ESRD facility, and for comprehensive outpatient rehabilitation facility (CORF) services: Conditions.
410.172 Payment for partial hospitalization services in CMHCs: Conditions.
410.175 Alien absent from the United States.

AUTHORITY: Secs. 1102, 1834, 1871, 1881, and 1893 of the Social Security Act (42 U.S.C. 1302. 1395m, 1395hh, and 1395ddd.

SOURCE: 51 FR 41339, Nov. 14, 1986, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 410 appear at 62 FR 46037, Aug. 29, 1997.

## Subpart A—General Provisions

### §410.1 Basis and scope.

(a) *Statutory basis*. This part is based on the indicated provisions of the following sections of the Act:

(1) Section 1832—Scope of benefits furnished under the Medicare Part B supplementary medical insurance (SMI) program.

(2) Section 1833 through 1835 and 1862—Amounts of payment for SMI services, the conditions for payment, and the exclusions from coverage.

(3) Section 1861(qq)—Definition of the kinds of services that may be covered.

(4) Section 1865(b)—Permission for CMS to approve and recognize a national accreditation organization for the purpose of deeming entities accredited by the organization to meet program requirements.

(5) Section 1881—Medicare coverage for end-stage renal disease beneficiaries.

(6) Section 1842(o)—Payment for drugs and biologicals not paid on a cost or prospective payment basis.

(b) *Scope of part*. This part sets forth the benefits available under Medicare Part B, the conditions for payment and the limitations on services, the percentage of incurred expenses that Medicare Part B pays, and the deductible and copayment amounts for which the beneficiary is responsible. (Exclusions applicable to these services are set forth in subpart C of part 405 of this chapter. General conditions for Medicare payment are set forth in part 424 of this chapter.)

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 55 FR 53521, Dec. 31, 1990; 59 FR 63462, Dec. 8, 1994; 63 FR 58905, Nov. 2, 1998; 65 FR 83148, Dec. 29, 2000; 69 FR 66420, Nov. 15, 2004]

### §410.2 Definitions.

As used in this part—

*Community mental health center (CMHC)* means an entity that—

(1) Provides 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;

(2) Provides 24-hour-a-day emergency care services;

(3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;

(4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission;

(5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located; and

(6) Provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.

*Encounter* means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

*Nominal charge provider* means a provider that furnishes services free of charge or at a nominal charge, and is either a public provider or another provider that (1) demonstrates to CMS's satisfaction that a significant portion of its patients are low-income; and (2) requests that payment for its services be determined accordingly.

*Outpatient* means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

*Partial hospitalization services* means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.43.

*Participating* refers to a hospital, CAH, SNF, HHA, CORF, or hospice that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has a provider agreement to participate in Medicare but only for purposes of providing outpatient physical therapy, occupational therapy, or speech pathology services; or a CMHC that has in effect a similar agreement but only for purposes of providing partial hospitalization services, and *nonparticipating* refers to a hospital, CAH, SNF, HHA, CORF, hospice, clinic, rehabilitation agency, public health agency, or CMHC that does not have in effect a provider agreement to participate in Medicare.

*Preventive services* means all of the following:

(1) The specific services listed in section 1861(ww)(2) of the Act, with the explicit exclusion of electrocardiograms;

(2) The Initial Preventive Physical Examination (IPPE) (as specified by section 1861(ww)(1) of the Act); and

(3) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) (as specified by section 1861(hhh)(1) of the Act).

[59 FR 6577, Feb. 11, 1994, as amended at 62 FR 46025, Aug. 29, 1997; 65 FR 18536, Apr. 7, 2000; 75 FR 72259, Nov. 24, 2010; 75 FR 73613, Nov. 29, 2010]

### § 410.3 Scope of benefits.

(a) *Covered services.* The SMI program helps pay for the following:

(1) Medical and other health services such as physicians' services, outpatient services furnished by a hospital or a CAH, diagnostic tests, outpatient physical therapy and speech pathology services, rural health clinic services, Federally qualified health center services, IHS, Indian tribe, or tribal organization facility services, and outpatient renal dialysis services.

(2) Services furnished by ambulatory surgical centers (ASCs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and partial hospitalization services provided by community mental health centers (CMHCs).

(3) Other medicial services, equipment, and supplies that are not covered under Medicare Part A hospital insurance.

(b) *Limitations on amount of payment.* (1) Medicare Part B does not pay the full reasonable costs or charges for all covered services. The beneficiary is responsible for an annual deductible and a blood deductible and, after the annual deductible has been satisfied, for coinsurance amounts specified for most of the services.

(2) Specific rules on payment are set forth in subpart I of this part.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 24981, June 12, 1992; 58 FR 30668, May 26, 1993; 59 FR 6577, Feb. 11, 1994; 66 FR 55328, Nov. 1, 2001; 75 FR 73613, Nov. 29, 2010]

### § 410.5 Other applicable rules.

The following other rules of this chapter set forth additional policies and procedures applicable to four of the kinds of services covered under the SMI program:

(a) Part 494: End-Stage Renal Disease Facilities.

(b) Part 405, Subpart X: Rural Health Clinic and Federally Qualified Health Center services.

(c) Part 416: Ambulatory Surgical Center services.

(d) Part 493: Laboratory Services.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 7134, Feb. 28, 1992; 57 FR 24981, June 12, 1992; 73 FR 20474, Apr. 15, 2008]

## Subpart B—Medical and Other Health Services

### § 410.10 Medical and other health services: Included services.

Subject to the conditions and limitations specified in this subpart, ''medical and other health services'' includes the following services:

(a) Physicians' services.

(b) Services and supplies furnished incident to a physician's professional services, of kinds that are commonly furnished in physicians' offices and are commonly either furnished without