

## § 410.152

## 42 CFR Ch. IV (10–1–16 Edition)

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 rea-

sonable 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 (RHC) and Federally qualified health center (FQHC) services.* Medicare Part B pays, for services by a participating RHC or FQHC that is authorized to bill under the reasonable cost system, 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 RHC or FQHC 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

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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 (1) 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 (1) 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.

(k) *Amount of payment: Outpatient CAH services.* (1) Payment for CAH out-

patient 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 Sections Affected, which appears in the

**Centers for Medicare & Medicaid Services, HHS**

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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.
- (iv) Psychiatric diagnostic services billed under CPT codes 90801 and 90802

(or successor codes) and diagnostic psychological and neuropsychological tests billed under CPT code range 96101 through 96125 (or successor codes) that are performed to establish a diagnosis.

(v) Medical management such as that furnished under CPT code 90862 (or its successor code), as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(3) *Payment amounts.* The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses	Patient pays	Medicare pays
CY 2009 and prior calendar years .....	62.50%	50%	50%
CYs 2010 and 2011 ..	68.75%	45%	55%
CY 2012 .....	75.00%	40%	60%
CY 2013 .....	81.25%	35%	65%
CY 2014 .....	100.00%	20%	80%

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

- (1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;
- (2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,
- (3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.
- (4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

[63 FR 20129, Apr. 23, 1998, as amended at 73 FR 69934, Nov. 19, 2008; 74 FR 62005, Nov. 25, 2009]

**§ 410.160 Part B annual deductible.**

(a) *Basic rule.* Except as provided in paragraph (b) of this section, incurred expenses (as defined in § 410.152) are subject to, and count toward meeting the annual deductible.

(b) *Exceptions.* Expenses incurred for the following services are not subject