The Statistics

- Mental health problems are common
- The latest data indicates
  - 1 in 5 American adults experienced a mental health issue
  - 1 in 10 young people experienced a period of major depression
  - 1 in 20 Americans lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression
  - Anxiety disorders affect 18% of the U.S. population
- Medicaid is the largest payer of mental health services
Insurers and employers covered treatment for mental health conditions differently than treatment for medical/surgical conditions:

- Mental health care usually had:
  - Higher cost-sharing (Medicare Part B services were covered at 50%)
  - More restrictive limits on the number of inpatient days and outpatient visits allowed
  - Separate annual and lifetime limits on coverage
  - Different prior authorization requirements
Important Legislation

- Mental Health Parity and Addiction Equity Act (MHPAEA) 2008
  - Prohibited certain discriminatory practices that limit insurance coverage for behavioral health treatment and services
    - Required many insurance plans that cover mental health or substance use disorders to offer coverage for those services that’s no more restrictive than the coverage for medical/surgical conditions

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
  - Increased Medicare’s coverage for Part B mental health services over 5 years from 50% to 80%
3 Ways the Affordable Care Act (ACA) Increased Access to Mental Health and Substance Use Disorder Services

1. The ACA expanded mental health and substance use disorder benefits and parity protections for 62 million Americans (amended the MHPAEA to include Medicaid and the Children’s Health Insurance Programs).

2. Most health plans must now cover preventive services like depression screening for adults and behavioral assessments for children at no cost.

3. Plans can no longer deny coverage or charge more due to pre-existing health conditions, including mental illnesses.
Qualifying for Medicare Based on Disability

- If you qualify for Social Security Disability Insurance (SSDI)
  - You may qualify for Medicare

- Medicare usually begins after getting Social Security Disability Insurance (SSDI) for 24 months
  - Unless you have Amyotrophic Lateral Sclerosis
    - Medicare begins first month entitled to SSDI

- Generally, this means you get Medicare in the 30th month after you become disabled
  - 5-month waiting period for SSDI benefits
  - Followed by 24-month waiting period for Medicare
43.7% of people receiving Social Security Disability Benefits in 2011 had a mental impairment.

<table>
<thead>
<tr>
<th>Impairment</th>
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<tr>
<td></td>
<td>Number</td>
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<td>Mental impairments</td>
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<td>Affective disorders</td>
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<td>Schizoaffective disorders</td>
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<td>Anxiety disorders</td>
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<td>Intellectual disability</td>
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<tr>
<td>Other mental impairments</td>
<td>607,739</td>
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</tr>
</tbody>
</table>
Prevalence of Chronic Conditions Among Medicare Fee-for-Service Beneficiaries by Age in 2012

- High blood pressure: 39% (Less than 65 years), 59% (65 years and older)
- High cholesterol: 30% (Less than 65 years), 48% (65 years and older)
- Arthritis: 22% (Less than 65 years), 30% (65 years and older)
- Ischemic heart disease: 17% (Less than 65 years), 31% (65 years and older)
- Diabetes: 25% (Less than 65 years), 27% (65 years and older)
- Chronic kidney disease: 12% (Less than 65 years), 16% (65 years and older)
- Depression: 13% (Less than 65 years), 28% (65 years and older)
- Heart failure: 10% (Less than 65 years), 16% (65 years and older)
- COPD: 11% (Less than 65 years), 11% (65 years and older)
- Alzheimer’s Disease/Dementia: 3% (Less than 65 years), 11% (65 years and older)
- Cancer: 3% (Less than 65 years), 9% (65 years and older)
- Atrial fibrillation: 2% (Less than 65 years), 9% (65 years and older)
- Osteoporosis: 2% (Less than 65 years), 7% (65 years and older)
- Asthma: 4% (Less than 65 years), 7% (65 years and older)
- Schizophrenia/Psychotic Disorders: 3% (Less than 65 years), 9% (65 years and older)
Mental Health Condition Coverage Requirement

- The “Diagnostic and Statistical Manual of Mental Disorders (DSM)”
  - The standard classification of mental disorders
    - Used by mental health professionals in the United States
- For Medicare to cover services for a mental health disorder, it must be listed in the DSM
What’s Covered Under Medicare Part A (Hospital Insurance)

- Inpatient stay in a general or psychiatric hospital
  - Room, meals, nursing care, and other related services and supplies
- If you’re in a psychiatric hospital (instead of a general hospital)
  - Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime
- Part A costs for inpatient care are the same regardless of receiving care for a medical/surgical diagnosis or mental health diagnosis
Requirements for Inpatient Psychiatric Facility (IPF) Services Coverage

