Centers for Medicare & Medicaid Services, HHS

§ 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

(b) If the bill or request for payment indicates that the test was performed by an outside laboratory, and identifies both the laboratory and the amount the laboratory charged, payment for the test will be based on the lower of—

(1) The laboratory’s reasonable charge for the service (as determined in accordance with §405.502), or

(2) The amount that the laboratory charged the physician for the service.

(c) If the bill or request for payment does not indicate that the conditions specified in paragraph (a) of this section were met, and does not identify both the laboratory and the amount the laboratory charged, payment will be based on the lowest charge at which the carrier estimates the test could have been secured from a laboratory serving the physician’s locality. The carrier will estimate this lowest amount twice a year by (i) obtaining lists of charges laboratories make to physicians from as many commercial laboratories serving the carrier’s area as possible (including laboratories in other States from which tests may be obtained by physicians in the carrier’s service area) and (ii) establishing a schedule of lowest prices based on this information. The carrier will take into consideration specific circumstances, such as a need for emergency services that may be costlier than routine services, in making the estimate in a particular case. However, in no case may this estimate be higher than the lowest customary charge for commercial laboratories, or when applicable to the laboratory service, the lowest charge level determined in accordance with §405.511, in the carrier’s service area.

§ 405.520 Payment for a physician assistant's, nurse practitioner's, and clinical nurse specialists' services and services furnished incident to their professional services.

(a) General rule. A physician assistant's, nurse practitioner's, and clinical nurse specialists' services, and services and supplies furnished incident to their professional services, are paid in accordance with the physician fee schedule. The payment for a physician assistants' services may not exceed the limits at §414.52 of this chapter. The payment for a nurse practitioners' and clinical nurse specialists' services may not exceed the limits at §414.56 of this chapter.

(b) Requirements. Medicare payment is made only if all claims for payment are made on an assignment-related basis in accordance with §424.55 of this chapter, that sets forth, respectively, the conditions for coverage of physician assistants' services, nurse practitioners' services and clinical nurse specialists' services, and services and supplies furnished incident to their professional services.

(c) Civil money penalties. Any person or entity who knowingly and willingly bills a Medicare beneficiary amounts in excess of the appropriate coinsurance and deductible is subject to a civil money penalty as described in §§402.1(c)(11), 402.105(d)(2)(viii), and 402.107(b)(8) of this chapter.

§ 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 payment limit for the procedure. For screening mammography services furnished in CY 1994, the payment limit is $59.63. On January 1 of each subsequent year, the payment limit is updated by the percentage increase in the Medicare Economic Index.