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 the drug or biological or the lowest average wholesale price of the brand name forms of the drug or biological.

§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.