



Medicare & Your Mental Health Benefits

This **official** government booklet has information about mental health benefits for people with Original Medicare, including:

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





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

“Medicare & 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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If you or someone you know is in crisis and would like to speak with a crisis counselor, call the free and confidential National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255). TTY users should call 1-800-799-4TTY (1-800-799-4889). You can call and speak with a counselor 24 hours a day, 7 days a week. Call the Lifeline:

- To speak to someone who cares
- If you feel you might be in danger of hurting yourself
- If you're concerned about a family member or friend
- To find referrals to mental health treatments and services in your area

If you're in immediate medical crisis, call 911.

Introduction

Mental health care & 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 other health care provider if you have:

- Thoughts of ending your life (like a fixation on death or suicidal thoughts or attempts)
- Sad, empty, or hopeless feelings
- Loss of self worth (like worries about being a burden, feelings of worthlessness, or self-loathing)
- Social withdrawal and isolation (reluctance to be with friends, engage in activities, or leave home)
- Little interest in things you used to enjoy
- A lack of energy
- Trouble concentrating
- Trouble sleeping (like difficulty falling asleep or staying asleep, oversleeping, or daytime sleepiness)
- Weight loss or loss of appetite
- Increased use of alcohol or other drugs

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 you may need to treat a mental health condition. This booklet gives you information about mental health benefits in **Original Medicare**.

Highlighted words are defined here.

If you get your Medicare benefits through a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan, check your plan's membership materials and call the plan for details about how to get your Medicare-covered mental health benefits.

Medicare helps cover mental health services

Medicare Part A (hospital insurance) helps cover mental health care if you're a hospital inpatient. 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 of 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. Part B may also pay for partial hospitalization services, if you need intensive coordinated outpatient care. See more information about partial hospitalization services.

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

Section 1: Outpatient mental health care & professional services

What **Original Medicare** covers

Medicare Part B helps cover mental health services and visits with the following types of health professionals (**deductibles** and **coinsurance** may apply):

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

The health professionals listed above (except psychiatrists and other doctors) must accept **assignment** if they participate in the Medicare program. Ask your health care provider if they accept assignment before you schedule an appointment.



Medicare Part B covers outpatient mental health services, including 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. Part B helps pay for the following covered services (**deductibles** and **coinsurance** may 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're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Occupational therapy that's part of your mental health treatment.
- Certain prescription drugs that aren't usually "self administered" (drugs you would normally take on your own), like some injections.
- Individual patient training and education about your condition.
- Diagnostic tests.
- Partial hospitalization may be covered. See more info.
- A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your potential risk factors for depression. (**Note:** This visit is only covered if you get it within the first 12 months you have Part B.) You pay nothing for this visit if your doctor or other health care provider accepts **assignment**.
- A yearly "Wellness" visit. Medicare covers a yearly "Wellness" visit once every 12 months (if you've had Part B for longer than 12 months). This is a good time to talk to your doctor or other health care provider about changes in your mental health so he or she can evaluate your changes year to year. You pay nothing for your yearly "Wellness" visit if your doctor or other health care provider accepts assignment.
- A yearly depression screening. Medicare covers one depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. You pay nothing for your yearly depression screening if your doctor or health care provider accepts assignment.

What you pay

After you pay your yearly **Medicare Part B deductible**, 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 (like psychotherapy), you pay 40% of the Medicare-approved amount in 2012. Congress passed legislation that reduces how much people with Medicare pay for outpatient mental health treatment to be consistent with **coinsurance** amounts for other medical services. How much you pay for these services will decrease to 35% in 2013 and 20% in 2014.

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%–40% of the Medicare-approved amount.

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



Medicare may cover partial hospitalization

Medicare Part B covers partial hospitalization in some cases. Partial hospitalization is 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. Medicare helps cover partial hospitalization services when they're provided through a hospital outpatient department or community mental health center.

