§ 405.517  Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) Applicability—(1) Payment for drugs and biologicals before January 1, 2004. Payment for a drug or biological that is not paid on a cost or prospective payment basis is determined by the standard methodology described in paragraph (b) of this section. Examples of when this procedure applies include a drug or biological furnished incident to a physician's service, a drug or biological furnished by an independent dialysis facility that is not included in the ESRD composite rate set forth in § 413.170(c) of this chapter, and a drug or biological furnished as part of the durable medical equipment benefit.

(2) Payment for drugs and biologicals on or after January 1, 2004. Effective January 1, 2004, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with Part 414, subpart I of this chapter.

(3) Payment for drugs and biologicals on or after January 1, 2005. Effective January 1, 2005, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with part 414, subpart K of this chapter.

(b) Methodology. Payment for a drug or biological described in paragraph (a) of this section is based on the lower of the actual charge on the Medicare claim for benefits or 95 percent of the national average wholesale price of the drug or biological.

(c) Multiple-source drugs. For multiple-source drugs and biologicals, for purposes of this regulation, the average wholesale price is defined as the lesser of the median average wholesale price for all sources of the generic forms of

(d) When a physician bills, in accordance with paragraph (b) or (c) of this section, for a laboratory test and indicates that it was performed by an independent laboratory, a nominal payment will also be made to the physician for collecting, handling, and shipping the specimen to the laboratory, if the physician bills for such a service.

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§ 405.534 Limitation on payment for screening mammography services.

The provisions in paragraphs (a), (b), and (c) of this section apply for services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are paid under the physician fee schedule in accordance with §414.2 of this chapter.

(a) Basis and scope. This section implements section 1834(c) of the Act by establishing a limit on payment for screening mammography examinations. There are three categories of billing for screening mammography services. Those categories and the payment limitations on each are set forth in paragraphs (b) through (d) of this section.

(b) Global or complete service billing representing both the professional and technical components of the procedure. If a fee is billed for a global service, the amount of payment subject to the deductible is equal to 80 percent of the least of the following:

1. The actual charge for the service.
2. The amount established for the global procedure for a diagnostic bilateral mammogram under the fee schedule for physicians’ services set forth at part 414, subpart A.
3. The professional component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

(c) Professional component billing representing only the physician’s interpretation for the procedure. If the professional component of screening mammography services is billed separately, the amount of payment for that professional component, subject to the deductible, is equal to 80 percent of the least of the following:

1. The actual charge for the professional component of the service.
2. The amount established for the professional component of a diagnostic bilateral mammogram under the fee schedule for physicians’ services.
3. The technical component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

(d) Technical component billing representing other resources involved in furnishing the procedure. If the technical component of screening mammography services is billed separately, the