DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Mental Health Services

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This publication provides the following information about Medicare mental health services:

- Covered mental health services;
- Mental health services that are not covered;
- Eligible professionals;
- Outpatient psychiatric hospital services;
- Inpatient psychiatric hospital services; and
- Resources.

COVERED MENTAL HEALTH SERVICES

The mental health services that may be covered under the Medicare Program include:

- Psychiatric diagnostic interviews;
- Individual psychotherapy;
- Interactive psychotherapy;
- Family psychotherapy (with the patient present and the primary purpose of which is treatment of the individual's condition);
- Family psychotherapy (without the patient present that is medically reasonable and necessary and the primary purpose of which is treatment of the individual's condition);
- Group psychotherapy;
- Psychoanalysis;
- Pharmacologic management;
- Electroconvulsive therapy (ECT);
- Diagnostic psychological and neuropsychological tests;
- Hypnotherapy;
- Narcosynthesis;
- Biofeedback therapy; and
- Individualized activity therapy (as part of a Partial Hospitalization Program [PHP] and that is not primarily recreational or diversionary).

MENTAL HEALTH SERVICES THAT ARE NOT COVERED

The mental health services that are not covered under the Medicare Program are:

- Environmental intervention;
- Geriatric day care programs;
- Individual psychophysiological therapy that incorporates biofeedback training (any modality);
- Marriage counseling;
- Pastoral counseling;
- Report preparation;
- Interpretation or explanation of results or data;
- Transportation and meals; and
- Telephone services.

ELIGIBLE PROFESSIONALS

The following are recognized as being eligible under Part B of the Medicare Program to provide diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders 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); and
- Independently Practicing Psychologists (IPP).

The charts on the following pages provide information about required qualifications and coverage and payment criteria for each provider type.

PSYCHIATRISTS

REQUIRED QUALIFICATIONS	COVERAGE	PAYMENT
❖ He or she must meet the following qualifications: ◆ Is a MD or a DO; and ◆ Is acting within the scope of his or her license.	❖ The following coverage criteria apply: ◆ He or she is legally authorized to practice medicine in the State in which the services are performed; ◆ He or she may perform the general supervision assigned to diagnostic psychological and neuropsychological tests; ◆ Services and supplies may be furnished incident to his or her professional services; and ◆ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary.	❖ The following payment criteria apply: ◆ Payment for assigned services is made at 100 percent of the amount a physician is paid under the Medicare Physician Fee Schedule (PFS).

CLINICAL PSYCHOLOGISTS (CP)

REQUIRED QUALIFICATIONS	COVERAGE	PAYMENT
❖ He or she must meet the following qualifications: ◆ Has a Doctoral degree in psychology; and ◆ Is licensed or certified, on the basis of the Doctoral degree in psychology, by the State in which he or she practices at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.	❖ The following coverage criteria apply: ◆ He or she is legally authorized to furnish the services in the State where they are performed; ◆ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ◆ Upon the patient's consent, he or she must attempt to consult with the patient's attending or primary care physician regarding the services being furnished and: - Document the date of consent or declination of consent to consultations and the date of consultations in the patient's medical record; or - If consultations do not succeed, document the date and manner of notification to the physician in the patient's medical record (does not apply if the physician referred the patient to the CP); ◆ He or she may perform the general supervision assigned to diagnostic psychological and neuropsychological tests; and ◆ Services and supplies may be furnished incident to his or her professional services, with the exception of services furnished to hospital patients.	❖ The following payment guidelines apply: ◆ Payment is made only on an assignment basis; and ◆ Services are paid at 100 percent of the amount that a physician is paid under the PFS.

CLINICAL SOCIAL WORKERS (CSW)

REQUIRED QUALIFICATIONS

- He or she must meet the following qualifications:
  - Has a Master's or Doctoral degree in social work;
  - Has performed at least two years of supervised clinical social work; and
  - Is licensed or certified as a CSW by the State in which the services are performed; or
  - If the individual practices in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post Master's degree supervised clinical social work practice under the supervision of a Master's level social worker in an appropriate setting (e.g., a hospital, Skilled Nursing Facility [SNF], or clinic).

