

CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare and Your Mental Health Benefits

This is the **official** government booklet about mental health benefits for people with Original Medicare. This booklet has important information about the following:

- ★ Who is eligible
- ★ Outpatient benefits
- ★ Inpatient benefits
- ★ Prescription drug coverage
- ★ Help for people with limited income and resources
- ★ Where to get the help you need





The information in this booklet was correct when it was printed. Changes may occur after printing. Call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to get the most current information. TTY users should call 1-877-486-2048.

“Medicare and Your Mental Health Benefits” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Introduction

Mental health care and Medicare

Mental health conditions like depression or anxiety can come at any age and can happen to anyone. If you think you may have problems that affect your mental health, you can get help. Talk to your doctor or health care provider if you have any of the following symptoms:

- Sad, empty, or hopeless feelings
- A lack of energy
- Trouble concentrating
- Difficulty sleeping
- Little interest in things you used to enjoy
- Thoughts of ending your life

Mental health care includes services and programs to help diagnose and treat mental health conditions. These services and programs may be provided in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs. This booklet gives you information about mental health benefits in **Original Medicare**.

If you get your Medicare benefits through a Medicare health plan, check your plan's membership materials and call the plan for details about your Medicare-covered mental health benefits. These plans provide all your Part A and Part B coverage.

If you need immediate help for yourself or someone in a crisis, call The National Suicide Prevention Lifeline at 1-800-273-TALK or 1-800-SUICIDE (1-800-273-8255). TTY users should call 1-800-799-4TTY (1-800-799-4889). Call the Lifeline for any reason such as the following:

- To speak with someone who cares
- If you feel you might be in danger of hurting yourself
- To speak to a crisis worker if you're concerned about someone
- To find referrals to mental health services in your area

Words in red
are defined on
pages 21–23.

How **Original Medicare** covers mental health services

Medicare Part A (Hospital Insurance) helps cover mental health care if you are a hospital inpatient. Medicare Part A covers your room, meals, nursing care, and other related services and supplies.

Medicare Part B (Medical Insurance) helps cover mental health services that you would generally get outside a hospital, including visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests ordered by your doctor. Medicare Part B may also pay for partial hospitalization services, if you need intensive coordinated outpatient care. See page 9 for more information about partial hospitalization services.

Medicare Part D (Medicare prescription drug coverage) helps cover prescription drugs you may need to treat a mental health condition.



Section 1: Outpatient Mental Health Care and Professional Services

What Original Medicare covers

If you are in **Original Medicare** and have **Medicare Part B (Medical Insurance)**, Medicare helps cover visits with these types of health professionals:

- A psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician's assistant

It's important to know that Medicare only covers these visits when they are provided by a health care provider who accepts Medicare payment. **To pay even less, you should also ask your health care providers if they accept assignment before you schedule an appointment. See page 9.**

Medicare Part B helps cover outpatient mental health services. This includes services that are usually provided outside a hospital (like in a clinic, or doctor's or therapist's office), and those provided in a hospital's outpatient department. Medicare helps cover the following services (**deductibles** and **coinsurance** apply):

- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state to give these services.
- Family counseling if the main purpose is to help with your treatment.
- Testing to find out if you are getting the services you need and/or if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Occupational therapy that's part of your mental health treatment.

Words in **red** are defined on pages 21–23.

What Original Medicare covers (continued)

- Certain prescription drugs that aren't usually self-administered, like some injections.
- Individual patient training and education about your condition.
- Diagnostic tests.
- A screening for depression during the one-time “Welcome to Medicare” physical exam. (**Note:** This physical exam is only covered if you have it within the first 12 months you have **Medicare Part B.**)
- Partial hospitalization may be covered. See page 9.

What you pay

After you pay your yearly Medicare Part B **deductible** (\$155 in 2010), how much you pay for mental health services will depend on whether the purpose of your visit is to diagnose your condition or to get treatment.

- For visits to a doctor or other health care provider to **diagnose** your condition, you pay 20% of the **Medicare-approved amount**.
- For outpatient **treatment** of your condition (such as psychotherapy), you pay 45% of the Medicare-approved amount in 2010 (which is less than in 2009). Congress passed legislation that reduces how much people with Medicare pay for outpatient mental health treatment to be in line with **coinsurance** amounts for other medical services. How much you pay for these services will continue to decrease over the next few years as follows:

In this year	You pay
2010 and 2011	45%
2012	40%
2013	35%
2014	20%

Note: If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an **additional copayment** or coinsurance amount to the hospital. This amount will vary depending on the service provided but will be between 20% and 40% of the Medicare-approved amount.

