

§ 414.100

§ 414.92 Electronic Prescribing Incentive Program.

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(c) \* \* \*

(2) \* \* \*

(ii) Significant hardship exception. CMS may, on a case-by-case basis, exempt an eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) from the application of the payment adjustment under paragraph (c)(2) of this section if, CMS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship. Eligible professionals (or, in the case of a group practice under paragraph (e) of this section, a group practice) may request consideration for a significant hardship exemption from the 2012 eRx payment adjustment if one of the following circumstances apply:

(A) The practice is located in a rural area without high speed internet access.

(B) The practice is located in an area without sufficient available pharmacies for electronic prescribing.

(C) Registration to participate in the Medicare or Medicaid EHR Incentive Program and adoption of Certified EHR Technology.

(D) Inability to electronically prescribe due to local, State or Federal law or regulation.

(E) Limited prescribing activity.

(F) Insufficient opportunities to report the eRx measure due to limitations of the measure's denominator.

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Subpart C—Fee Schedules for Parenteral and Enteral Nutrition (PEN) Nutrients, Equipment and Supplies

SOURCE: 66 FR 45176, Aug. 28, 2001, unless otherwise noted.

§ 414.100 Purpose.

This subpart implements fee schedules for PEN items and services as authorized by section 1842(s) of the Act.

§ 414.102 General payment rules.

(a) General rule. For items and services furnished on or after January 1, 2002, Medicare pays for the items and services as described in paragraph (b) of this section on the basis of 80 percent of the lesser of—

(1) The actual charge for the item or service; or

(2) The fee schedule amount for the item or service, as determined in accordance with § 414.104.

(b) Payment classification. (1) CMS or the carrier determines fee schedules for Parenteral and enteral nutrition (PEN) nutrients, equipment, and supplies, as specified in § 414.104.

(2) CMS designates the specific items and services in each category through program instructions.

(c) Updating the fee schedule amounts. For each year subsequent to 2002, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI-U for the 12-month period ending with June of the preceding year.

§ 414.104 PEN Items and Services.

(a) Payment rules. Payment for PEN items and services is made in a lump sum for nutrients and supplies that are purchased and on a monthly basis for equipment that is rented.

(b) Fee schedule amount. The fee schedule amount for payment for an item or service furnished in 2002 is the lesser of—

(i) The reasonable charge from 1995; or

(ii) The reasonable charge that would have been used in determining payment for 2002.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

§ 414.200 Purpose.

This subpart implements sections 1834 (a) and (h) of the Act by specifying how payments are made for the purchase or rental of new and used durable medical equipment and prosthetic and orthotic devices for Medicare beneficiaries.

[57 FR 57689, Dec. 7, 1992]

§ 414.202 Definitions.

For purposes of this subpart, the following definitions apply:

Complex rehabilitative power-driven wheelchair means a power-driven wheelchair that is classified as—

(1) Group 2 power wheelchair with power options that can accommodate

rehabilitative features (for example, tilt in space); or

(2) Group 3 power wheelchair.

*Covered item update* means the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) for the 12-month period ending with June of the previous year.

*Durable medical equipment* means equipment, furnished by a supplier or a home health agency that—

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to an individual in the absence of an illness or injury; and

(4) Is appropriate for use in the home. (See §410.38 of this chapter for a description of when an institution qualifies as a home.)

*Prosthetic and orthotic devices* means—

(1) Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies;

(2) One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens; and

(3) Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the beneficiary's physical condition.

The following are neither prosthetic nor orthotic devices—

(1) Parenteral and enteral nutrients, supplies, and equipment;

(2) Intraocular lenses;

(3) Medical supplies such as catheters, catheter supplies, ostomy bags, and supplies related to ostomy care that are furnished by an HHA as part of home health services under §409.40(e) of this chapter;

(4) Dental prostheses.

*Region* means those carrier service areas administered by CMS regional offices.

[57 FR 57689, Dec. 7, 1992, as amended at 75 FR 73622, Nov. 29, 2010]

#### §414.210 General payment rules.

(a) *General rule.* For items furnished on or after January 1, 1989, except as provided in paragraphs (c) and (d) of

this section, Medicare pays for durable medical equipment, prosthetics and orthotics, including a separate payment for maintenance and servicing of the items as described in paragraph (e) of this section, on the basis of 80 percent of the lesser of—

(1) The actual charge for the item;

(2) The fee schedule amount for the item, as determined in accordance with the provisions of §§414.220 through 414.232.

(b) *Payment classification.* (1) The carrier determines fee schedules for the following classes of equipment and devices:

(i) Inexpensive or routinely purchased items, as specified in §414.220.

(ii) Items requiring frequent and substantial servicing, as specified in §414.222.

(iii) Certain customized items, as specified in §414.224.

(iv) Oxygen and oxygen equipment, as specified in §414.226.

(v) Prosthetic and orthotic devices, as specified in §414.228.

(vi) Other durable medical equipment (capped rental items), as specified in §414.229.

(vii) Transcutaneous electrical nerve stimulators (TENS), as specified in §414.232.

(2) CMS designates the items in each class of equipment or device through its program instructions.

(c) *Exception for certain HHAs.* Public HHAs and HHAs that furnish services or items free-of-charge or at nominal prices to a significant number of low-income patients, as defined in §413.13(a) of this chapter, are paid on the basis of 80 percent of the fee schedule amount determined in accordance with the provision of §§414.220 through 414.230.

(d) *Prohibition on special limits.* For items furnished on or after January 1, 1989 and before January 1, 1991, neither CMS nor a carrier may establish a special reasonable charge for items covered under this subpart on the basis of inherent reasonableness as described in §405.502(g) of this chapter.

(e) *Maintenance and servicing—(1) General rule.* Except as provided in paragraph (e)(3) of this section, the carrier pays the reasonable and necessary charges for maintenance and servicing