

part 405 of this chapter, to the extent those costs are reasonable and related to the cost of furnishing rural health clinic or Federally qualified health center services or reasonable on the basis of other tests specified by HCFA.

(g) *Amount of payment: Used durable medical equipment furnished by other than an HHA.* Medicare Part B pays the following amounts for used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment:

(1) For used DME furnished by, or under arrangements made by, a nominal charge provider, 100 percent of fair compensation.

(2) For used DME furnished by or under arrangements made by a provider that is not a nominal charge provider, 100 percent of the reasonable cost of the service or the customary charge for the service, whichever is less.

(3) For used DME furnished by other than a provider, 100 percent of the reasonable charge.

(h) *Amount of payment: Pneumococcal vaccine.* Medicare Part B pays for pneumococcal vaccine and its administration as follows:

(1) For services furnished by a nominal charge provider, 100 percent of fair compensation.

(2) For services furnished by a provider that is not a nominal charge provider, the reasonable cost of the services or the customary charge for the service, whichever is less.

(3) For services furnished by other than a provider, a rural health clinic or a Federally qualified health center, 100 percent of the reasonable charge.

(4) For services furnished by a rural health clinic or a Federally qualified health center, 100 percent of the reasonable cost.

(i) *Amount of payment: ASC facility services.* For ASC facility services that are furnished in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead

amount, as specified in § 416.120(c) of this chapter.<sup>1</sup>

(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.* Payment for critical access hospital 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 and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter. Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts with Part B coinsurance being calculated as 20 percent of the customary (in so far as reasonable) charges of the CAH for the services.

(l) *Amount of payment: Flu vaccine.* Medicare Part B pays 100 percent of the Medicare allowed charge.

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#### § 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* Only 62½ percent of the expenses incurred for services subject to the limit as specified in paragraph (b) of this section are considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under §§ 410.152 and 410.160, respectively.

(b) *Application of the limitation—(1) Services subject to the limitation.* Except as specified in paragraph (b)(2) of this

<sup>1</sup>For services furnished before July 1, 1987, Medicare Part B paid 100 percent of the standard amount.

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section, the following 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.

(iii) Partial hospitalization services not directly provided by a physician.

(iv) Diagnostic services, such as psychological testing, that are performed to establish a diagnosis.

(v) Medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(c) *Examples.* (1) A clinical psychologist submitted a claim for \$200 for outpatient treatment of a beneficiary's mental disorder. The Medicare approved amount was \$180. Since clinical psychologists must accept assignment, the beneficiary is not liable for the \$20 in excess charges. The beneficiary previously satisfied the \$100 annual Part B deductible. The limitation reduces the amount of incurred expenses to 62½ percent of the approved amount. After subtracting any unmet deductible, Medicare pays 80 percent of the remaining incurred expenses. Medicare payment and beneficiary liability are computed as follows:

1. Actual charges .....	\$200.00
2. Medicare approved amount .....	180.00
3. Medicare incurred expenses (0.625 × line 2) .....	112.50
4. Unmet deductible .....	0.00
5. Remainder after subtracting deductible (line 3 minus line 4) .....	112.50
6. Medicare payment (0.80 × line 5) .....	90.00
7. Beneficiary liability (line 2 minus line 6)	90.00

(2) A clinical social worker submitted a claim for \$135 for outpatient treatment of a beneficiary's mental disorder. The Medicare approved amount was \$120. Since clinical social workers must accept assignment, the beneficiary is not liable for the \$15 in excess charges. The beneficiary previously satisfied \$70 of the \$100 annual Part B deductible, leaving \$30 unmet.

1. Actual charges .....	\$135.00
2. Medicare approved amount .....	120.00
3. Medicare incurred expenses (0.625 × line 2) .....	75.00
4. Unmet deductible .....	30.00
5. Remainder after subtracting deductible (line 3 minus line 4) .....	45.00
6. Medicare payment (0.80 × line 5) .....	36.00
7. Beneficiary liability (line 2 minus line 6)	84.00

(3) A physician who did not accept assignment submitted a claim for \$780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare approved amount was \$750. Because the physician did not accept assignment, the beneficiary is liable for the \$30 in excess charges. The beneficiary had not satisfied any of the \$100 Part B annual deductible.