Assignment

Getting treatment from a doctor or provider who accepts “assignment” can reduce your out-of-pocket costs. If doctors or providers accept assignment, they agree to the following conditions:

- To accept only the amounts Medicare approves for their services
- To be paid by Medicare
- To only charge you, or other insurance you may have, the Medicare **deductible** or **coinsurance** amount

Medicare may cover partial hospitalization

Medicare Part B covers partial hospitalization in some cases. It’s a structured program of outpatient active psychiatric treatment that’s more intense than the care you get in a doctor’s or therapist’s office. This type of treatment is provided during the day and doesn’t require an overnight stay. These programs are usually given through hospital outpatient departments and local community mental health centers.

Your doctor or therapist may think that you could benefit from a partial hospitalization program. For Medicare to cover a partial hospitalization program, a doctor must certify that you would otherwise need inpatient treatment. Your doctor and the partial hospitalization program must accept Medicare payment.

In 2010, you pay a percentage of the **Medicare-approved amount** for each service you get from a qualified professional (see page 8). You also pay 20% of the Medicare-approved amount for each day of service when provided in a hospital outpatient department or a community mental health center.

What **Original Medicare** doesn't cover

Medicare doesn't cover the cost of the following:

- Meals.
- Transportation to or from mental health care services.
- Support groups that bring people together to talk and socialize. (Unlike group psychotherapy, which is covered. See page 7.)
- Testing or training for job skills that isn't part of your mental health treatment.

Note: If you have a **Medigap (Medicare Supplement Insurance) policy**, an employee or retiree plan, or other health insurance coverage, be sure to tell your doctor or other health care provider so your bills get paid correctly.



Section 2: Inpatient Mental Health Care

What Original Medicare covers

If you have **Original Medicare** and **Medicare Part A (Hospital Insurance)**, Medicare helps pay for mental health services given in a hospital that require you to be admitted as an inpatient. These services can be provided in a general hospital or in a psychiatric hospital that only cares for people with mental health conditions. Regardless of which type of hospital you choose, Medicare Part A will help cover mental health services.

If you're in a psychiatric hospital (instead of a general hospital), Medicare Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

What you pay

Medicare measures your use of hospital services, including services you get in a psychiatric hospital, in benefit periods. A benefit period begins the day you go into a hospital or skilled nursing facility for either physical or mental health care. The benefit period ends after you haven't had hospital or skilled nursing care for 60 days in a row. If you go into a hospital again after 60 days, a new benefit period begins, and you must pay a new inpatient hospital **deductible**.

There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but remember, there's a lifetime limit of 190 days.

What you pay (continued)

For each benefit period, you pay the following in 2010:

- \$1,100 **deductible** and no **coinsurance** for days 1–60 of each benefit period
- \$275 per day for days 61–90 of each benefit period
- \$550 per “**lifetime reserve day**” after day 90 of each benefit period (up to 60 days over your lifetime)

Note: **Medicare Part B** helps cover mental health services provided by doctors and other providers if you’re admitted as a hospital inpatient. You pay 20% of the **Medicare-approved amount** for these mental health services while you’re a hospital inpatient.

What **Original Medicare** doesn’t cover

Medicare doesn’t cover the cost of private duty nursing, a telephone or television in your room, personal items (like toothpaste, socks, or razors), or a private room unless **medically necessary**.

Note: If you have **Medigap** (Medicare Supplement Insurance) or other health insurance coverage, be sure to tell your doctor or other health care provider so your bills get paid correctly.

Section 3: Medicare Prescription Drug Coverage (Medicare Part D)

About Medicare prescription drug coverage

Medicare offers prescription drug coverage for everyone with Medicare. To get Medicare prescription drug coverage, you must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each Medicare drug plan can vary in cost and in the specific drugs it covers. It's important to know your plan's coverage rules and your rights as a member of a Medicare drug plan.

Medicare drug plans have special rules

The formulary

Almost all Medicare drug plans have a list of drugs that the plan covers, called a formulary. In general, Medicare drug plans aren't required to cover all drugs. However, they are required to cover all or almost all anti-depressant, anticonvulsant, and antipsychotic medications, which may be necessary to keep you mentally healthy. Medicare reviews each plan's formulary to make sure it contains a wide range of medically-necessary drugs and that it doesn't discriminate against certain groups (like people with disabilities or mental health conditions).

