

Subpart E—Community Mental Health Centers (CMHCs) Providing Partial Hospitalization 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]

Subparts F–H—[Reserved]

Subpart I—Payment of SMI Benefits

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§410.150 To whom payment is made.

(a) *General rules.* (1) Any SMI enrollee is, subject to the conditions, limitations, and exclusions set forth in this part and in parts 405, 416 and 424 of this chapter, entitled to have payment made as specified in paragraph (b) of this section.

(2) The services specified in paragraphs (b)(5) through (b)(14) of this section must be furnished by a facility that has in effect a provider agreement or other appropriate agreement to participate in Medicare.

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

(1) To the individual, or to a physician or other supplier on the individual's behalf, for medical and other health services furnished by the physician or other supplier.

(2) To a nonparticipating hospital on the individual's behalf for emergency outpatient services furnished by the hospital, in accordance with subpart G of part 424 of this chapter.

(3) To the individual, for emergency outpatient services furnished by a nonparticipating hospital, in accordance with §424.53 of this chapter.

(4) To the individual, for physicians' services and ambulance services furnished outside the United States in accordance with §424.53 of this chapter.

(5) To a provider on the individual's behalf for medical and other health services furnished by the provider (or by others under arrangements made with them by the provider).

(6) To a home health agency on the individual's behalf for home health services furnished by the home health agency.

(7) To a clinic, rehabilitation agency, or public health agency on the individual's behalf for outpatient physical therapy or speech pathology services furnished by the clinic or agency (or by others under arrangements made with them by the clinic or agency).

(8) To a rural health clinic or Federally qualified health center on the individual's behalf for rural health clinic or Federally qualified health center services furnished by the rural health clinic or Federally qualified health center, respectively.

(9) To an ambulatory surgical center (ASC) on the individual's behalf for covered ambulatory surgical center facility services that are furnished in connection with surgical procedures performed in an ASC, as provided in part 416 of this chapter.

(10) To a comprehensive outpatient rehabilitation facility (CORF) on the individual's behalf for comprehensive outpatient rehabilitation facility services furnished by the CORF.

(11) To a renal dialysis facility, on the individual's behalf, for institutional or home dialysis services, supplies, and equipment furnished by the facility.

(12) To a critical access hospital (CAH) on the individual's behalf for outpatient CAH services furnished by the CAH.

(13) To a community mental health center (CMHC) on the individual's behalf, for partial hospitalization services furnished by the CMHC (or by others under arrangements made with them by the CMHC).

(14) To an SNF for services (other than those described in § 411.15(p)(2) of this chapter) that are furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of the SNF.

(15) To the qualified employer of a physician assistant for professional services furnished by the physician assistant and for services and supplies furnished incident to his or her services. Payment is made to the employer of a physician assistant regardless of whether the physician assistant furnishes services under a W-2, employer-employee employment relationship, or whether the physician assistant is an independent contractor who receives a 1099 reflecting the relationship. Both types of relationships must conform to the appropriate guidelines provided by the Internal Revenue Service. A qualified employer is not a group of physician assistants that incorporate to bill for their services. Payment is made only if no facility or other provider charges or is paid any amount for services furnished by a physician assistant.

(16) To a nurse practitioner or clinical nurse specialist for professional services furnished by a nurse practitioner or clinical nurse specialist in all settings in both rural and nonrural areas and for services and supplies furnished incident to those services. Payment is made only if no facility or other provider charges, or is paid, any amount for the furnishing of the professional services of the nurse practitioner or clinical nurse specialist.

(17) To a clinical psychologist on the individual's behalf for clinical psychologist services and for services and supplies furnished as an incident to his or her services.

(18) To a clinical social worker on the individual's behalf for clinical social worker services.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 24981, June 12, 1992; 58 FR 30668, May 26, 1993; 59 FR 6577, Feb. 11, 1994; 63 FR 20129, Apr. 23, 1998; 63 FR 26308, May 12, 1998; 63 FR 58909, Nov. 2, 1998]

§ 410.152 Amounts of payment.

(a) *General provisions*—(1) *Exclusion from incurred expenses.* As used in this section, "incurred expenses" are expenses incurred by an individual, during his or her coverage period, for covered Part B services, excluding the following:

(i) Expenses incurred for services for which the beneficiary is entitled to have payment made under Medicare Part A or would be so entitled except for the application of the Part A deductible and coinsurance requirements.

(ii) Expenses incurred in meeting the Part B blood deductible (§ 410.161).

(iii) In the case of services payable under a formula that takes into account reasonable charges, reasonable costs, customary charges, customary (insofar as reasonable) charges, charges related to reasonable costs, fair compensation, a pre-treatment prospective payment rate, or a standard overhead amount, or any combination of two or more of these factors, expenses in excess of any factor taken into account under that formula.

(iv) Expenses in excess of the outpatient mental health treatment limitation described in § 410.155.

(v) In the case of expenses incurred for outpatient physical therapy services including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.60(e). In the case of expenses incurred for outpatient occupational therapy including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.59(e).

(2) *Other applicable provisions.* Medicare Part B pays for incurred expenses the amounts specified in paragraphs (b) through (k) of this section, subject to the following:

(i) The principles and procedures for determining reasonable costs and reasonable charges and the conditions for Medicare payment, as set forth in parts 405 (subparts E and X), 413, and 424 of this chapter.

(ii) The Part B annual deductible (§ 410.160).

(iii) The special rules for payment to health maintenance organizations (HMOs), health care prepayment plans (HCPPs), and competitive medical