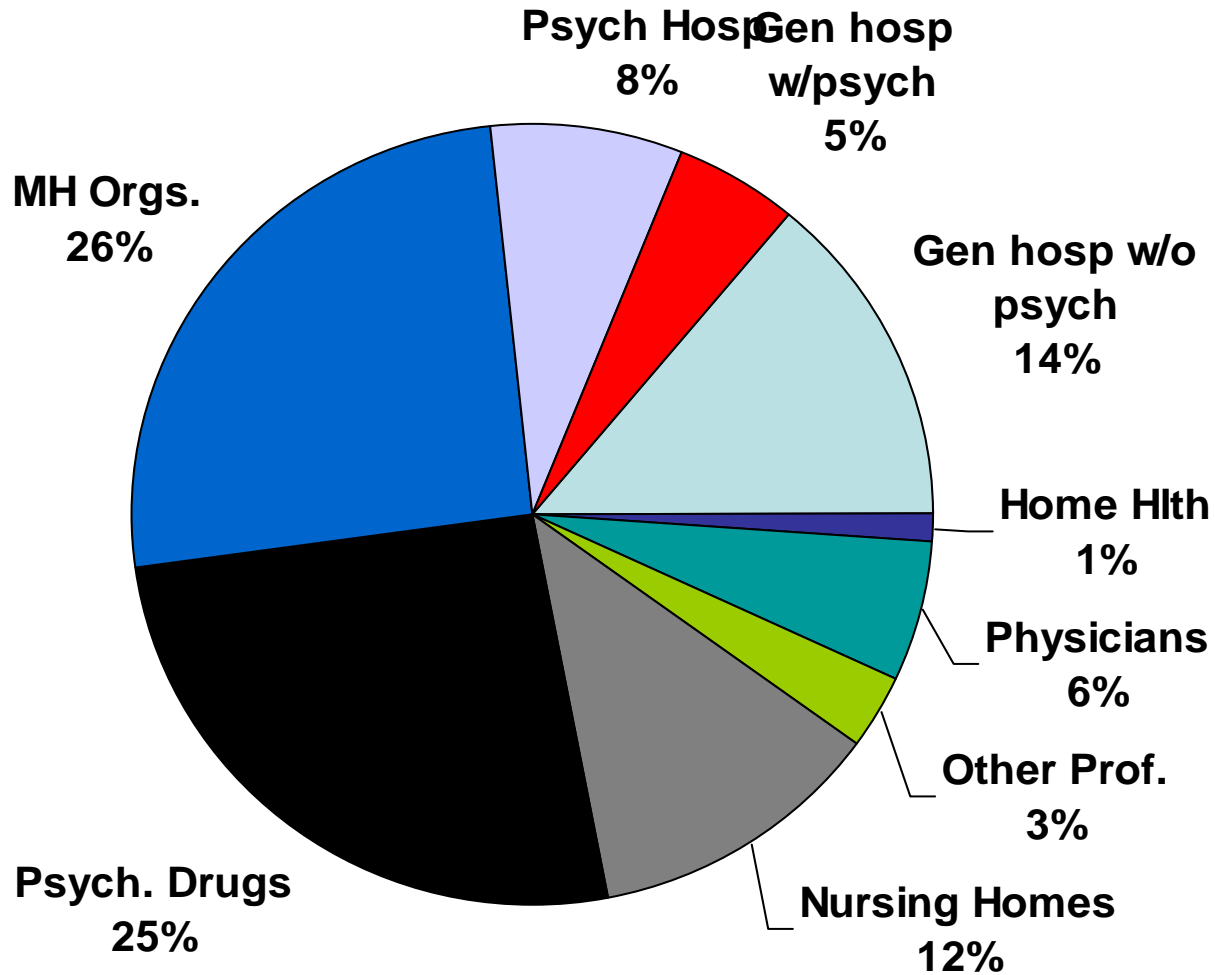
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# Medicaid Facts

