§ 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) 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 exams).
(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).

EDITORIAL NOTE: For Federal Register citations affecting § 410.152, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

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(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 90802 (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:

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Recognized incurred expenses</th>
<th>Patient pays</th>
<th>Medicare pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2009 and prior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CY 2009 and prior</td>
<td>62.50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>CYs 2010 and 2011</td>
<td>68.75%</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>CY 2012</td>
<td>75.00%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>CY 2013</td>
<td>81.25%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>

(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.

§ 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 to the Part B annual deductible and do not count toward meeting that deductible:
   (1) Home health services.
   (2) Pneumococcal, influenza, and hepatitis b vaccines and their administration.
   (3) Federally qualified health center services.
   (4) ASC facility services furnished before July 1987 and physician services furnished before April 1988 that met the requirements for payment of 100 percent of the reasonable charges.
   (5) Screening mammography services as described in §410.34 (c) and (d).
   (6) Screening pelvic examinations as described in §410.56.
   (7) Beginning January 1, 2007, colorectal cancer screening tests as described in §410.37.