

when a further take home supply of these medications is medically reasonable and necessary. The opioid treatment program must document in the medical record the reason(s) for the exception. The amount of the drug component of the adjustment will be determined using the methodology in paragraph (d)(2)(i) of this section. The amount of the non-drug component of the adjustment will be determined based on the CY 2020 Medicare payment rate for CPT code 96161.

(F) For OTP intensive outpatient services, an adjustment will be made when at least nine OTP intensive outpatient services described in paragraph (ix) of the definition of *opioid use disorder treatment service* in paragraph (b) of this section are furnished in a week. This adjustment will be based on the per diem payment rate for intensive outpatient services at hospital-based programs defined at § 410.44(c) and multiplied by a factor of three for a weekly payment adjustment.

(ii) The payment amounts for the non-drug component of the bundled payment for an episode of care, the adjustments for counseling or therapy, intake activities, periodic assessments, and OTP intensive outpatient services, and the non-drug component of the adjustment for take-home supplies of opioid antagonist medications will be geographically adjusted using the geographic adjustment factor described in § 414.26 of this chapter. For purposes of this adjustment, OUD treatment services that are furnished via an OTP mobile unit will be treated as if they were furnished at the physical location of the OTP registered with the Drug Enforcement Administration (DEA) and certified by SAMHSA.

(iii) The payment amounts for the non-drug component of the bundled payment for an episode of care, the adjustments for counseling or therapy, intake activities, periodic assessments and OTP intensive outpatient services, and the non-drug component of the adjustment for take-home supplies of opioid antagonist medications will be updated annually using the Medicare Economic Index described in § 405.504(d) of this chapter.

(5) Payment for medications delivered, administered or dispensed to a

beneficiary as part of the bundled payment or an adjustment to the bundled payment under paragraph (d)(4)(i) of this section is considered a duplicative payment if a claim for delivery, administration or dispensing of the same medications for the same beneficiary on the same date of service was also separately paid under Medicare Part B or Part D. CMS will recoup the duplicative payment made to the opioid treatment program.

(6) For purposes of the adjustment to the bundled payment under paragraph (d)(4)(i)(A) of this section, after the end of the Public Health Emergency as defined in § 400.200 of this chapter, when services are furnished using audio-only technology the practitioner must certify, in a form and manner specified by CMS, that they had the capacity to furnish the services using two-way, audio/video communication technology, but used audio-only technology because audio/video communication technology was not available to the beneficiary.

(e) *Beneficiary cost-sharing.* A beneficiary copayment amount of zero will apply.

[84 FR 63189, Nov. 15, 2019, as amended at 85 FR 19286, Apr. 6, 2020; 85 FR 27620, May 8, 2020; 85 FR 85026, Dec. 28, 2020; 86 FR 65664, 66036, Nov. 19, 2021; 87 FR 70224, Nov. 18, 2022; 88 FR 79528, Nov. 16, 2023; 88 FR 82178, Nov. 22, 2023]

§ 410.68 Antigens: Scope and conditions.

Medicare Part B pays for—

(a) Antigens that are furnished as services incident to a physician's professional services; or

(b) A supply of antigen sufficient for not more than 12 months that is—

(1) Prepared for a patient by a doctor of medicine or osteopathy who has examined the patient and developed a plan of treatment including dosage levels; and

(2) Administered—

(i) In accord with the plan of treatment developed by the doctor of medicine or osteopathy who prepared the antigen; and

(ii) By a doctor of medicine or osteopathy or by a properly instructed person under the supervision of a doctor of medicine or osteopathy.

[54 FR 4026, Jan. 27, 1989, as amended at 65 FR 65440, Nov. 1, 2000]

§ 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

(a) *Basic rule.* Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist or an anesthesiologist's assistant who is legally authorized to perform the services by the State in which the services are furnished.

(b) *Definitions.* For purposes of this part—

Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.

Anesthesiologist's assistant means a person who—

(1) Works under the direction of an anesthesiologist;

(2) Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and

(3) Is a graduate of a medical school-based anesthesiologist's assistant educational program that—

(A) Is accredited by the Committee on Allied Health Education and Accreditation; and

(B) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Anesthetist includes both an anesthesiologist's assistant and a certified registered nurse anesthetist.

Certified registered nurse anesthetist means a registered nurse who:

(1) Is licensed as a registered professional nurse by the State in which the nurse practices;

(2) Meets any licensure requirements the State imposes with respect to nonphysician anesthetists;

(3) Has graduated from a nurse anesthesia educational program that meets

the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and

(4) Meets the following criteria:

(i) Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or

(ii) Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(i) of this definition.

(5) For certified registered nurse anesthetist services, the certified registered nurse anesthetist may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the certified registered nurse anesthetist's presence and participation in the service.

[57 FR 33896, July 31, 1992, as amended at 77 FR 69363, Nov. 16, 2012; 84 FR 63190, Nov. 15, 2019]

§ 410.71 Clinical psychologist services and services and supplies incident to clinical psychologist services.

(a) *Included services.* (1) Medicare Part B covers services furnished by a clinical psychologist, who meets the requirements specified in paragraph (d) of this section, that are within the scope of his or her State license, if the services would be covered if furnished by a physician or as an incident to a physician's services.

(2) Medicare Part B covers services and supplies incident to the services of a clinical psychologist if the requirements of § 410.26 are met.

(b) *Application of mental health treatment limitation.* The treatment services of a clinical psychologist and services and supplies furnished as an incident to