If you take a prescription drug for a mental health condition, it's important that you know whether a plan covers the drug before you enroll.

There are certain drugs that Medicare drug plans aren't required to cover, such as benzodiazepines, barbiturates, or drugs for weight loss or gain. Some Medicare drug plans may choose to pay for these drugs as an added benefit. Also, some states may cover these drugs if you have Medicaid. See page 18 for more information about Medicaid. Be sure to ask your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) and your plan any questions you may have about the drugs you need.

Medicare drug plans have special rules (continued)

The formulary can change

A Medicare drug plan can make some changes to its formulary during the year according to guidelines set by Medicare. If you are currently taking a drug and the plan's formulary changes, in almost all cases, you will be notified before the change is made, and the plan will usually cover the drug for you for the rest of the plan year. The cost of a drug can also change during the year, but your **copayments** should stay the same.

What if my prescriber thinks I need a certain drug that my plan doesn't cover?

If you belong to a Medicare drug plan, you have the right to do the following:

- Get a written explanation (called a “**coverage determination**”) from your Medicare drug plan if your plan won't cover or pay for a certain prescription drug you need, or if you're asked to pay a higher share of the cost.
- Ask your Medicare drug plan for an **exception** (which is a type of coverage determination). If you ask for an exception, your prescriber must give your drug plan a supporting statement that says why you need the drug you're requesting. You can ask for an exception for these reasons:
 - You or your prescriber believes you need a drug that isn't on your drug plan's list of covered drugs.
 - You or your prescriber believes that a coverage rule (such as prior authorization) should be waived.
 - You believe you should get a non-preferred drug at a lower copayment because you can't take any of the alternative drugs on the drug plan's list of preferred drugs.

You or your prescriber must contact your plan to ask for a coverage determination. If your network pharmacy can't fill a prescription as written, the pharmacist will give or show you a notice that explains how to contact your Medicare drug plan so you can make your request.

Medicare drug plans have special rules (continued)

What if my prescriber thinks I need a certain drug that my plan doesn't cover? (continued)

A standard request for a **coverage determination** (including an **exception**) must be made in writing (unless your plan accepts requests by phone). You or your prescriber can also call or write your plan for an expedited (fast) request. **If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why similar drugs covered by your plan won't work or may be harmful to you.**

Once your Medicare drug plan gets your request for a coverage determination (or your prescriber's statement if you are requesting an exception), the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision. If the drug plan doesn't give you a prompt decision, and you can show the delay would affect your health, the plan's failure to act is considered a coverage determination.

If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to **appeal** the decision. The plan's written decision will explain how to file an appeal. Read this decision carefully.

For more information on Medicare appeal rights, view the following publications:

- "Your Medicare Rights and Protections" booklet—Visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf.
- "Medicare & You" handbook—Visit www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Learn more about Medicare prescription drug coverage

To find out more about Medicare prescription drug coverage, look in your “Medicare & You” handbook or the “Your Guide to Medicare’s Prescription Drug Coverage” booklet. View or download these booklets by visiting www.medicare.gov. You can also learn more about Medicare prescription drug coverage and get personalized help comparing plans by doing the following:

- Visit www.medicare.gov and select “Compare Drug Plans.”
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your **State Health Insurance Assistance Program (SHIP)**. To get their number call 1-800-MEDICARE. You can also visit www.medicare.gov, and select “Find Helpful Phone Numbers and Websites.” Then, search by the word “organization” or “SHIP.”

Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.



Section 4: Getting the Help You Need

Medicare is here to help you get the information you need.

This section includes information about the following:

- Help for people with limited income and resources
- Your rights as a person with Medicare
- Your Medicare **appeal** rights
- Information about mental health

Help for people with limited income and resources

Extra Help paying for Medicare prescription drug coverage (Part D)

You may qualify for Extra Help, also called the low-income subsidy, from Medicare to pay costs for a **Medicare drug plan** if your yearly income and resources are below certain levels. For more information, call Social Security at 1-800-772-1213, or visit www.socialsecurity.gov. TTY users should call 1-800-325-0778.

State Pharmacy Assistance Programs

Many states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will help you in different ways. To find out about the SPAP in your state, call your **State Health Insurance Assistance Program (SHIP)**. To get their number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

Medicare Savings Programs

States have programs that pay Medicare premiums and, in some cases, may also pay Part A and Part B **deductibles** and **coinsurance**. These programs help people with Medicare save money each year. To qualify, you must meet certain conditions.

Words in **red** are defined on pages 21–23.