- Active psychiatric treatment can be reasonably expected to improve condition

- A physician must
  - Certify at or near admission that the patient needs, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel
    - First re-certification as of the 12th day of hospitalization; and
    - Subsequent re-certifications at intervals established by the utilization review committee
    - No less than every 30 days

- Patients treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness (60-day lifetime reserve days)
What You Pay For Medicare Part A
Inpatient Costs in 2015

- Hospital Inpatient Stay
  - $1,260 deductible for days 1–60 of each benefit period
  - $315 coinsurance per day for days 61–90
  - $630 coinsurance per “lifetime reserve day” after day 90 of each benefit period (up to 60 days over your lifetime-total of 150 days)
    - All costs for each day after the lifetime reserve days
- Inpatient mental health care in a psychiatric hospital
  - Limited to 190 days in a lifetime
Part B helps cover mental health services
- Provided by doctors and other health care professionals

The providers must accept assignment if they participate in Medicare
- Except for psychiatrists and other doctors
- Non-participating providers can charge more and may require you to pay the entire charge at the time of service
- You may have to submit your own claim to Medicare to get paid back

*Assignment is an agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the Medicare-approved amount as full payment for covered services and not to bill you for anymore than the Medicare deductible and coinsurance.*
Part B Covered Outpatient Mental Health Services—Eligible Professionals

- Outpatient mental health services include visits with these types of health professionals to the extent permitted under state law
  - Physicians (medical doctors [MD] and doctors of osteopathy [DO]), particularly psychiatrists
  - Clinical psychologists (CP)*
  - Clinical social workers (CSW)*
  - Clinical nurse specialists (CNS)*
  - Nurse practitioners (NP)*
  - Physician assistants (PA)*
  - Certified nurse-midwives (CNM)*
  - Independently Practicing Psychologists (IPP)

*Are always subject to assignment
Part B Covered Mental Health Services

- Psychiatric diagnostic interviews
- Individual and interactive psychotherapy
- Family psychotherapy (with the patient present and the primary purpose is treatment of the individual’s condition)
- Family psychotherapy (without the patient present, is medically reasonable and necessary, and the primary purpose is treatment of the individual’s condition)
- Group psychotherapy
- Psychoanalysis
- Pharmacologic management
- Electroconvulsive therapy (ECT)
- Diagnostic psychological and neuropsychological tests
- Hypnotherapy
- Narcosynthesis
- Biofeedback therapy
- Individualized activity therapy (as part of a Partial Hospitalization Program [PHP] and not primarily recreational or diversionary)
Part B Covered Mental Health Services Continued

- Preventive services
  - One depression screening per year (primary care setting)
  - One alcohol misuse screening per year (primary care setting)

- Mental health prescription drugs (limited)
  - Like some intramuscular injections i.e.; a biweekly or monthly maintenance antipsychotic drug for treatment of lifelong schizophrenia (Risperdal®, Invega®, Prolixin®, etc.)

- Partial hospitalization services
Part B Coverage of Partial Hospitalization Services

- An intensive, structured program of outpatient psychiatric services provided to patients as an alternative to inpatient psychiatric care including active treatment and a plan of care
  - Provided through a
    - Hospital outpatient department, or
    - Community mental health center
      - Must meet applicable licensing or certification requirements in the state where it’s located and other criteria, including
        - At least 40% of its services must be provided to non-Medicare patients
Your Cost Under Medicare Part B for Provider Services

- For most mental health services provided by doctors or other health care professionals to diagnose or treat your condition
  - You pay 20% of the Medicare-approved amount after the Part B deductible is met
What’s Covered Under Medicare Prescription Drug Coverage (Part D)

- To be covered by Medicare, a drug must be available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically-accepted indication

- Part D covers a variety of medications, including oral and injectable medications used to treat mental health symptoms and conditions

- Medicare drug plans are required to cover all of these protected classes (categories) frequently used for mental health treatment (with limited exceptions)
  - Antidepressant
  - Anticonvulsant
  - Antipsychotic medications
What Is Not Covered by Medicare?

- Environmental intervention
- Geriatric day care programs
- Individual psychophysiological therapy that incorporates biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling
- Transportation and meals
- Telephone services
- Report preparation/Interpretation or explanation of results or data as a separate service
Representatives/Surrogates

- Representatives may be appointed or authorized
  - May act on behalf of the enrollee in
    - Filing a grievance
    - Requesting an organization determination
    - Dealing with any of the levels of the appeals process
  - Under some circumstances, a physician can request an organization determination or appeal on behalf of a plan enrollee without being an appointed representative.