1. Actual charges .....	\$780.00
2. Medicare approved amount .....	750.00
3. Medicare incurred expenses (0.625 × line 2) .....	468.75
4. Unmet deductible .....	100.00
5. Remainder after subtracting deductible (line 3 minus line 4) .....	368.75
6. Medicare payment (0.80 × line 5) .....	295.00
7. Beneficiary liability (line 1 minus line 6)	485.00

(4) A beneficiary's only Part B expenses during 1995 were for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization. The remaining services were furnished on an outpatient basis. The beneficiary had not satisfied any of the \$100 annual Part B deductible in 1995. The physician, who accepted assignment, submitted a claim for \$780. The Medicare-approved amount was \$750. The beneficiary incurred \$350 of the approved amount while a hospital inpatient and incurred the remaining \$400 of the approved amount for outpatient services. Only \$400 of the approved amount is subject to the 62½ percent

limitation because the statutory limitation does not apply to services furnished to hospital inpatients.

1. Actual charges .....	\$780.00
2. Medicare approved amount .....	\$750.00
2A. Inpatient portion .....	\$350
2B. Outpatient portion .....	\$400
3. Medicare incurred expenses .....	\$600.00
3A. Inpatient portion .....	\$350
3B. Outpatient portion (0.625 × line 2B)	\$250
4. Unmet deductible .....	\$100.00
5. Remainder after subtracting deductible (line 3 minus line 4) .....	\$500.00
6. Medicare payment (0.80 × line 5) .....	\$400.00
7. Beneficiary liability (line 2 minus line 6)	\$350.00

[63 FR 20129, Apr. 23, 1998]

**§ 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 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.

(c) *Application of the Part B annual deductible.* (1) Before payment is made under § 410.152, an individual's incurred expenses for the calendar year are reduced by the Part B annual deductible.

(2) The Part B annual deductible is applied to incurred expenses in the order in which claims for those expenses are processed by the Medicare program.

(3) Only one Part B annual deductible may be imposed for any calendar year and it may be met by any combination of expenses incurred in that year.

(d) *Special rule for services reimbursable on a formula basis.* (1) In applying the

formula that takes into account reasonable costs, customary charges, and customary (insofar as reasonable) charges, and is used to determine payment for services furnished by a provider that is not a nominal charge provider, the Medicare intermediary takes the following steps:

(i) Reduces the customary charges for the services by an amount equal to any unmet portion of the deductible for the calendar year, in accordance with paragraph (b) of this section. (The amount of this reduction is considered to be the amount of the deductible that is met on the basis of the services to which it is applied.)

(ii) Determines 20 percent of any remaining portion of the customary (insofar as reasonable) charge.

(iii) Determines the lesser of the reasonable cost of the services and the customary charges for the services.

(iv) Reduces the amount determined under paragraph (c)(1)(iii) of this section by the sum of the reduction made under paragraph (c)(1)(i) of this section and the amount determined under paragraph (c)(1)(ii) of this section.

(v) Reduces the reasonable cost of the services by the amount of the reduction made under paragraph (c)(1)(i) of this section and multiplies the result by 80 percent.

(2) In accordance with § 410.152(b)(1), the amount payable is the amount determined under paragraph (c)(1)(iv) of this section, or the amount determined under paragraph (c)(1)(v) of this section, whichever is less.

(e) *Special rule for services of an independent rural health clinic.* Application of the Part B annual deductible to rural health clinic services is in accordance with § 405.2425(b)(2) of this chapter.

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 1982, the Part B annual deductible is \$75.

(2) From 1973 through 1981, the deductible was \$60.

(3) From 1966 through 1972, the deductible was \$50.

(g) *Carryover of Part B annual deductible.* For calendar years before 1982, the Part B annual deductible was reduced by the amount of expenses incurred