

furnished incident to his or her services. Payment is made to the employer of a physician assistant regardless of whether the physician assistant furnishes services under a W-2, employer-employee employment relationship, or whether the physician assistant is an independent contractor who receives a 1099 reflecting the relationship. Both types of relationships must conform to the appropriate guidelines provided by the Internal Revenue Service. A qualified employer is not a group of physician assistants that incorporate to bill for their services. Payment is made only if no facility or other provider charges or is paid any amount for services furnished by a physician assistant.

(16) To a nurse practitioner or clinical nurse specialist for professional services furnished by a nurse practitioner or clinical nurse specialist in all settings in both rural and nonrural areas and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges, or is paid, any amount for the furnishing of the professional services of the nurse practitioner or clinical nurse specialist.

(17) To a clinical psychologist on the individual's behalf for clinical psychologist services and for services and supplies furnished as an incident to his or her services.

(18) To a clinical social worker on the individual's behalf for clinical social worker services.

(19) To a participating HHA, for home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

(20) To a certified nurse-midwife for professional services furnished by the certified nurse-midwife in all settings and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges or is paid any amount for

the furnishing of the professional services of the certified nurse-midwife.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 24981, June 12, 1992; 58 FR 30668, May 26, 1993; 59 FR 6577, Feb. 11, 1994; 63 FR 20129, Apr. 23, 1998; 63 FR 26308, May 12, 1998; 63 FR 58909, Nov. 2, 1998; 65 FR 41211, July 3, 2000; 66 FR 39599, July 31, 2001; 75 FR 73615, Nov. 29, 2010]

#### §410.152 Amounts of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses*. As used in this section, “incurred expenses” are expenses incurred by an individual, during his or her coverage period, for covered Part B services, excluding the following:

(i) Expenses incurred for services for which the beneficiary is entitled to have payment made under Medicare Part A or would be so entitled except for the application of the Part A deductible and coinsurance requirements.

(ii) Expenses incurred in meeting the Part B blood deductible (§410.161).

(iii) In the case of services payable under a formula that takes into account reasonable charges, reasonable costs, customary charges, customary (insofar as reasonable) charges, charges related to reasonable costs, fair compensation, a pre-treatment prospective payment rate, or a standard overhead amount, or any combination of two or more of these factors, expenses in excess of any factor taken into account under that formula.

(iv) Expenses in excess of the outpatient mental health treatment limitation described in §410.155.

(v) In the case of expenses incurred for outpatient physical therapy services including speech-language pathology services, the expenses excluded are from the incurred expenses under §410.60(e). In the case of expenses incurred for outpatient occupational therapy including speech-language pathology services, the expenses excluded are from the incurred expenses under §410.59(e).

(2) *Other applicable provisions*. Medicare Part B pays for incurred expenses the amounts specified in paragraphs (b) through (k) of this section, subject to the following:

(i) The principles and procedures for determining reasonable costs and reasonable charges and the conditions for Medicare payment, as set forth in parts 405 (subparts E and X), 413, and 424 of this chapter.

(ii) The Part B annual deductible (§410.160).

(iii) The special rules for payment to health maintenance organizations (HMOs), health care prepayment plans (HCPPs), and competitive medical plans (CMPs) that are set forth in part 417 of this chapter. (A prepayment organization that does not qualify as an HMO, CMP, or HCPP is paid in accordance with paragraph (b)(4) of this section.)

(b) *Basic rules for payment.* Except as specified in paragraphs (c) through (h) of this section, Medicare Part B pays the following amounts:

(1) For services furnished by, or under arrangements made by, a provider other than a nominal charge provider, whichever of the following is less:

(i) 80 percent of the reasonable cost of the services.

(ii) The reasonable cost of, or the customary charges for, the services, whichever is less, minus 20 percent of the customary (insofar as reasonable) charges for the services.

(2) For services furnished by, or under arrangements made by, a nominal charge provider, 80 percent of fair compensation.

(3) For emergency outpatient hospital services furnished by a non-participating hospital that is eligible to receive payment for those services under subpart G of part 424 of this chapter, the amount specified in paragraph (b)(1) of this section.

(4) For services furnished by a person or an entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the payment amount computed on any other payment basis for the services.

(c) *Amount of payment: Home health services other than durable medical equipment (DME).* For home health services other than DME furnished by, or under arrangements made by, a participating HHA, Medicare Part B pays the following amounts:

(1) For services furnished by an HHA that is a nominal charge provider, 100 percent of fair compensation.

(2) For services furnished by an HHA that is not a nominal charge provider, the lesser of the reasonable cost of the services and the customary charges for the services.

(d) *Amount of payment: DME furnished as a home health service—*(1) *Basic rule.* Except as specified in paragraph (d)(2) of this section—

(i) For DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 80 percent of fair compensation.

(ii) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays the lesser of the following:

(A) 80 percent of the reasonable cost of the service.

(B) The reasonable cost of, or the customary charge for, the service, whichever is less, minus 20 percent of the customary (insofar as reasonable) charge for the service.

(2) *Exception.* If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for new equipment—

(i) For used DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 100 percent of fair compensation.

(ii) For used DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays 100 percent of the reasonable cost of, or the customary charge for, the services, whichever is less.

(e) *Amount of payment: Renal dialysis services, supplies, and equipment.* Effective for services furnished on or after August 1, 1983, Medicare Part B pays for the institutional dialysis services specified in §409.250 and the home dialysis services, supplies, and equipment specified in §409.252, as follows:

(1) Except as provided in paragraph (d)(2) of this section, 80 percent of the per treatment prospective reimbursement rate established under §413.170 of this chapter, for outpatient maintenance dialysis furnished by ESRD facilities approved in accordance with part 494 of this chapter.