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

In 2012, you pay a percentage of the **Medicare-approved amount** for each service you get from a qualified professional (see more info). You 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:

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

Section 2: Inpatient mental health care

What **Original Medicare** covers

Medicare Part A helps pay for mental health services you get in a hospital that require you to be admitted as an inpatient. You can get these services either 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, Part A will help cover mental health services.

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.

What you pay

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

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 there's a lifetime limit of 190 days.

For each benefit period as a hospital inpatient, you pay the following in 2012:

- \$1,156 **deductible** per benefit period
- \$0 for the first 60 days of each benefit period
- \$289 per day for days 61–90 of each benefit period
- \$578 per “**lifetime reserve day**” after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)

Note: **Medicare Part B** also helps cover mental health services provided by doctors and other health care professionals 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.

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

What **Original Medicare** doesn’t cover

Medicare doesn’t cover:

- Private duty nursing
- A phone or television in your room
- Personal items (like toothpaste, socks, or razors)
- A private room (unless **medically necessary**).



Section 3: Medicare prescription drug coverage (Part D)

To get Medicare prescription drug coverage, you must join a [Medicare Prescription 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.

Medicare drug plans have special rules

Will my plan cover the drugs I need?

Most Medicare drug plans have a list of drugs that the plan covers, called a formulary. Medicare drug plans aren't required to cover all drugs, but they're 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 drugs and that it doesn't discriminate against certain groups (like people with disabilities or mental health conditions).

If you take prescription drugs 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, like 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 more information on 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 have about the drugs you need.

Can my drug plan's formulary change?

A Medicare drug plan can make some changes to its formulary during the year according to guidelines set by Medicare. If you're currently taking a drug and the plan's formulary changes, in most cases, you'll 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** or **coinsurance** 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 request a **coverage determination** (including an **exception**).

Request a coverage determination

You, your doctor, or other prescriber can request that your plan cover a drug you need. You can request a coverage determination if your pharmacist or plan tells you:

- A drug you believe should be covered isn't covered
- A drug is covered at a higher cost than you think you should have to pay
- You have to meet a plan coverage rule (like prior authorization) before you can get the drug you requested
- It won't cover a drug on the formulary because the plan believes you don't need the drug



Request an exception

You, your doctor, or other prescriber can request an **exception** (a type of **coverage determination**) if:

- You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules (like prior authorization, step therapy, or quantity or dosage limits)
- You think your plan should charge a lower amount for a drug you're taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you

If you request an exception, your doctor or prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. Check with your plan to find out if it will require your prescriber to submit a supporting statement in writing.

What if I disagree with my plan's coverage determination or exception decision?

Once your plan has gotten your request, in most cases, it has 72 hours (or 24 hours if you request that a fast decision be made) to notify you of its decision. 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 how to file an appeal and your appeal rights:

- Visit www.medicare.gov/publications to view or print the booklet "Medicare Appeals."
- Visit www.medicare.gov/appeals.
- 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, visit www.medicare.gov/publications to view or print “Your Guide to Medicare’s Prescription Drug Coverage.” You can also learn more and get personalized help comparing plans by:

- Visiting www.medicare.gov/find-a-plan.
- Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Calling your **State Health Insurance Assistance Program (SHIP)**. To get their phone number, visit www.medicare/contacts, or call 1-800-MEDICARE.

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



Section 4: Get the help you need

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

This section includes information about the following:

- Help if you have limited income & resources
- Your rights as a person with Medicare
- Your Medicare **appeal** rights
- Mental health resources

Help if you have limited income & resources

Extra Help paying your Medicare prescription drug costs

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs. You may qualify for Extra Help if your yearly income and resources are below certain amounts. If you don't automatically qualify for Extra Help, you can still apply.

For more information:

- Visit www.socialsecurity.gov. To apply for Extra Help online, visit www.socialsecurity.gov/i1020.
- Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can apply for Extra Help by phone or get a paper application.
- Visit or call your State Medical Assistance (Medicaid) office. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.

