

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

[63 FR 58905, Nov. 2, 1998, as amended at 69 FR 1116, Jan. 7, 2004; 69 FR 66420, Nov. 15, 2004]

**§ 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.

[63 FR 58905, Nov. 2, 1998, as amended at 66 FR 49547, Sept. 28, 2001]

**§ 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