COVERAGE

- The following coverage criteria apply:
  - He or she is legally authorized to furnish the services in the State where they are performed;
  - Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary;
  - Services are for the diagnosis and treatment of mental illnesses;
  - CSW services furnished to hospital inpatients are not covered as CSW services;
  - CSW services to hospital outpatients are covered and paid under the CSW benefit when billed by the hospital to a Part B Carrier or Medicare Contractor under the CSW's National Provider Identifier;
  - CSW services furnished to patients under a PHP that is provided by a hospital outpatient department or Community Mental Health Center (CMHC) are not covered and paid under the CSW benefit;
  - CSW services furnished to SNF inpatients and patients in Medicare-participating End-Stage Renal Disease facilities are not covered and paid under the CSW benefit if the services furnished are required under the respective requirements for participation;
  - Incident to services that CSWs furnish for physicians, CPs, CNSs, NPs, PAs, or CNMs may be covered; and
  - Services furnished as an incident to a CSW's personal professional services are not covered.

PAYMENT

- The following payment guidelines apply:
  - Payment is made only on an assignment basis; and
  - Services are paid at 75 percent of the amount that a CP is paid under the PFS.

CLINICAL NURSE SPECIALISTS (CNS)

REQUIRED QUALIFICATIONS	COVERAGE	PAYMENT
❖ He or she must meet the following qualifications: ◆ Is a registered nurse (RN) currently licensed to practice in the State where the individual practices and is authorized to furnish the services of a CNS in accordance with State law; ◆ Has a Doctor of Nursing Practice or Master's degree in a defined clinical area of nursing from an accredited educational institution; and ◆ Is certified as a CNS by a recognized national certifying body that has established standards for CNSs.	❖ The following coverage criteria apply: ◆ He or she is legally authorized and qualified to furnish the services in the State where they are performed; ◆ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ◆ Services are the type considered physicians' services if furnished by a MD or a DO; ◆ Services are performed in collaboration with a physician; ◆ Assistant-at-surgery services furnished by a CNS are covered; ◆ He or she may personally perform diagnostic psychological and neuropsychological tests in collaboration with a physician as required under the CNS benefit and to the extent permitted under State law; and ◆ Incident to services and supplies may be covered.	❖ The following payment guidelines apply: ◆ Payment is made only on an assignment basis; ◆ Services are paid directly to the CNS at 85 percent of the amount that a physician is paid under the PFS; and ◆ Payment is made directly to the CNS for assistant-at-surgery services at 85 percent of 16 percent of the amount that a physician is paid under the PFS for assistant-at-surgery services.

NURSE PRACTITIONERS (NP)

REQUIRED QUALIFICATIONS

- He or she must meet the following qualifications:
  - Is a registered professional nurse authorized by the State in which the services are furnished to practice as a NP in accordance with State law and meets one of the following criteria:
    - Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003, and:
      - Is certified as a NP by a recognized national certifying body that has established standards for NPs; and
      - Has a Master's degree in nursing or a Doctor of Nursing Practice Doctoral degree;
    - Obtained Medicare billing privileges as a NP for the first time before January 1, 2003, and meets the certification requirements described above; or
    - Obtained Medicare billing privileges as a NP for the first time before January 1, 2001.

COVERAGE

- The following coverage criteria apply:
  - He or she is legally authorized and qualified to furnish the services in the State where they are performed;
  - Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary;
  - Services are the type considered physicians' services if furnished by a MD or a DO;
  - Services are performed in collaboration with a physician;
  - Assistant-at-surgery services furnished by a NP are covered;
  - He or she may personally perform diagnostic psychological and neuropsychological tests in collaboration with a physician as required under the NP benefit and to the extent permitted under State law; and
  - Incident to services and supplies may be covered.

PAYMENT

- The following payment guidelines apply:
  - Payment is made only on an assignment basis;
  - Services are paid at 85 percent of the amount that a physician is paid under the PFS; and
  - Payment is made directly to the NP for assistant-at-surgery services at 85 percent of 16 percent of the amount that a physician is paid under the PFS for assistant-at-surgery services.

PHYSICIAN ASSISTANTS (PA)

REQUIRED QUALIFICATIONS

- He or she must meet the following qualifications:
  - Is licensed by the State to practice as a PA and one of the following criteria:
    - Has graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs, and the Committee on Allied Health Education and Accreditation); or
    - Has passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

COVERAGE

- The following coverage criteria apply:
  - He or she is legally authorized to furnish the services in the State where they are performed;
  - Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary;
  - Services are the type considered physicians' services if furnished by a MD or a DO;
  - Services are performed by an individual who meets all PA qualifications;
  - Services are performed under the general supervision of a MD or a DO;
  - The physician supervisor or designee need not be physically present when a service is being furnished unless State law or regulations require otherwise;
  - Assistant-at-surgery services furnished by a PA are covered;
  - He or she may personally perform diagnostic psychological and neuropsychological tests under the general supervision of a physician as required under the PA benefit and to the extent permitted under State law; and
  - Incident to services and supplies may be covered.