A representative (surrogate) may be authorized by the court or act in accordance with state law to act on behalf of an enrollee. Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate isn’t required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee’s authorized representative.
Bob’s father lives with him. Bob contacts your office after his father received a Transcranial Magnetic Stimulation (TMS) procedure to treat his unremitting depression.

He tells you his father has Original Medicare (Part A and Part B). He received a bill today that said Medicare didn’t cover his treatment. Depression runs in the family and he knows that his aunt, who lives in another state, received the same treatment and it was covered.
It isn’t possible for a procedure to be covered by Medicare in one area, and not another.

1. True
2. False
Finding Coverage Determinations

CMS.gov/medicare-coverage-database/overview-and-quick-search.aspx
If Bob’s father didn’t get an Advanced Beneficiary Notice, he isn’t responsible for the bill.

1. True
2. False
Mary has been anxious, unable to sleep, and frequently tearful for several weeks. Her primary care physician conducted a depression screening and gave her a prescription for a new antidepressant drug *Fetzima*®.

Mary came to you because the pharmacist said her Part D plan won’t cover the drug.
What could be a valid reason this drug wasn’t covered by Mary’s Part D plan?

a. It hasn’t been approved by the FDA
b. It’s a step-therapy drug and Mary hasn’t tried a generic/lower cost drug
c. It’s not on her plan’s formulary
d. All of the above
Mary can request a coverage determination (including an exception).

a. True
b. False
Eloise has Original Medicare. She was in an inpatient psychiatric facility (IPF) for 8 months. She reached her 190-day Medicare lifetime maximum. She has been out of the IPF for 2 years. Her doctor determines she has a medically necessary need for inpatient care to adjust her medications because her mental health condition has deteriorated. She is an inpatient in for 8 days.
Medicare will cover Eloise’s 8-day stay in the inpatient psychiatric facility.

a. True
b. False
Medicare would cover Eloise’s 8-day stay if it was at a general hospital.

a. True

b. False
Helpful Resources

“Medicare & Your Mental Health Benefits”
Medicare.gov/Pubs/pdf/10184.pdf

Medicaid.gov Behavioral Health Services
Medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html

Medicare Learning Network Publications
CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html

MentalHealth.gov provides information on mental health and can help you find local organizations

SAMHSA.gov is the website for the Substance Abuse & Mental Health Services Administration (SAMHSA) and the treatment facility locator and mental health services locator
To view all available NTP training materials, or to subscribe to our email list, visit [CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html](https://CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html)

For questions about training products email [training@cms.hhs.gov](mailto:training@cms.hhs.gov)
## Appointment of Representative Form

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<thead>
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<th>Field</th>
<th>Instructions</th>
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<tbody>
<tr>
<td>Name of Party</td>
<td></td>
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<tr>
<td>Medicare or National Provider Identifier Number</td>
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</tr>
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### Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, ______________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title X of the Act. I authorize this individual to make any request, to present or to elicit evidence, to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

<table>
<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
<td>Signature of Party Seeking Representation</td>
<td>Date</td>
</tr>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
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<tr>
<td>City</td>
<td>State</td>
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</table>

### Section 2: Acceptance of Appointment

To be completed by the representative:

I, ______________________ hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, at this time, a current or former employee of the United States, disqualified from acting as the party’s representative; and I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an ______________________

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

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<tbody>
<tr>
<td>Signature of Representative</td>
<td>Date</td>
</tr>
<tr>
<td>Street Address</td>
<td>Phone Number (with Area Code)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
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</tbody>
</table>

### Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing ______________________ before the Secretary of the Department of Health and Human Services.

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<tr>
<td>Signature</td>
<td>Date</td>
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</table>

### Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

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<th>Field</th>
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<tbody>
<tr>
<td>Signature</td>
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</table>

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Individuals who represent enrollees may either be appointed or authorized, they are both referred to as “representatives” to act on behalf of the enrollee in filing a grievance, requesting an organization determination, or in dealing with any of the levels of the appeals process. An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative.

Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of an enrollee. A surrogate could include, but isn’t limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute. Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate isn’t required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee’s authorized representative. Medicare health plans with service areas comprising more than one state should develop internal policies to ensure that they are aware of the different State representation requirements in their service areas.

Send this form to the same location where you're sending your appeal if you're (1) filing an appeal, (2) filing a grievance, or (3) requesting an initial determination or decision.