Primary Care Depression Reimbursement
Myths vs. Facts

Employer and health system members of the Mid-America Coalition on Health Care are working together to address the human and financial costs of depression, both in the workplace and in the community. Early in this initiative, primary care physician partners noted that an important barrier to utilizing depression claim codes was the failure of health plans to reimburse them for their diagnosis and treatment of depressed patients. The ensuing "***Life of a Depression Claim***" project addressed this issue and in the process determined that there were several misconceptions commonly held by the provider community about the issues of reimbursement for depression treatment in primary care settings.

Myth #1: Health Plans do not pay for depression treatment in the primary care setting
Fact: Kansas City regional health plans do pay for the treatment of depression in primary care settings.

Discussion:
The majority of local and national health plans conducted tests of typical claims to determine if those with a primary diagnosis of depression would be paid in the primary care setting. During the test claim process, any system errors found that previously prevented the payment of a depression claim were corrected. Each plan's analysis now confirms that when a primary care physician submits a CPT E&M office visit code (e.g. 99213 or 99202) along with a depression diagnosis (e.g., ICD-9 code 311) the visit will be paid according to the member's benefit plan.

Subsequent analysis of over 100,000 primary care depression claims revealed 3,176 had a primary diagnosis of depression. Of these claims, 270 were not paid for reasons common to all claim non-payment reasons regardless of diagnosis (e.g. deductible not met, patient co-insurance due, etc.). In fact, less than <1% (.00002, n=2) of the non-paid claims were actually denied because of the depression diagnosis, which is no more or less than other claims denials.

Myth #2: Medicare always applies a statutory "psychiatric reduction" in payment (80% allowable payment is reduced to 62.5%) of depression claims.
Fact: Medicare only applies the psychiatric reduction to primary diagnosis claims. A Medicare depression claim submitted with secondary or tertiary diagnosis of depression is not subject to the psychiatric reduction.

Myth #3: Health plans always follow Medicare reimbursement guidelines for depression care. Consequently, they apply a "psychiatric reduction" for a primary diagnosis of depression in the primary care setting.
Fact: Non-Medicare commercial and Medicaid health plans **do not** follow Medicare reimbursement guidelines for depression.

***Discussion*:**
These health plans do reimburse for depression in primary care settings according to contracted physician fee schedules. However, the reimbursement for a depression claim is subject to the limitations of the member's medical benefit package – just like any other diagnosis.

Myth #4: Self-insured employers routinely exclude mental health coverage from employee benefit packages.
Fact: Self-insured employers do not routinely exclude mental health coverage for employees.

Discussion:
Local and national employer broker and third party administrator organizations agree that self-insured employer benefit packages are predominantly based on "industry standard" health plan benefit designs. Typically, self-insured employers do not deviate from these widely accepted industry practices. In the future, mental health parity legislation may correct any additional deviations from industry standard benefit designs.

Myth #5: My patients will not benefit from a depression diagnosis.
Fact: A patient who is appropriately diagnosed with depression is afforded the opportunity to access additional employer and community resources not readily available in the physician office (e.g., counseling programs, disease management programs). Furthermore, a diagnosis of depression is not necessarily an automatic denial for life or health insurance. In most cases, the diagnosis is subject to same actuarial guidelines as other chronic diseases, and ironically, appropriate treatment may reduce denials for coverage.

For additional provider information and resources for the management of depression visit www.machc.org

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