

§ 410.110

42 CFR Ch. IV (10–1–24 Edition)

be furnished, and indicates the diagnosis and anticipated rehabilitation goals.

(2) The plan must be reviewed at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy and speech-language pathology services by a facility physician or the referring physician who, when appropriate, consults with the professional personnel providing the services.

(3) The reviewing physician must certify or recertify that the plan is being followed, the patient is making progress in attaining the rehabilitation goals, and the treatment is having no harmful effects on the patient.

(d) *Claims.* Effective for dates of service on and after January 1, 2020 physical therapy or occupational therapy services covered as part of a rehabilitation plan of treatment described in paragraph (c) of this section, as applicable—

(1) Claims for such services furnished in whole or in part by a physical therapist assistant or an occupational therapy assistant must be identified with the inclusion of the respective prescribed modifier; and

(2) Effective for dates of service on and after January 1, 2022, such claims are paid an amount equal to 85 percent of the amount of payment otherwise applicable for the service as defined at section 1834(k) of the Act.

(3) For purposes of this paragraph, “furnished in whole or in part” means when the physical therapist assistant or occupational therapy assistant either—

(i) Furnishes all the minutes of a service exclusive of the respective physical therapist or occupational therapist; or

(ii) Except as provided in paragraph (d)(3)(iii) of this section, furnishes a portion of a service, or in the case of a 15-minute (or other time interval) timed code, a portion of a unit of service, separately from the part furnished by the physical or occupational therapist such that the minutes for that portion of a service (or unit of a service) exceed 10 percent of the total time for that service (or unit of a service).

(iii) Paragraph (d)(3)(ii) of this section does not apply when determining

whether the prescribed modifier applies to the last 15-minute unit of a service billed for a patient on a treatment day when the physical or occupational therapist provides more than the midpoint of a 15-minute timed code, that is, 8 or more minutes, regardless of any minutes for the same service furnished by the physical therapist assistant or occupational therapy assistant.

(iv) Where there are two remaining 15-minute units to bill of the same service and the physical therapist and the physical therapist assistant or the occupational therapist and the occupational therapy assistant, as applicable, each provided between 9 and 14 minutes, with a total time of at least 23 minutes, one unit of the service is billed with the prescribed modifier for the minutes furnished by the physical therapist assistant or occupational therapy assistant and one unit is billed without the prescribed modifier for the service provided by the physical therapist or occupational therapist.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8841, Mar. 1, 1991; 72 FR 66400, Nov. 27, 2007; 77 FR 69363, Nov. 16, 2012; 83 FR 60073, Nov. 23, 2018; 84 FR 63191, Nov. 15, 2019; 86 FR 65666, Nov. 19, 2021]

Subpart E—Community Mental Health Centers (CMHCs) Providing Partial Hospitalization Services and Intensive Outpatient Services

§ 410.110 Requirements for coverage of partial hospitalization services by CMHCs.

Medicare part B covers partial hospitalization services furnished by or under arrangements made by a CMHC if they are provided by a CMHC as defined in § 410.2 that has in effect a provider agreement under part 489 of this chapter and if the services are—

(a) Prescribed by a physician and furnished under the general supervision of a physician;

(b) Subject to certification by a physician in accordance with § 424.24(e)(1) of this subchapter; and

(c) Furnished under a plan of treatment that meets the requirements of § 424.24(e)(2) of this subchapter.

[59 FR 6577, Feb. 11, 1994]

§ 410.111 Requirements for coverage of intensive outpatient services in CMHCs.

Medicare part B covers intensive outpatient services furnished by or under arrangements made by a CMHC if they are provided by a CMHC as defined in § 410.2 that has in effect a provider agreement under part 489 of this chapter and if the services are—

(a) Prescribed by a physician and furnished under the general supervision of a physician;

(b) Subject to certification by a physician in accordance with § 424.24(d)(1) of this chapter; and

(c) Furnished under a plan of treatment that meets the requirements of § 424.24(d)(2) of this chapter.

[88 FR 82179, Nov. 22, 2023]

Subpart F [Reserved]**Subpart G—Medical Nutrition Therapy**

SOURCE: 66 FR 55331, Nov. 1, 2001, unless otherwise noted.

§ 410.130 Definitions.

For the purposes of this subpart, the following definitions apply:

Chronic renal insufficiency means the stage of renal disease associated with a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate [GFR] 15–59 ml/min/1.73m²).

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism.

Episode of care means services covered in a 12-month time period when coordinated with initial diabetes self-management training (DSMT) and one calendar year for each year thereafter, starting with the assessment and including all covered interventions based on referral(s) from a physician as specified in § 410.132(c). The time period covered for gestational diabetes extends only until the pregnancy ends.

Medical nutrition therapy services means nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or a renal disease.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section of 1101(a)(7) of the Act).

Renal disease means chronic renal insufficiency, end-stage renal disease when dialysis is not received, or the medical condition of a beneficiary for 36 months after kidney transplant.

[66 FR 55331, Nov. 1, 2001, as amended at 68 FR 63261, Nov. 7, 2003; 86 FR 65667, Nov. 19, 2021; 88 FR 79529, Nov. 16, 2023]

§ 410.132 Medical nutrition therapy.

(a) *Conditions for coverage of MNT services.* Medicare Part B pays for MNT services provided by a registered dietitian or nutrition professional as defined in § 410.134 when the beneficiary is referred for the service by a physician.

(b) *Limitations on coverage of MNT services.* (1) MNT services based on a diagnosis of renal disease as described in this subpart are not covered for beneficiaries receiving maintenance dialysis for which payment is made under section 1881 of the Act.

(2) A beneficiary may only receive the maximum number of hours covered under the DSMT benefit for both DSMT and MNT during the initial DSMT training period unless additional hours are determined to be medically necessary under the national coverage determination process.

(3) In years when the beneficiary is eligible for MNT and follow-up DSMT, the beneficiary may only receive the maximum number of hours covered under MNT unless additional hours are determined to be medically necessary under the national coverage determination process.

(4) If a beneficiary has both diabetes and renal disease, the beneficiary may only receive the maximum number of hours covered under the renal MNT benefit in one episode of care unless he or she is receiving initial DSMT services, in which case the beneficiary would receive whichever is greater.

(5) An exception to the maximum number of hours in paragraphs (b)(2), (3), and (4) of this section may be made when a physician determines that