PAYMENT

- The following payment guidelines apply:
  - Payment is made only on an assignment basis;
  - Payment may be made only to his or her:
    - Qualified employer who is eligible to enroll in the Medicare Program under existing provider/supplier categories; or
    - Contractor;
  - Services are paid at 85 percent of the amount that a physician is paid under the PFS; and
  - Payment is made to the PA's employer or contractor for assistant-at-surgery services at 85 percent of 16 percent of the amount that a physician is paid under the PFS for assistant-at-surgery services.

CERTIFIED NURSE–MIDWIVES (CNM)

REQUIRED QUALIFICATIONS	COVERAGE	PAYMENT
❖ He or she must meet the following qualifications: ◆ Is a RN who is legally authorized to practice as a nurse-midwife in the State where services are performed; ◆ Has successfully completed a program of study and clinical experience for nurse-midwives that is accredited by an accrediting body approved by the U.S. Department of Education; and ◆ Is certified as a nurse-midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council.	❖ The following coverage criteria apply: ◆ He or she is legally authorized and qualified to furnish the services in the State where they are performed; ◆ Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary; ◆ Services are the type considered physicians' services if furnished by a MD or a DO; ◆ Services are performed without physician supervision and without association with a physician or other health care provider, unless otherwise required by State law; ◆ He or she may personally perform diagnostic psychological and neuropsychological tests without physician supervision or oversight as authorized under the CNM benefit and to the extent permitted under State law; and ◆ Incident to services and supplies may be covered.	❖ The following payment guidelines apply: ◆ Payment is made only on an assignment basis; and ◆ Services are paid at 80 percent of the lesser of the actual charge or 100 percent of the amount that a physician is paid under the PFS (effective January 1, 2011).

INDEPENDENTLY PRACTICING PSYCHOLOGISTS (IPP)

REQUIRED QUALIFICATIONS

- He or she must meet the following qualifications:
  - Is a psychologist who is not a CP and one of the following criteria:
    - Practices independently of an institution, agency, or physician's office and is licensed or certified to practice psychology in the State or jurisdiction where the services are performed; or
    - Is a practicing psychologist that performs services in a jurisdiction that does not issue licenses.

COVERAGE

- The following coverage criteria apply:
  - Services are not otherwise precluded due to a statutory exclusion, and the services must be reasonable and necessary;
  - Performs services on his or her own responsibility, free of the administrative and professional control of an employer (e.g., a physician, institution, or agency);
  - The individuals treated are his or her own patients;
  - He or she has the right to bill directly and collect and retain the fee for his or her services;
  - When he or she practices in an office that is located in an institution:
    - The office is confined to a separately-identified part of the facility that he or she uses solely as an office and cannot be construed as extending throughout the entire institution; and
    - He or she conducts a private practice (i.e., services are furnished to patients outside the institution as well as to institutional patients); and
  - He or she may perform diagnostic psychological and neuropsychological tests when a physician orders such tests.

PAYMENT

- The following payment guidelines apply:
  - Diagnostic psychological and neuropsychological tests are not subject to assignment; however, the name and address of the physician who ordered the tests must be included on the claim form; and
  - Assigned payment is made to the IPP at 100 percent of the PFS amount.

If a psychiatrist is a Medicare participating physician who chooses to accept assignment for his or her services, assigned payment must be accepted for all covered services for all Medicare beneficiaries. If a psychiatrist chooses not to participate under Medicare, he or she can choose to accept assignment on a case-by-case basis. However, if this nonparticipating physician does not choose to accept assignment, payment is made at 95 percent of the Medicare PFS amount.

The services of CPs, CSWs, CNSs, NPs, PAs, and CNMs are always subject to assignment. Accordingly, regardless of whether these non-physician practitioners (NPP) participate in the Medicare Program, payment for their services is always made under assignment.

IPPs who are authorized by Medicare to perform only diagnostic psychological and neuropsychological tests are not required to accept assigned payment for these tests. Therefore, payment for these tests is made to participating IPPs at 100 percent of the PFS amount and to nonparticipating IPPs at 95 percent of the PFS amount.

Assignment means that the provider or supplier:

- Will be paid the Medicare allowed amount as payment in full for his or her services; and
- May not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance.

All services provided to Medicare beneficiaries must be furnished by practitioners who, by virtue of their specific State licensure, certification, and training, are professionally qualified to provide medically necessary services.

