

Medicare General Information, Eligibility, and Entitlement

Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations

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10 - Hospital Insurance (Part A)

10.1 - Inpatient Hospital Deductible - (Rev. 1, 09-11-02)

The patient is responsible for a deductible amount for inpatient hospital services in each benefit period. For each year after 1991, the Secretary of the Department of Health and Human Services (DHHS) is required to set the deductible and coinsurance amounts between September 1 and September 15 of the preceding year. The deductible will be set at an amount equal to the deductible for the preceding year, changed by the same percentage as applies to PPS payment rates, and adjusted to reflect changes in real case mix. The deductible and coinsurance amounts are shown in the chart in §10.3 of this chapter.

The coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur. The deductible is satisfied only by charges for covered Part A services. Expenses for covered services count toward the deductible on an incurred, rather than paid, basis. Expenses incurred in one benefit period cannot be applied toward the deductible in a later benefit period. Expenses incurred in meeting the blood deductible do not count toward the inpatient hospital deductible.

A reduction in benefit days resulting from confinement in a psychiatric hospital, on and immediately preceding the date of entitlement, does not affect the amount of the deductible for which the patient is responsible.

If the actual charge is less than the deductible and the customary charge, the customary charge is applied to the deductible.

A beneficiary is not responsible for payment of the deductible for an inpatient stay if the provider has been determined to be liable because the care was not medically necessary or because the care provided was custodial.

10.2 - Coinsurance- (Rev. 1, 09-11-02)

The following subsections describe coinsurance.

10.2.1 - Inpatient Services - (Rev. 1, 09-11-02)

In each benefit period, the patient is responsible for coinsurance amounts equal to:

- One-fourth of the inpatient hospital deductible for each day of inpatient hospital services from the 61st through the 90th days;
- One-half of the inpatient hospital deductible for each lifetime reserve day (the 91st through the 150th days of inpatient hospital services); and
- One-eighth of the inpatient hospital deductible for each day of extended care services from the 21st through the 100th days. A beneficiary is not responsible for payment of the coinsurance for a stay if the provider has been determined to be liable because the care was not medically necessary or because the care provided was custodial.

Use the chart in §10.3 of this chapter to determine the applicable coinsurance amounts.

Where the actual charge to the patient for the 61st through the 90th days of inpatient hospital services is less than the applicable coinsurance amount, the coinsurance is the actual charge per day. Where the actual charge to the patient for lifetime reserve days is less than the coinsurance amount for those days, the beneficiary may be deemed to have elected not to use the days because he/she would not benefit from their utilization.

10.2.2 - Durable Medical Equipment (DME) Furnished as a Home Health Benefit - (Rev. 1, 09-11-02)

The patient is responsible for 20 percent of the payment amount for DME furnished as a home health benefit.

10.3 - Basis for Determining the Part A Coinsurance Amounts - (Rev. 1, 09-11-02)

The applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). Except for 1989, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.

When Deductible and/or Coinsurance Are Applicable for Part A



Inpatient Hospital- First 60 Days	Deductible applicable equal to national average cost per day
Inpatient Hospital- 61st thru 90th Day	Coinsurance per day always equal to 1/4 of inpatient hospital deductible
Inpatient Hospital- 60 Lifetime Reserve Days (nonrenewable) - 91st thru 150th day	Coinsurance always equal to 1/2 of inpatient hospital deductible
Skilled Nursing Facility 21st thru 100th Day	Coinsurance Always equal to 1/8 of inpatient hospital deductible
Home Health Agency	No Deductible No Coinsurance (except for 20 percent coinsurance for DME and prosthetics/ orthotics)
Blood	1st 3 pints (or equivalent units of packed red blood cells) in a calendar year - combined Part A and B
Hospice * a. Drugs and Biologicals b. Respite Care	a. 5 percent of the cost determined by the drug copayment schedule (may not exceed \$5 per prescription) b. 5 percent of the payment for a respite care

day

*Hospices may charge coinsurance for two services only, drugs and biologicals, and respite care. The amount of coinsurance for each prescription may not exceed \$5.00. The amount for respite care may not exceed the inpatient deductible for the year in which the hospital coinsurance period began.