Help for people with limited income and resources (continued)

For more information on Medicare Savings Programs

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on **Medicare Savings Programs**. The names of these programs and how they work may vary by state. Call if you think you qualify for any of these programs, even if you aren't sure.
- Call 1-800-MEDICARE, and say “Medicaid” to get the telephone number for your state.
- Visit www.medicare.gov/Publications/Pubs/pdf/10126.pdf to view the brochure, “Get Help With Your Medicare Costs: Getting Started.”
- Contact your **State Health Insurance Assistance Program (SHIP)** for free health insurance counseling. To get their number, call 1-800-MEDICARE. You can also visit www.medicare.gov, and select “Find Helpful Phone Numbers and Websites.” Then, search by the word “organization” or “SHIP.”

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs if you have limited income and resources and meet other requirements. Some people qualify for both Medicare and Medicaid (these people are called “dual eligibles”).

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered.
- Medicaid programs vary from state to state. They may also be called by different names, like “Medical Assistance” or “Medi-Cal.”
- People with Medicaid may get coverage for services that Medicare doesn't fully cover, such as nursing home and home health care.
- Each state has different Medicaid income and resource limits and other eligibility requirements.
- In some states, you may need to apply for Medicare to be eligible for Medicaid.
- Call your State Medical Assistance (Medicaid) office for more information and to see if you qualify. Call 1-800-MEDICARE (1-800-633-4227), and say “Medicaid” to get the telephone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

Your rights as a person with Medicare

As a person with Medicare, you have certain guaranteed rights. Your rights include the right to participate in treatment decisions, to know your treatment choices, and to have your personal and health information kept private. You also have the right to **appeal** Medicare decisions about coverage of your services, supplies, and prescriptions. See below. Read more about these rights and protections in the following publications:

- “Your Medicare Rights and Protections”—Visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf.
- “Medicare & You” handbook—Visit www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your Medicare appeal rights

If you have **Original Medicare**, you can file an appeal if you think Medicare should have paid, or didn't pay enough, for an item or service. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill wasn't paid and what appeal steps you can take.

For more information about your Medicare appeal rights and how to ask for an appeal, do the following:

- Look at the “Your Medicare Rights and Protections” booklet or your “Medicare & You” handbook on the web. See above.
- Call 1-800-MEDICARE.
- Visit www.medicare.gov, and select “Medicare Appeals.”

Mental health resources

If you have questions or concerns about your mental health, talk to your doctor or other health care provider.



For more information about Medicare mental health benefits and coverage, you can call the following:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Your **State Health Insurance Assistance Program (SHIP)**. To get their phone number call 1-800-MEDICARE. You can also visit www.medicare.gov, and select “Find Helpful Phone Numbers and Websites.” Then, search by the word “organization” or “SHIP.”

To find out more about mental health or to find mental health treatment in your community, talk to your doctor or other health care provider. You can also contact the following organizations:

- National Alliance on Mental Illness (NAMI)—Visit www.nami.org. You can also call the HelpLine at 1-800-950-NAMI (1-800-950-6264), or email NAMI at info@nami.org.
- Mental Health America—Visit www.mentalhealthamerica.net. You can also call 1-800-969-6642. TTY users should call 1-800-433-5959.
- Substance Abuse & Mental Health Services Administration (SAMHSA)—Visit www.samhsa.gov. SAMHSA has a treatment facility locator and a mental health services locator on its Web site.
- National Institute of Mental Health, National Institutes of Health—Visit www.nimh.nih.gov.
- National Council on Community Behavioral Healthcare—Visit www.nccbh.org.

Section 5: Words to Know

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of the following:

- Your request for a health care service, supply, or prescription that you think you should be able to get
- Your request for payment for health care or a prescription drug you already got
- Your request to change the amount you must pay for a prescription drug

You can also appeal if you are already getting coverage and Medicare or your plan stops paying.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Coverage Determination—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including the following:

- Whether a particular drug is covered
- Whether you have met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it

If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Exception—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its formulary or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that is on its non-preferred drug tier. You must request an exception, and your doctor or other prescriber must send a supporting statement explaining the medical reason for the exception.

Lifetime Reserve Days—In Original Medicare, these are additional days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare-approved Amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Health Plan—A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan.

Medicare Part A (Hospital Insurance)—Coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Coverage for certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Savings Program—A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

Original Medicare—Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

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To get this booklet in Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

My Health.
My Medicare.

¿Necesita usted una copia de esta guía en Español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al 1-877-486-2048.