

items are combined into a single code, the fee schedule amounts for the new code are established using the average (arithmetic mean), weighted by allowed services, of the fee schedule amounts for the formerly separate codes.

[84 FR 60806, Nov. 8, 2019]

§414.112 Establishing fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history.

(a) *General rule.* If a HCPCS code is new and describes items and services that do not have a fee schedule pricing history (classified and paid for previously under a different code), the fee schedule amounts for the new code are established based on the process described in paragraphs (b) or (c) of this section.

(b) *Comparability.* Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services based on a comparison of: Physical components; mechanical components; electrical components; function and intended use; and additional attributes and features. If there are no items with existing fee schedule amounts that are comparable to the items and services under the new code, the fee schedule amounts for the new code are established in accordance with paragraph (c) of this section.

(c) *Use of supplier or commercial price lists.* (1) Fee schedule amounts for items and services without a fee schedule pricing history described by new HCPCS codes that are not comparable to items and services with existing fee schedule amounts may be established using supplier price lists, including catalogs and other retail price lists (such as internet retail prices) that provide information on commercial pricing for the item. Potential appropriate sources for such commercial pricing information can also include payments made by Medicare Advantage plans, as well as verifiable information from supplier invoices and non-Medicare payer data. If the only available

price information is from a period other than the fee schedule base period, deflation factors are applied against current pricing in order to approximate the base period price.

(i) The annual deflation factors are specified in program instructions and are based on the percentage change in the consumer price index for all urban consumers (CPI-U) from the mid-point of the year the prices are in effect to the mid-point of the fee schedule base period, as calculated using the following formula: ((base CPI-U minus current CPI-U) divided by current CPI-U) plus one.

(ii) The deflated amounts are then increased by the update factors specified in §414.102(c).

(2) If within 5 years of establishing fee schedule amounts using supplier or commercial prices, the supplier or commercial prices decrease by less than 15 percent, a one-time adjustment to the fee schedule amounts is made using the new prices. The new supplier or commercial prices would be used to establish the new fee schedule amounts in the same way that the older prices were used, including application of the deflation formula in paragraph (c)(1) of this section.

[84 FR 60806, Nov. 8, 2019]

§414.114 Procedures for making benefit category determinations and payment determinations for new PEN items and services covered under the prosthetic device benefit; splints and casts; and IOLs inserted in a physician's office covered under the prosthetic device benefit.

(a) *Definitions.* For the purpose of this subpart:

Benefit category determination means a national determination regarding whether an item or service meets the Medicare definition of a prosthetic device at section 1861(s)(8) of the Act or is a splint, cast, or device used for reduction of fractures or dislocations subject to section 1842(s) of the Act and the rules of this subpart and is not otherwise excluded from coverage by statute.

(b) *General rule.* The procedures for determining whether new items and services addressed in a request for a HCPCS Level II code(s) or by other

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means meet the definition of items and services that may be covered and paid for in accordance with this subpart are as follows:

(1) At the start of a HCPCS coding cycle, CMS performs an analysis to determine if the item or service is statutorily excluded from coverage under Medicare under section 1862 of the Act, and, if not excluded by statute, whether the item or service is parenteral or enteral nutrients, supplies, and equipment covered under the prosthetic device benefit, splints and casts or other devices used for reductions of fractures or dislocations, or IOLs inserted in a physician's office covered under the prosthetic device benefit.

(2) If a preliminary determination is made that the item or service is parenteral or enteral nutrients, supplies, and equipment covered under the prosthetic device benefit, splints and casts or other devices used for reductions of fractures or dislocations, or IOLs inserted in a physician's office covered under the prosthetic device benefit, CMS makes a preliminary payment determination for the item or service.

(3) CMS posts preliminary benefit category determinations and payment determinations on *CMS.gov* approximately 2 weeks prior to a public meeting.

(4) After consideration of public consultation provided at a public meeting on preliminary benefit category determinations and payment determinations for items and services, CMS establishes the benefit category determinations and payment determinations for items and services through program instructions.

[86 FR 73910, Dec. 28, 2021]

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

§ 414.200 Purpose.

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

[78 FR 72253, Dec. 2, 2013]

42 CFR Ch. IV (10–1–23 Edition)

§ 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 meets the following conditions:

(1) Can withstand repeated use.

(2) Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.

(3) Is primarily and customarily used to serve a medical purpose.

(4) Generally is not useful to an individual in the absence of an illness or injury.

(5) Is appropriate for use in the 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.