Deductible and Coinsurance Amounts

Year	Inpatient Hospital Deductible, 1st 60 Days	Inpatient Hospital Coinsurance, 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Coinsurance
1986	\$492	123	246	61.50
1987	520	130	260	65.00
1988	540	135	270	67.50
1989	560	0 (1)	0 (1)	0(2)
1990	592	148	296	74.00
1991	628	157	314	78.50
1992	652	163	326	81.50
1993	676	169	338	84.50
1994	696	174	348	87.00
1995	716	179	358	89.50
1996	736	184	368	92.00
1997	760	190	380	92.00
1998	764	191	382	95.50
1999	768	192	384	96.00
2000	776	194	388	97.00
2001	792	198	396	99.00

2002	812	203	406	101.50
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1. Coinsurance was not charged for inpatient hospital care in CY 1989 due to Catastrophic Coverage. The deductible was applied.
2. Under Catastrophic Coverage, a coinsurance payment of \$25.50 was due for days 1-8 of SNF care. No SNF coinsurance was due after day 8 in 1989.

10.4 - Benefit Period (Spell of Illness)- (Rev. 1, 09-11-02)

A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. For example, a patient is eligible for 90 days of hospital care in a benefit period and 100 days of extended care services during the same benefit period. A patient may be eligible for as many as 150 days of hospital care in a benefit period if he/she draws on his/her lifetime reserve. As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods he/she may have. The term "benefit period" is synonymous with spell of illness. Since the term "spell of illness" could connote a single illness or a particular "spell" of sickness, the term benefit period is used in communications with the public.

10.4.1 - Starting a Benefit Period - (Rev. 1, 09-11-02)

A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.

A provider qualified to start a benefit period is a hospital (including a psychiatric hospital) or SNF that meets all the requirements of the definition of such an institution. A hospital which meets all requirements in Chapter 5, §20 of this manual is also a qualified hospital for purposes of beginning a benefit period when it furnishes the patient covered inpatient emergency services. Thus, generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual. However, the noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or a SNF which meets all requirements in the definition of such an institution even though it may not be participating.. A qualified hospital in Canada or Mexico is also a qualified provider for purposes of beginning a benefit period when it furnishes covered inpatient hospital services. If a person is in a nonqualified institution and is subsequently transferred to a qualified hospital (general or psychiatric), his/her benefit period begins on admission to the qualified hospital.

Admission to a qualified SNF or to the SNF level of care in a swing bed hospital begins a benefit period even though payment for the services cannot be made because the prior

hospitalization or transfer requirement has not been met. Inpatient care in a Religious Non-Medical Health Care Institution (whether as hospital or extended care services) can begin or prolong a benefit period.

10.4.2 - Ending a Benefit Period - (Rev. 1, 09-11-02)

The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF. To determine the 60 consecutive day period, begin counting with the day the individual was discharged. (See §10.4.3.2 of this chapter for determining the end of a benefit period when an individual remains in a SNF.)

10.4.3 - Definition of Hospital or SNF for Ending a Benefit Period - (Rev. 1, 09-11-02)

It is important to note that a benefit period cannot end while a beneficiary is an inpatient of a hospital, even if the hospital does not meet all of the requirements that are necessary for starting a benefit period. Similarly, a benefit period cannot end while a beneficiary is an inpatient of a SNF, as defined below.

10.4.3.1 - Hospital Stay and End of Benefit Period - (Rev. 1, 09-11-02)

In order to end a benefit period, for at least 60 consecutive days, a beneficiary cannot have been in a hospital which meets the initial requirement in the definitions in Chapter 5, §20.1 through §20.7 of this publication. That is, the beneficiary cannot have been in a facility that is primarily engaged in providing, by or under the supervision of a physician(s), to inpatients:

- Diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill persons. A stay in a hospital outside the United States prolongs a benefit period. It may be assumed, in the absence of evidence to the contrary, that:
- A foreign hospital in which a beneficiary spent one or more days meets the requirement of the definition in Chapter 5, §20 of this manual; and
- The beneficiary's statement about length and place of stay is correct.

