

§ 410.155

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 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.

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(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 Finding Aids section of the printed volume and at 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 de-

ductible 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 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.

(8) Beginning January 1, 2007, ultrasound screening for abdominal aortic aneurysms described in §410.19.

(9) Beginning January 1, 2009, initial preventive physical examinations as described in §410.16.

(10) Bone mass measurement.

(11) Medical nutrition therapy (MNT) services.

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

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