(2) *Exception.* If a home dialysis patient elects to obtain home dialysis supplies or equipment (or both) from a party other than an approved ESRD facility, payment is in accordance with paragraph (b)(4) of this section.

(f) *Amount of payment: Rural health clinic and Federally qualified health center services.* Medicare Part B pays, for services by a participating independent rural health clinic or Federally qualified health center, 80 percent of the costs determined under subpart X of part 405 of this chapter, to the extent those costs are reasonable and related to the cost of furnishing rural health clinic or Federally qualified health center services or reasonable on the basis of other tests specified by CMS.

(g) *Amount of payment: Used durable medical equipment furnished by other than an HHA.* Medicare Part B pays the following amounts for used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment:

(1) For used DME furnished by, or under arrangements made by, a nominal charge provider, 100 percent of fair compensation.

(2) For used DME furnished by or under arrangements made by a provider that is not a nominal charge provider, 100 percent of the reasonable cost of the service or the customary charge for the service, whichever is less.

(3) For used DME furnished by other than a provider, 100 percent of the reasonable charge.

(h) *Amount of payment: Pneumococcal vaccine.* Medicare Part B pays for pneumococcal vaccine and its administration as follows:

(1) For services furnished by a nominal charge provider, 100 percent of fair compensation.

(2) For services furnished by a provider that is not a nominal charge provider, the reasonable cost of the services or the customary charge for the service, whichever is less.

(3) For services furnished by other than a provider, a rural health clinic or a Federally qualified health center, 100 percent of the reasonable charge.

(4) For services furnished by a rural health clinic or a Federally qualified

health center, 100 percent of the reasonable cost.

(i) *Amount of payment: ASC facility services.* (1) For ASC facility services furnished on or after July 1, 1987 and before January 1, 2008, in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead amount as specified in §416.120(c) of this chapter, except that, for screening flexible sigmoidoscopies and screening colonoscopies, Part B coinsurance is 25 percent of the standard overhead amount and Medicare Part B pays 75 percent of the standard overhead amount.

(2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in §416.166 of this subchapter, except as provided in paragraphs (i)(2)(i), (i)(2)(ii), and (l) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable.

(i) If the limitation described in §416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount, except as provided in paragraph (l) of this section.

(ii) Between January 1, 2008 and December 31, 2010, Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.

(j) *Amount of payment: services of Federally funded health facilities prior to October 1, 1991.* Medicare Part B pays 80 percent of charges related to the reasonable costs that a Federally funded health facility incurs in furnishing the services. See §411.8(b)(6) of this chapter.

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(k) *Amount of payment: Outpatient CAH services.* (1) Payment for CAH outpatient services is the reasonable cost of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act, with § 413.70(b) and (c) of this chapter, and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter.

(2) Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts, except as described in § 413.70(b)(2)(iii) of this chapter, with Part B coinsurance being calculated as 20 percent of the customary (insofar as reasonable) charges of the CAH for the services.

(1) *Amount of payment: Preventive services.* Medicare Part B pays 100 percent of the Medicare payment amount established under the applicable payment methodology for the service setting for providers and suppliers for the following preventive services:

(1) Pneumococcal (as specified in paragraph (h) of this section), influenza, and hepatitis B vaccine and administration.

(2) Screening mammography.

(3) Screening pap tests and screening pelvic exam.

(4) Prostate cancer screening tests (excluding digital rectal examinations).

(5) Colorectal cancer screening tests (excluding barium enemas).

(6) Bone mass measurement.

(7) Medical nutrition therapy (MNT) services.

(8) Cardiovascular screening blood tests.

(9) Diabetes screening tests.

(10) Ultrasound screening for abdominal aortic aneurysm (AAA).

(11) Additional preventive services identified for coverage through the national coverage determination (NCD) process.

(12) Initial Preventive Physical Examination (IPPE).

(13) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

[51 FR 41339, Nov. 14, 1986; 52 FR 4499, Feb. 12, 1987]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 410.152, see the List of CFR

## 42 CFR Ch. IV (10–1–13 Edition)

Sections Affected, which appears in the Finding Aids section of the printed volume and at [www.fdsys.gov](http://www.fdsys.gov).

### § 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160 of this part, respectively, is as follows:

(1) For expenses incurred in years before 2010, 62½ percent.

(2) For expenses incurred in 2010 and 2011, 68¾ percent.

(3) For expenses incurred in 2012, 75 percent.

(4) For expenses incurred in 2013, 81¼ percent.

(5) For expenses incurred in CY 2014 and subsequent years, 100 percent.

(b) *Application of the limitation—*(1) *Services subject to the limitation.* Except as specified in paragraph (b)(2) of this section, services furnished by physicians and other practitioners, whether furnished directly or incident to those practitioners' services, are subject to the limitation if they are furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder (that is, any condition identified by a diagnosis code within the range of 290 through 319) and are furnished to an individual who is not an inpatient of a hospital:

(i) Services furnished by physicians and other practitioners, whether furnished directly or as an incident to those practitioners' services.

(ii) Services provided by a CORF.

(2) *Services not subject to the limitation.* Services not subject to the limitation include the following:

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders *billed under HCPCS code M0064 (or its successor).*

(iii) Partial hospitalization services not directly provided by a physician.