

§ 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

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 (MEI) and reflects the relationship between the relative value units for the professional and technical components of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(c) *Professional component billing representing only the physician's interpretation for the procedure.* If the professional component of screening mammography services is billed separately, the amount of payment for that professional component, subject to the deductible, is equal to 80 percent of the least of the following:

- (1) The actual charge for the professional component of the service.
- (2) The amount established for the professional component of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(3) The professional component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

(d) *Technical component billing representing other resources involved in furnishing the procedure.* If the technical component of screening mammography services is billed separately, 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 technical component of the service.
- (2) The amount established for the technical component of a diagnostic bi-

lateral mammogram under the fee schedule for physicians' services.

(3) The technical component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

[55 FR 53521, Dec. 31, 1990, as amended at 59 FR 49833, Sept. 30, 1994; 66 FR 55328, Nov. 1, 2001]

§ 405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are physician services pursuant to § 414.2 of this chapter paid under the physician fee schedule. If screening mammography services are furnished to a beneficiary by a nonparticipating physician or supplier that does not accept assignment, a limiting charge applies to the charges billed to the beneficiary. The limiting charge is the lesser of the following:

(a) 115 percent of the payment limit set forth in § 405.534(b)(3), (c)(3), and (d)(3) (limitations on the global service, professional component, and technical component of screening mammography services, respectively).

(b) The limiting charge for the global service, professional component, and technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services set forth at § 414.48(b) of this chapter.

[59 FR 49833, Sept. 30, 1994, as amended at 62 FR 59098, Oct. 31, 1997; 66 FR 55328, Nov. 1, 2001]

Subparts F– G [Reserved]

Subpart H—Appeals Under the Medicare Part B Program

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