OUTPATIENT PSYCHIATRIC HOSPITAL SERVICES

Outpatient psychiatric hospital services and supplies must:

- Be medically reasonable and necessary for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. For every service that is billed, the provider must indicate the specific sign, symptom, or patient complaint necessitating the service. Medically necessary services and supplies:
  - Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
  - Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
  - Meet the standards of good medical practice; and
  - Are not mainly for the convenience of the beneficiary, provider, or supplier;

- Be furnished under an individualized written plan of care (POC) that states:
  - The type, amount, frequency, and duration of services to be furnished;
  - The diagnosis; and
  - Anticipated goals (except when only a few brief services are furnished);
- Be supervised and periodically evaluated by a physician who:
  - Prescribes the services;
  - Determines the extent to which treatment goals have been reached and whether changes in direction or emphasis are needed;
  - Provides supervision and direction to the therapists involved in the patient's treatment; and
  - Documents his or her involvement in the patient's medical record; and
- Be for the purpose of diagnostic study or, at a minimum, designed to reduce or control the patient's psychiatric symptoms so as to prevent a relapse or hospitalization **and** improve or maintain the patient's level of functioning.

In general, the following services are covered for the treatment of outpatient hospital psychiatric patients:

- Medically necessary diagnostic services that are for the purpose of diagnosing individuals for which extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and formulate a POC;
- Individual and group psychotherapy with physicians, CPs, CSWs, or other eligible professionals authorized or licensed by the State where the services are performed;
- Services of social workers, psychiatric nurses, and other staff trained to work with psychiatric patients;
- Occupational therapy services, as part of a PHP, that:
  - Require the skills of a qualified occupational therapist;
  - Are performed by or under the supervision of a qualified occupational therapist; and
  - Are included in the patient's POC;
- Activity therapies, as part of a PHP, that:
  - Are individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals; and
  - Are clearly justified in the POC and state the need for each particular therapy utilized (may not be primarily recreational or diversionary);

- Family counseling services with members of the patient's household when the **primary** purpose is the treatment of the patient's condition;
- Patient training and education when they are closely and clearly related to the care and treatment of the individual's diagnosed psychiatric condition; and
- Drugs and biologicals furnished that are for therapeutic purposes and that cannot be self-administered.

In general, the following services are not covered for the treatment of outpatient hospital psychiatric patients:

- Meals and transportation;
- Activity therapies, group activities, or other services and programs that are primarily recreational or diversionary;
- Psychosocial programs (psychosocial components of an outpatient program that are **not** primarily for social or recreational purposes are covered); and
- Vocational training related **solely** to specific employment opportunities.

Partial Hospitalization Program

A PHP is furnished by a hospital to outpatients or by a CMHC that provides partial hospitalization services. Partial hospitalization services are a distinct and organized intensive ambulatory psychiatric treatment program that offers less than 24-hour daily care to patients who either:

- Have been discharged from inpatient hospital treatment and the PHP is in lieu of continued inpatient treatment; or
- Would be at reasonable risk of requiring inpatient hospitalization in the absence of partial hospitalization.

The following Program and patient criteria must be met:

- Active treatment is furnished that incorporates an individual POC with a coordination of services designed for the needs of the patient;
- Treatment includes a multidisciplinary team approach to patient care under the direction of a physician who certifies the patient's need for partial hospitalization and for a minimum of 20 hours per week of therapeutic services, as evidenced by the POC;
- Treatment goals should be:
  - Measurable;
  - Functional;
  - Time-framed;
  - Medically necessary; and
  - Directly related to the reason for admission;
- The patient requires comprehensive, highly structured and scheduled multimodal treatment that requires medical supervision and coordination under an individualized POC because of a mental disorder that severely interferes with multiple areas of daily life (social, vocational, and/or educational functioning); and
- The patient is able to cognitively and emotionally participate in the active treatment process and is capable of tolerating the intensity of a PHP.

Community Mental Health Centers

A CMHC is an entity that provides partial hospitalization services under Part B of the Medicare Program. For a CMHC to be authorized to provide these services, it must:

- Meet applicable licensing or certification requirements for CMHCs in the State where it is located; and
- Provide:
  - Outpatient services including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;
  - Twenty-four-hour emergency care services that provide access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record;
  - Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services that provide structured day programs with treatment plans that vary in intensity of services and frequency and duration of services based on the needs of the patient;
  - At least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Social Security Act; and
  - Screening for patients who are being considered for admission to a State mental health facility to determine the appropriateness of such admission by an entity that has the appropriate clinical personnel and authorization under State law to perform all steps in the clinical evaluation process, with the exception of those that must be provided by a 24-hour facility. A CMHC that operates in a State that by law precludes it from providing these services may provide for such services by contract with an approved organization or entity (as determined by the Secretary of the Department of Health and Human Services) that, among other things, meets applicable licensure or certification requirements for CMHCs in the State where it is located.