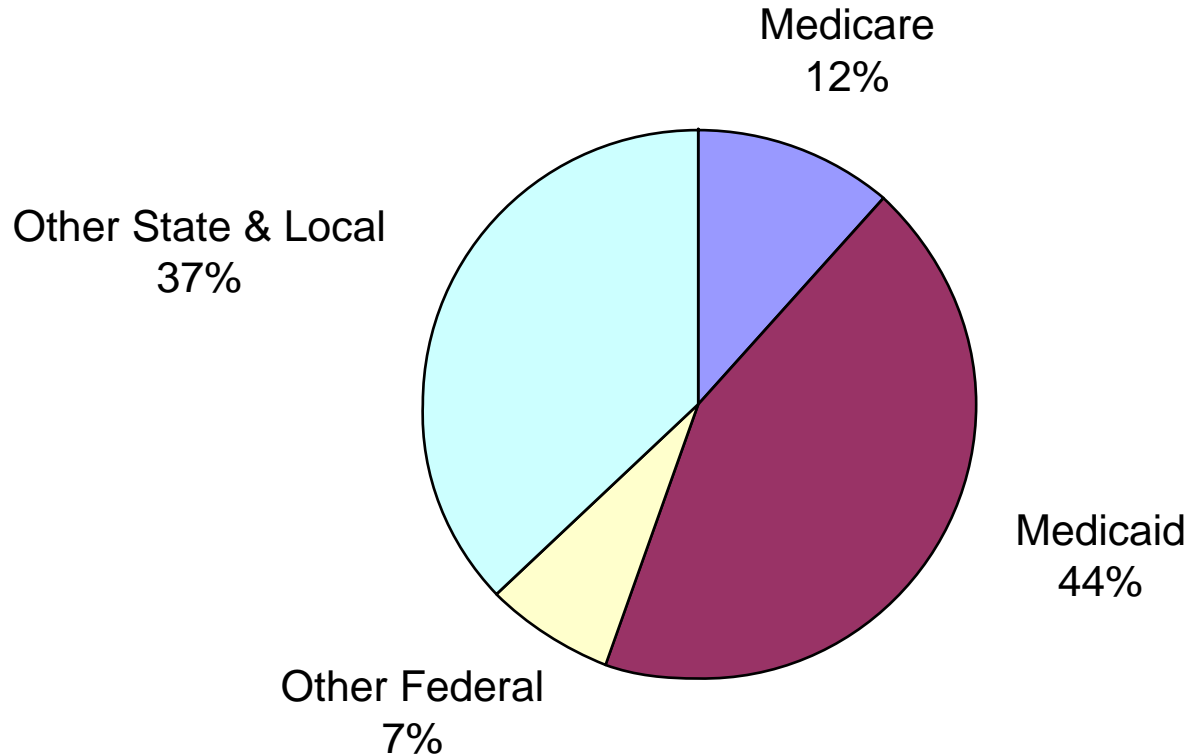
- In FY 2007, Medicaid will provide services to 52.9 million individuals: 26.8 % will be aged and disabled; 48.8% will be children; 22.5% will be adults.
- For FY 2005, Medicaid made up 7.7% of the Federal budget, but was estimated to make up 22.5% of State spending.
- The federal government's estimated share of Medicaid spending is \$199.4 billion for FY 2007.
- On average, feds pay for 57% of total Medicaid expenditures.

# Medicaid MH Spending

(2001 = \$21.7 bil.)



## Distribution of Public MH Expenditures by Public Payer, 2001



**All Public = \$53.6 billion**

# Medicaid State Plan and Waiver Program Basics

- Some 30 statutory categories of services listed in Section 1905(a) of the Social Security Act for which matching funds are available
- Some are mandatory meaning States must provide them if they choose to participate in Medicaid
- Some are optional – States may choose to provide them

# Review - General Coverage Rules

- Medical Services
  - Services must be listed in Section 1905(a) of the Social Security Act to be covered by Medicaid.
  - Services must be medically necessary. State Medicaid officials have latitude in deciding medical necessity.
- Provided to Medicaid-Eligibles
  - Services are provided directly to or directed exclusively for the treatment of Medicaid-eligible individuals.
- Qualified Providers
- Amount, Duration, and Scope

# Medicaid Eligibility

- An individual must meet the eligibility criteria for a “group”.
- Some groups are mandatory, others optional.
- Financial eligibility must be met – Medicaid considers income and resources.