State Pharmacy Assistance Programs (SPAPS)

Many states have SPAPs that help certain people pay for prescription drugs based on financial need, age, or medical condition. Each SPAP makes its own rules on how to provide assistance to its members. To find out if there's an SPAP in your state and how it works, call your **State Health Insurance Assistance Program (SHIP)**. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs (like **deductibles** and **coinsurance**) if you meet certain conditions.

For more information:

- Call or visit your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. Call if you think you qualify, even if you aren't sure. To get the phone number for your state, visit www.medicare.gov/contacts, or call 1-800-MEDICARE.
- Visit www.medicare.gov/publications to view the brochure "Get Help With Your Medicare Costs: Getting Started." You can also call 1-800-MEDICARE to find out if a copy can be mailed to you.
- Contact your **State Health Insurance Assistance Program (SHIP)**. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE to get the phone number.

Medicaid

Medicaid (also called Medical Assistance) is health coverage available to certain people and families who have limited income and resources. The rules for counting your income and resources depend on which state you live in. Eligibility may also depend on other factors, like how old you are and whether you're blind or have other disabilities. Even if you aren't sure whether you qualify, if your income is limited, and if you or someone in your family needs health care, you should apply for Medicaid and have a qualified caseworker in your state look at your situation.

For more information:

- To see if you qualify, call your State Medical Assistance (Medicaid) office. Visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.
- To learn about the Medicaid program, visit www.medicare.gov/publications to view or print the brochure “Medicaid: Getting Started.”

Your rights as a person with Medicare

All people with Medicare have certain rights and protections designed to protect you when you get health care, make sure you get the health care services that the law says you can get, protect you against unethical practices, and protect your privacy. To learn more about your rights as a person with Medicare, visit www.medicare.gov/publications to view the booklet “Medicare Rights and Protections.” You can call 1-800-MEDICARE to see if a copy can be mailed to you.

Your Medicare appeal rights

An **appeal** is the action you take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. If you decide to file an appeal, you can ask your doctor or other health care provider or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of the appeal.

For more information about your Medicare appeal rights and how to ask for an appeal:

- Visit www.medicare.gov/publications to view the booklet “Medicare Appeals.” You can call 1-800-MEDICARE to see if a copy can be mailed to you.
- Visit www.medicare.gov/appeals.
- Call 1-800-MEDICARE.

Mental health resources

If you're in immediate medical crisis, call 911.

For more information about Medicare mental health benefits and coverage:

- Call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.
- Call your **State Health Insurance Assistance Program (SHIP)**. Visit www.medicare.gov/ contacts to get the phone number.

Talk to your doctor or other health care provider if you have questions or concerns about your mental health, to find out more about mental health, or to find mental health treatment. You can also contact:

National Institute of Mental Health, National Institutes of Health:

- Visit www.nimh.nih.gov.
- Call 1-866-615-6464. TTY users should call 1-866-415-8051.
- Email nimhinfo@nih.gov.

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.
- Call 1-877-SAMHSA-7 (1-877-726-4727). TTY users should call 1-800-487-4889.
- Email SAMHSAInfo@samhsa.hhs.gov.

Mental Health America:

- Visit www.mentalhealthamerica.net.
- Call 1-800-969-6642. TTY users should call 1-800-433-5959.
- Email infoctr@mentalhealthamerica.net.

National Alliance on Mental Illness (NAMI):

- Visit www.nami.org.
- Call the Helpline at 1-800-950-NAMI (1-800-950-6264).
- Email info@nami.org.

National Council for Community Behavioral Healthcare:

- Visit www.thenationalcouncil.org.
- Call 202-684-7457.
- Email Communications@thenationalcouncil.org.

Section 5: Definitions

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're already getting coverage and Medicare or your plan stops paying.

Assignment—An agreement by your doctor or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

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, hospital outpatient 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've 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 drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's 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're 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 may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

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 health plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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1-800-MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al
1-877-486-2048.