

## Centers for Medicare & Medicaid Services, HHS

**§ 405.506**

### MEDICARE ECONOMIC INDEX EXPENDITURE CATEGORIES, WEIGHTS, AND PRICE PROXIES—Continued

Expense category	1989 weights <sup>1 2</sup> (percent)	Price proxy <sup>3</sup>
2. Physician Practice Expense .....	45.8	
a. Non-physician Employee Compensation ....	16.3	
(1) Wages and Salaries .....	13.8	Employment Cost Index, wages and salaries weighted for occupational mix of non-physician employees. <sup>4</sup>
(2) Fringe Benefits .....	2.5	Employment Cost Index, fringe benefits, white collar. <sup>4</sup>
b. Office Expense .....	10.3	CPI-U, housing.
c. Medical Materials and Supplies .....	5.2	PPI, ethical drugs; PPI, surgical appliances and supplies; and CPI-U medical equipment and supplies (equally weighted).
d. Professional Liability Insurance .....	4.8	CMS survey of change in average liability premiums for \$100,000/\$300,000 liability coverage among 9 major insurers.
e. Medical Equipment .....	2.3	PPI, medical instruments and equipment.
f. Other Professional Expense .....	6.9	
(1) Professional Car .....	1.4	CPI-U, private transportation.
(2) Other .....	5.5	CPI-U, all items less food and energy.

<sup>1</sup> Sources: Martin L. Gonzalez, ed.: *Physician Marketplace Statistics, Fall, 1990*. Center for Health Policy Research, Chicago, American Medical Association, 1990; Mark Holoweiko, "Practice Expenses Take the Leap of the Decade," *Medical Economics*, November 12, 1990; and CMS, OACT special study.

<sup>2</sup> Due to rounding, weights may not sum to 100.0%.

<sup>3</sup> All price proxies are for annual percent changes for the 12 months ending June 30th.

<sup>4</sup> Annual percent change values for Physicians' Own Time and Non-physician Employee Compensation are net of the change in the 10-year moving average of output per man-hour to exclude changes in non-farm business sector labor productivity.

(3) If there is no methodological change, CMS publishes a notice in the FEDERAL REGISTER to announce the annual increase in the MEI before the beginning of the update year to which it applies. If there are changes in the base year weights or price proxies, or if there are any other MEI methodological changes, they are published in the FEDERAL REGISTER with an opportunity for public comment.

[32 FR 12600, Aug. 31, 1967, as amended at 40 FR 25447, June 16, 1975; 42 FR 18275, Apr. 6, 1977. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 43 FR 4430, Feb. 2, 1978; 47 FR 63274, Dec. 31, 1982; 51 FR 34978, Oct. 1, 1986; 53 FR 6648, Mar. 2, 1988; 57 FR 55912, Nov. 25, 1992]

#### **§ 405.505 Determination of locality.**

"Locality" is the geographical area for which the carrier is to derive the reasonable charges or fee schedule amounts for services or items. Usually, a locality may be a State (including the District of Columbia, a territory, or a Commonwealth), a political or economic subdivision of a State, or a group of States. It should include a cross section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis con-

stituting medical services areas (inter-state or otherwise), comparable in concept to "trade areas." Localities may differ in population density, economic level, and other major factors affecting charges for services. Carriers therefore shall delineate localities on the basis of their knowledge of local conditions. However, distinctions between localities are not to be so finely made that a locality includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city).

[57 FR 27305, June 18, 1992]

#### **§ 405.506 Charges higher than customary or prevailing charges or lowest charge levels.**

A charge which exceeds the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or an applicable lowest charge level may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort or expense which support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. The

mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination that it is reasonable.

(Secs. 1102, 1842(b) and 1871, 1903(i)(1) of the Social Security Act; 49 Stat. 647, 79 Stat. 302, 310, 331; 86 Stat. 1395, 1454; (42 U.S.C. 1302, 1395u(b), 1395hh, 1396b(i)(1)))

[43 FR 32300, July 26, 1978]

**§ 405.507 Illustrations of the application of the criteria for determining reasonable charges.**

The following examples illustrate how the general criteria on customary charges and prevailing charges might be applied in determining reasonable charges under the supplementary medical insurance program. Basically, these examples demonstrate that, except where the actual charge is less, reasonable charges will reflect current customary charges of the particular physician or other person within the ranges of the current prevailing charges in the locality for that type and level of service:

The prevailing charge for a specific medical procedure ranges from \$80 to \$100 in a certain locality.

Doctor A's bill is for \$75 although he customarily charges \$80 for the procedure.

Doctor B's bill is his customary charge of \$85

Doctor C's bill is his customary charge of \$125

Doctor D's bill is for \$100, although he customarily charges \$80, and there are no special circumstances in the case.

The reasonable charge for Doctor A would be limited to \$75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for the locality.

The reasonable charge for Doctor B would be \$85, because it is his customary charge and it falls within the range of prevailing charges for that locality.

The reasonable charge for Doctor C could not be more than \$100, the top of the range of prevailing charges.

The reasonable charge for Doctor D would be \$80, because that is his customary charge. Even though his actual charge of \$100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.

**§ 405.508 Determination of comparable circumstances; limitation.**

(a) *Application of limitation.* The carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the carrier would be obligated to pay. Under certain circumstances, some carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individuals. Payment under the supplementary medical insurance program would not be limited to these lower amounts.

(b) *When comparability exists.* "Comparable circumstances," as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:

(1) The carrier bases payment under its program on the customary charges, as presently constituted, of physicians or other persons and on current prevailing charges in a locality, and

(2) The determination does not preclude recognition of factors such as speciality status and unusual circumstances which affect the amount charged for a service.

(c) *Responsibility for determining comparability.* Responsibility for determining whether or not a carrier's program has comparability will in the first instance fall upon the carrier in reporting pertinent information about its programs to the Centers for Medicare & Medicaid Services. When the pertinent information has been reported, the Centers for Medicare & Medicaid Services will advise the carrier whether any of its programs have comparability.