# Policies Pertaining to Use of HCPCS/CPT Codes in the Medicaid Program

- Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are used by providers in the claims they submit to identify the medical services, items and products they provide on an outpatient/ambulatory basis.



# Overview

- Health insurers/payers reimburse providers on the basis of the codes they submit.
- With the implementation of Administrative Simplification provisions of HIPAA in 2002/2003, HCPCS and CPT became the recognized HIPAA-compliant standard codes that medical providers and payers must use in submitting and processing electronic claims in these settings.

# CMS Policies - Codes

- Other than HIPAA, there are no Federal requirements/policies specified by CMS that pertain to how HCPCS and CPT codes should be used by Medicaid enrolled providers or State Medicaid agencies.
- If not specified by the State, Medicaid providers should use the most appropriate HCPCS and/or CPT codes.

# CMS Policies – Coverage and Payment

- There are a number of (broad) Federal requirements that pertain to the services that are coverable under the Medicaid program and how these services, products, and items are to be reimbursed.
- Specific HCPCS and CPT codes are not generally identified in State Plans or waivers.

# Health Insurance Portability and Accountability Act (HIPAA)

- The Administrative Simplification provisions of HIPAA required DHHS to establish national standards for electronic health care transactions.
- The Secretary delegated CMS the rulemaking authority to adopt electronic standards and general administrative requirements to implement and enforce those standards.

# HIPAA - continued

- The Health Care Common Procedural Coding System represents two of the standard code sets adopted by the Secretary.
- HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

# CPT – Level I

- Level I of the HCPCS is comprised of the current CPT, a numeric coding system maintained by the American Medical Association.
- CMS rep, insurance company reps, specialty society reps. take part in the discussions about new code requests.
- CPT codes are published and updated annually.

# HCPCS Codes – Level II

- Level II, commonly referred to as HCPCS, is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment.
- Level II codes are referred to as alpha-numeric codes – they consist of a single alphabetical letter followed by 4 numeric digits. (CPT codes are 5 numeric digits.)

# More Information

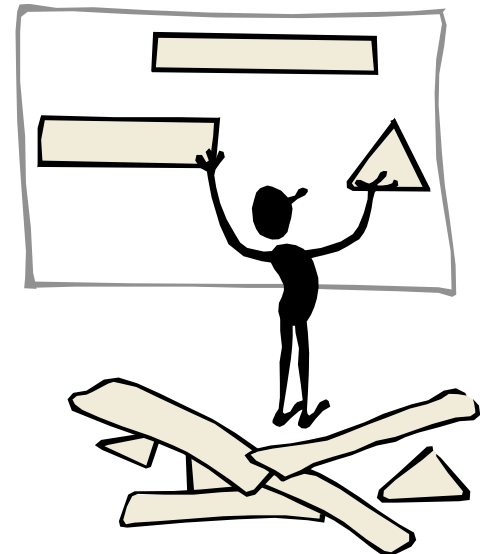
- The public may submit requests for new Level II codes to the CMS HCPCS Workgroup.
- The standard HCPCS code request application may be obtained from the CMS website at [www.cms.hhs.gov/hcpcs](http://www.cms.hhs.gov/hcpcs)

This application should be used for requests for new codes or modifications to existing codes.



# Pilot Medicaid Code Request Process

- The Pilot provides State Medicaid agencies with a mechanism for State Medicaid programs interested in requesting new HCPCS code or modifications to the existing codes that represent national Medicaid program operating needs.



# Same Day Billing Issues – Policies in Medicaid

- Will discuss individual practitioners who typically individually/independently bill Medicaid for mental health services provided in an office-based practice and to FQHC/RHC settings where such services are often provided to Medicaid beneficiaries.
- Mental health practitioners include psychiatrists, psychologists, licensed clinical social workers and other licensed practitioners providing services within the scope of State practice acts.