10.4.3.2 - SNF Stay and End of Benefit Period - (Rev. 1, 09-11-02)

Similarly, to end a benefit period, a beneficiary cannot have been an inpatient (see subsection 10.4.4) of a SNF for at least 60 consecutive days; where SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Examples: An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

Example 1: X was born 8/9/36. On 7/28/2001, X entered a participating general hospital. After he/she had been in the hospital for 2 weeks, X was discharged on 8/11/2001. On his/her doctor's orders, X entered a participating SNF on 8/15/2001, and remained an inpatient there (see subsection 10.4.4) until his/her discharge on 10/27/2001. He/she had no further inpatient stays in 2001.

X's benefit period began on 8/1/2001, the first day of the month he/she attained age 65 and was entitled to hospital insurance. The benefit period ended 12/25/2001, the end of the 60-day period beginning with the date of his/her last discharge.

Example 2: Y, over age 65, entered a participating general hospital on 8/28/2000 for treatment of a heart condition. He/she was discharged on 9/11/2000. On 10/3/2000, Y entered a Medicaid-only nursing facility, and remained an inpatient of this facility (see subsection 10.4.4) until his/her discharge on 11/17/2000. On 12/26/2000, Y was again admitted to a participating hospital because of injuries suffered in an accident. He/she was discharged on 1/13/2001 and had no further inpatient stays in 2001.

Y's benefit period began on 8/28/2000. His/her stay in the nursing facility began less than 60 days after his/her hospital stay and the benefit period was continued because he/she remained an inpatient there (see subsection 10.4.4) even though Medicare did not cover the stay. The subsequent hospital stay began less than 60 days after the nursing facility stay and continued the benefit period although the condition treated was unrelated to his/her prior stays. The benefit period ended on 3/14/2001, the end of the 60-day period beginning with the day of last discharge.

Example 3: Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on 8/1/2000 and discharged on 8/10/2000, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements of an emergency hospital, Z's benefit period did not begin with his/her admission to this hospital because:

1. The hospital did not meet all of the requirements in the definition of a hospital; and
2. Although the hospital satisfied the minimum requirements for coverage of emergency services, Z did not receive emergency inpatient care there.

(As noted previously, a stay in an emergency hospital does not begin a benefit period unless it actually involves the receipt of covered inpatient emergency services; by contrast, even a nonemergency stay in such a hospital can serve as a qualifying hospital stay for purposes of coverage under the posthospital extended care benefit.) Z was

admitted to Haven Convalescent Home on 8/20/2000 and remained an inpatient of the home (see subsection 10.4.4) until his/her discharge on 3/1/2001. He/she had no further inpatient stays in 2001. Haven Convalescent Home became a participating SNF on 1/1/2001.

Z's benefit period began 1/1/2001, the day Haven Convalescent Home was determined to be a qualified SNF. The services Z received from that date through discharge were extended care services even though they were not covered and, therefore, not charged against Z's Medicare SNF utilization. (The services were not covered posthospital extended care services because Z was not admitted to a participating SNF within 30 days after discharge from the hospital.) Z's benefit period ended 4/29/2001, the end of the 60-day period beginning with the date of his discharge from the convalescent home.

10.4.4 - Definition of Inpatient for Ending a Benefit Period - (Rev. 1, 09-11-02)

Generally, a beneficiary is an inpatient of a hospital if the beneficiary is receiving inpatient services in the hospital (i.e., not on an outpatient basis). The type of care actually received is not relevant.

However, a different definition of inpatient applies in determining the end of a benefit period for a beneficiary in a SNF. A beneficiary is an inpatient in a SNF only if the beneficiary's care in the SNF meets certain skilled level of care standards. The beneficiary must need and receive a skilled level of care while in the SNF. This means that in order to have been an inpatient while in a SNF, the beneficiary must have required and received skilled services on a daily basis which could, as a practical matter, only have been provided in a SNF on an inpatient basis. If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF for purposes of prolonging the benefit period.

Use the following presumptions for determining whether the skilled level of care standards were met during a prior SNF stay.

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation on liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a non-certified bed.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules. (This presumption does not apply to placement in a non-certified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in a SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation.

Presumptions 5 through 7 can be rebutted by the beneficiary showing that the level of care needed or received is other than that which the presumption dictates.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. Specifically, the requirement referred to in Chapter 4, §40.2 regarding prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for a SNF stay on level of care grounds (i.e., not even waiver payment was made) because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when Medicare SNF payment is denied on level of care grounds, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily

mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption. Therefore, the previous references to Medicaid claims have been deleted from those presumptions which establish that an individual does meet the Medicare standards.

