

§ 410.155

(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).

(i) For the colorectal cancer screening tests described in § 410.37(j), Medicare Part B pays at the specified percentage as follows:

(A) 80 percent for CY 2022.

(B) 85 percent for CY 2023 through 2026.

(C) 90 percent for 2027 through 2029.

(D) 100 percent beginning January 1, 2030.

(ii) [Reserved]

(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).

(m) *Amount of payment: Rebatable drugs.* In the case of a rebatable drug (as defined in section 1847A(i)(2)(A) of the Act), including a selected drug (as defined in section 1192(c) of the Act), furnished by providers on or after April 1, 2023, in a calendar quarter during which the payment amount for such drug as specified in section 1847A(i)(3)(A)(ii)(I)(aa) or (bb), as applicable, exceeds the inflation-adjusted amount (as defined in section 1847A(i)(3)(C) of the Act) for such drug, Medicare Part B pays, subject to the deductible, the difference between the allowed payment amount determined under section 1847A of the Act and 20 percent of the inflation-adjusted amount, which is applied as a percent to the payment amount for such calendar quarter.

(n) *Amount of payment: Insulin furnished through an item of durable medical equipment.* For insulin furnished on or

42 CFR Ch. IV (10–1–24 Edition)

after July 1, 2023 through an item of durable medical equipment (as defined in § 414.202), Medicare Part B pays the difference between the applicable payment amount for such insulin and the coinsurance amount, with the coinsurance amount not to exceed \$35 for a month's supply.

[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.govinfo.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.

Centers for Medicare & Medicaid Services, HHS

§ 410.160

(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 or intensive outpatient 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; 88 FR 82179, Nov. 22, 2023]

§ 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, and COVID-19 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, 2011, for a surgical service, and beginning January 1, 2015, for an anesthesia service, furnished in connection with, as a result of, and in the same clinical encounter as a planned colorectal cancer screening test. A surgical or anesthesia service furnished in connection with, as a result of, and in the same clinical encounter as a colorectal cancer screening test means—a surgical or anesthesia service furnished on the same date as a planned colorectal cancer screening test as described in § 410.37.

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

(10) Bone mass measurement.

(11) Medical nutrition therapy (MNT) services.