The following services are not covered under a PHP:

- Services to hospital inpatients;
- Meals, self-administered medications, and transportation; and
- Vocational training.

Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation (the limitation) generally applies to all covered mental health therapeutic services that are performed in an outpatient setting. The limitation also applies to mental, psychoneurotic, and personality disorder services that physicians, CPs, CNSs, NPs, PAs, and CNMs furnish to treat partial hospitalization patients because these individuals' services are paid separately from the program of services under a PHP. Psychological and neuropsychological testing services performed to evaluate a patient's progress during treatment are also subject to the limitation.

The following services are not subject to the outpatient mental health treatment limitation:

- Medical management of Alzheimer's Disease and related disorders (billed under Current Procedural Terminology code 90862 or any successor codes);
- Brief office visits for monitoring or to change drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders (billed under Healthcare Common Procedure Coding System code M0064 or any successor codes);
- Diagnostic psychiatric evaluations and psychological and neuropsychological tests performed to establish or confirm the patient's diagnosis;
- Partial hospitalization services that are not directly provided by a physician or NPP; and
- Partial hospitalization services billed by a CMHC, hospital outpatient department, or Critical Access Hospital.

Prior to 2010, Medicare beneficiaries were required to pay a 50 percent copayment for outpatient psychiatric services that were subject to the limitation. With enactment of the Medicare Improvements for Patients and Providers Act of 2008, the amount of the beneficiary's copayment for services subject to the limitation was reduced or will be reduced as shown in the chart below.

OUTPATIENT MENTAL HEALTH TREATMENT LIMITATION	
Year	**Beneficiary Copayment**
On January 1, 2010	45 percent
On January 1, 2012	40 percent
On January 1, 2013	35 percent
On January 1, 2014 (the final copayment reduction)	20 percent

Incident to Provision

A physician, CP, CNS, NP, PA, or CNM may have outpatient psychiatric services and supplies furnished incident to his or her professional service. To be covered under the Incident to Provision, the following requirements must be met:

- The services and supplies must be an integral part of the patient's normal course of treatment during which the physician or other listed NPP has personally performed an initial service and remains actively involved in the course of treatment;
- The services and supplies are commonly furnished without charge (included in the physician's or other listed NPP's bill);
- The services and supplies are an expense to the physician or other listed NPP;
- The services and supplies are commonly furnished in the physician's or other listed NPP's office or clinic; and

- The physician or other listed NPP provides direct supervision, which means that he or she is present in the office suite and immediately available if needed.

Services and supplies furnished by CPs, CSWs, CNSs, NPs, PAs, and CNMs may also be covered when furnished as an incident to the professional services of a physician or other specified NPP if they would have been covered when furnished incident to the services of a MD or a DO.

INPATIENT PSYCHIATRIC HOSPITAL SERVICES

The following requirements must be met for Medicare to pay for inpatient psychiatric hospital services:

- The patient must be furnished active psychiatric treatment that can reasonably be expected to improve his or her condition;
- Services must be furnished while the patient is receiving either active psychiatric treatment or admission and related services necessary for diagnostic treatment;
- A physician must provide certification at the time of admission or as soon thereafter as is reasonable and practicable that the patient needs, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of Inpatient Psychiatric Facility (IPF) personnel; and
- A physician must provide the first re-certification as of the 12th day of hospitalization and subsequent re-certifications at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days that the patient continues to need, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel.

Patients who are treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve and for 190 days of care in freestanding psychiatric hospitals.

These services are paid under the IPF Prospective Payment System under which Federal per diem rates include inpatient operating and capital related costs that are determined based on:

- Geographic factors;
- Patient characteristics; and
- Facility characteristics.

Additional payments are provided for:

- Patients treated in IPFs that have a qualifying emergency department;
- The number of ECT treatments furnished; and
- Outlier payments for cases that have extraordinarily high costs.

RESOURCES

For more information about Medicare mental health services, refer to the following:

- Chapters 2, 6, and 15 of the "Medicare Benefit Policy Manual" (Publication 100-02) and Chapters 3 and 4 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the Centers for Medicare & Medicaid Services (CMS) website;
- The Medicare Learning Network® (MLN) publication titled "Inpatient Psychiatric Facility Prospective Payment System" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/InpatientPsychFac.pdf on the CMS website; and
- The section for your provider type in the MLN publication titled "MLN Guided Pathways to Medicare Resources Provider Specific" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website.

For more information about inpatient psychiatric hospital services, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS on the CMS website. To find the compilation of Social Security laws, visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit http://www.medicare.gov on the CMS website.

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