Medicare no-payment bills submitted by a SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no-payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no-payment bills which lead to Medicaid program payment determinations. If a SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, intermediaries request a SNF to submit one. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Where the presumptions are rebuttable (i.e., 5 through 7), rebuttal showings are permitted at both intermediary determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Intermediaries evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial.

This special rule for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is in exhausted or copay status and is seeking to renew a benefit period. The rule has equal application where it results in the beneficiary starting a new benefit period and paying a new deductible without receiving an increase in the amount of Medicare benefits paid.

20 - Supplementary Medical Insurance (SMI) (Part B) - (Rev. 1, 09-11-02)

Supplementary Medical Insurance is described in the following subsections.

20.1 - Supplementary Medical Insurance Incurred Expenses - (Rev. 1, 09-11-02)

The SMI plan includes coverage for expenses incurred for the services described in Chapter 1, §10.3:

Payment may not be made under Part B for services furnished an individual entitled to have payment made for those services under Part A, e.g., if the expenses incurred were to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

20.2 - Part B Annual Deductible - (Rev. 1, 09-11-02)

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

- As of January 1, 1991, the deductible is \$100.
- From 1982 through 1990, the deductible was \$75.
- From 1973 through 1981, the deductible was \$60.



- From 1966 through 1972, the deductible was \$50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services which are not subject to the deductible cannot be used to satisfy the deductible.

20.3 - Part B Coinsurance - (Rev. 1, 09-11-02)

After the deductible has been satisfied, coinsurance of 20 percent is usually applicable.

For providers and suppliers that bill intermediaries, the 20 percent may be based on the allowed amount, billed charges, or a preset rate per service (APC), depending upon the type of service. See Claims Processing instructions for a description of coinsurance calculation for each benefit type.

Physicians and other suppliers will be paid 80 percent of allowed amount under the fee schedule amounts or in some instances reasonable charges incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the fee schedule amounts or reasonable charges for the items and services. (See §20.4 of this chapter for exceptions.)

20.4 - Exceptions to Annual Deductible and Coinsurance- (Rev. 1, 09-11-02)

There is no deductible for screening mammography effective for services January 1, 1998 and later.

Neither the annual deductible nor the 20 percent coinsurance apply with respect to:

- Inpatient hospital radiology or pathology physician services only if the physician agreed to accept assignment for all radiology and pathology services furnished to inpatients;
- Parts A and B home health services, except that there is a coinsurance of 20 percent of the payment amount for supplies, drugs, DME and prosthetics /orthotics furnished as a home health benefit;
- Clinical diagnostic laboratory tests (including specimen collection fees) performed or supervised by a physician, laboratory, or other entity paid on an assigned basis;
- Certain surgical procedures performed by a physician in an ambulatory surgical center or outpatient department of a hospital;
- Ambulatory surgical services in an ambulatory surgical center;
- Pneumococcal vaccine and its administration;
- Influenza vaccine and its administration; and
- Services or items denied as medically unnecessary.

NOTE: Services which are not subject to the deductible cannot be used to satisfy the deductible.

20.4.1 - Applications of Deductible and Coinsurance in Liability and Indemnification Situations - (Rev. 1, 09-11-02)

Under 1879 of the Act, a beneficiary is not responsible for payment of the Part B deductible or coinsurance for items or services that are neither reasonable and necessary to diagnose or treat the illness or injury, nor to improve the functioning of a malformed body member. If the provider knew, or should have known, that Medicare considered such services medically unnecessary, but failed to inform the beneficiary before furnishing them, the provider is held liable for their cost. If the beneficiary made payment  such items or services, he/she can be indemnified for them.

20.5 - Blood Deductibles (Part A and Part B) - (Rev. 1, 09-11-02)

Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received under Part A and Part B combined in a calendar year. However, blood processing (e.g., administration, storage) is not subject to the deductible.

The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

The deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood.

20.5.1 - Part A Blood Deductible - (Rev. 1, 09-11-02)

Blood must be furnished on a Medicare covered day in a hospital or SNF to be counted under Part A. Blood furnished to an inpatient after benefits exhausted or before entitlement is not counted toward the combined deductible. Blood furnished during a lifetime extension election period is counted toward the combined A/B 3 pint total.