# Office-Based Setting - Policies - continued

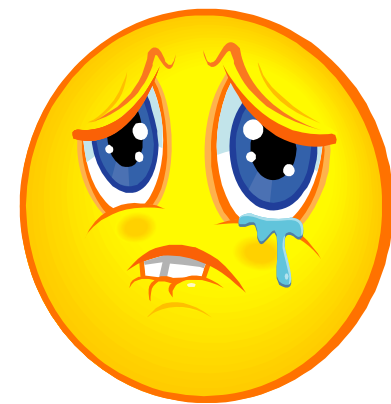
- Psychiatrists – Under Federal requirements at 42 CFR 440.50, services provided by or under the personal supervision of a licensed physician practicing within the scope of his/her State practice act is a **mandatory** benefit in Medicaid.
- Keep in mind medical necessity.
- Keep in mind ‘amount, duration and scope’.  
(CFR 42 440.230)

# Office-Based Setting - Policies - Continued

- Non-physician Licensed Practitioners: Under Federal requirements at 42 CFR 440.60, services provided by non-physician practitioners licensed by the State and practicing within their State practice act is an **optional** benefit in Medicaid.
- If State chooses to cover one or more of above, it may decide to limit such services based on diagnosis, condition, illness, number of visits, medical setting where service is provided, or even place dollar limitations on the service.

# Office-Based Setting – Policies - Continued

- Given these policies/requirements, States may place limits specifically on coverage/reimbursement for two or more visits on the same day to a non-physician practitioner.



# Same Day Billing – FQHCs - Medicaid

- Under the Social Security Act at 1905(L)(2), FQHS services mean physician services, nurse practitioner services (including certified nurse-midwife) physician assistance services, nurse-midwife services, clinical psychologist, clinical social worker and visiting nurse.
- There are no Federal Medicaid regulations that require the State to only reimburse one face-to-face visit per day.

# FQHCs - Continued

- States may, however, impose such a requirement or may follow Medicare's same day billing policy which permits one medical visit and one mental health visit to a clinical psychologist, clinical social worker or other mental health professional to be billed on the same day.

# FQHCs - Medicare

- Under the Act at 1861(aa)(3) and at 42 CFR 405.2446, FQHC services means physician services, nurse practitioner services (including certified nurse-midwife), physician assistant services, nurse-midwife services, clinical psychologist, clinical social worker and visiting nurse. Federal regulations at 42 CFR 405.2463 permit more than one billable face-to-face encounter per day. See Medicare Claims Processing Manual Chapter 9, section 20.1.



## RHCs - Medicaid

- Under the Act at 1905(L)(1) and Federal regulations at 42 CFR 440.20(b), RHC services means physician services, nurse practitioner services (including certified nurse-midwife), physician assistant services, nurse-midwife services, clinical psychologist, clinical social worker and visiting nurse. Federal regulations at 42 CFR 447.371 state that only one face-to-face encounter with a medical professional per day is reimbursable except when patient suffers further illness or injury requiring additional treatment.

# RHCs - Medicare

- Under the Act at 1861(aa)(1) and Federal regulations at 42 CFR 405.2463, RHC services means same as mentioned earlier. The Medicare Claims Processing Manual, Chapter 9, section 20.1, revised on 2-01-06 states that encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit for reimbursement purposes,

# RHCs – Medicare - Continued

- except when the patient has a medical visit and a clinical psychologist or clinical social work visit, in which case two visits on the same day would be reimbursable.

# Resources

- CMS Web Site: <http://www.cms.hhs.gov>  
or <http://www.cms.hhs.gov/hcpcs> or  
[http://www.cms.hhs.gov/HCPSCodesforMed/02\\_PilotMedicaidHCPCSCodesRequestProcess.asp](http://www.cms.hhs.gov/HCPSCodesforMed/02_PilotMedicaidHCPCSCodesRequestProcess.asp)

State Profiles of Mental Health and Substance Abuse  
Services in Medicaid:

[http://www.mentalhealth.org/publications/allpubs/state\\_med/default.asp](http://www.mentalhealth.org/publications/allpubs/state_med/default.asp)

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