20.5.2 - Part B Blood Deductible - (Rev. 1, 09-11-02)

Blood is furnished on an outpatient basis or is subject to the Part B blood deductible and is counted toward the combined limit. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in an outpatient setting. Blood is not covered for inpatient Part B services.

20.5.3 - Items Subject to Blood Deductibles - (Rev. 1, 09-11-02)

The blood deductibles apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biologicals.

20.5.4 - Obligations of the Beneficiary to Pay for or Replace Deductible Blood - (Rev. 1, 09-11-02)

A provider may charge the beneficiary or a third party its customary charge for whole blood or units of packed red cells which are subject to either the Part A or Part B blood deductible, unless the individual, another person, or a blood bank replaces the blood or arranges to have it replaced.

20.5.4.1 - Replacement of Blood - (Rev. 1, 09-11-02)

For replacement purposes, a pint of whole blood is considered equivalent to a unit of packed red cells. A deductible pint of whole blood or unit of packed red cells is considered replaced when a medically acceptable pint or unit is given or offered to the provider or, at the provider's request, to its blood supplier. Accordingly, where an individual or a blood bank offers blood as a replacement for a deductible pint or unit furnished a Medicare beneficiary, the provider may not charge the beneficiary for the blood, whether or not the provider or its blood supplier accepts the replacement offer. Thus a provider may not charge a beneficiary merely because it is the policy of the provider or its blood supplier not to accept blood from a particular source which has offered to replace blood on behalf of the beneficiary. However, a provider would not be barred from charging a beneficiary for deductible blood, if there is a reasonable basis for believing that replacement blood offered by or on behalf of the beneficiary would

endanger the health of a recipient or that the prospective donor's health would be endangered by making a blood donation. Once a provider accepts a pint of replacement blood from a beneficiary or another individual acting on his/her behalf, the blood is deemed to have been replaced, and, the beneficiary may not be charged for the blood, even though the replacement blood is later found to be unfit and has to be discarded.

When a provider accepts blood donated in advance, in anticipation of need by a specific beneficiary, whether the beneficiary's own blood, that is, an autologous donation, or blood furnished by another individual or blood assurance group, such donations are considered replacement for pints or units subsequently furnished the beneficiary.

30 - Outpatient Mental Health Treatment Limitation - (Rev. 1, 09-11-02)

Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare allowed amount for these services. The limitation is called the outpatient mental health treatment limitation. Since Part B deductible also applies the program pays for about half of the allowed amount recognized for mental health therapy services.

Expenses for diagnostic services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition.

30.1 - Application of Mental Health Limitation - Status of Patient - (Rev. 1, 09-11-02)

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a person in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician(s):

- Diagnostic and therapeutic services for medical diagnosis, and treatment, and care of injured, disabled, or sick persons;
- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

30.2 - Disorders Subject to Mental Health Limitation - (Rev. 1, 09-11-02)

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R).

If the treatment services rendered are for both a psychiatric condition and one or more nonpsychiatric conditions, the charges are separated to apply the limitation only to the mental health charge. Normally HCPCS code and diagnoses are used. Where HCPCS code is not available on the claim, revenue code is used.

If the service is primarily on the basis of a diagnosis of Alzheimer's Disease (coded 331.0 in the International Classification of Diseases, 9th Revision) or Alzheimer's or other disorders (coded 290.XX in DSM-III-R), treatment typically represents medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the limitation.

30.3 - Diagnostic Services - (Rev. 1, 09-11-02)

The mental health limitation does not apply to tests and evaluations performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric or psychological tests and interpretations, diagnostic consultations, and initial evaluations. However, testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.

40 - Limitation on Services of Physical or Occupational Therapist in Independent Practice - (Rev. 1, 09-11-02)

Coverage of outpatient physical or occupational therapy under Part B includes services of a qualified therapist in private practice when furnished in the therapist's office or the beneficiary's home. Payment for these services is based on the Medicare physician fee schedule less coinsurance and any deductible amounts due.

There was a limit for the amount of therapy expenses that would be recognized as payable for years before 2000. (For 1999 the limit is \$1500; for years 1994 through 1998, the limit is \$900; for years 1990 through 1993, the limit is \$750; and for years prior to 1990, the limit is \$500.)