

§ 414.1

414.1465 Physician-focused payment models.

Subpart P—Home Infusion Therapy Services Payment

CONDITIONS FOR PAYMENT

- 414.1500 Basis, purpose, and scope.
- 414.1505 Requirement for payment.
- 414.1510 Beneficiary qualifications for coverage of services.
- 414.1515 Plan of care requirements.

PAYMENT SYSTEM

- 414.1550 Basis of payment.

Subpart Q—Payment for Lymphedema Compression Treatment Items

- 414.1600 Purpose and definitions.
- 414.1650 Payment basis for lymphedema compression treatment items.
- 414.1660 Continuity of pricing when HCPCS codes are divided or combined.
- 414.1670 Procedures for making benefit category determinations and payment determinations for new lymphedema compression treatment items.
- 414.1680 Frequency limitations.
- 414.1690 Application of competitive bidding information.

Subpart R—Home Intravenous Immunoglobulin (IVIG) Items and Services Payment

- 414.1700 Basis of payment.

AUTHORITY: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(1).

SOURCE: 55 FR 23441, June 8, 1990, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 414 appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

Subpart A—General Provisions

§ 414.1 Basis and scope.

This part implements the following provisions of the Act:

1802—Rules for private contracts by Medicare beneficiaries.

1833—Rules for payment for most Part B services.

1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.

1834(l)—Establishment of a fee schedule for ambulance services.

1834(m)—Rules for Medicare reimbursement for telehealth services.

1834A—Improving policies for clinical diagnostic laboratory tests

1842(o)—Rules for payment of certain drugs and biologicals.

1847(a) and (b)—Competitive bidding for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

1848—Fee schedule for physician services.

1881(b)—Rules for payment for services to ESRD beneficiaries.

1887—Payment of charges for physician services to patients in providers.

[67 FR 9132, Feb. 27, 2002, as amended at 69 FR 1116, Jan. 7, 2004; 71 FR 48409, Aug. 18, 2006; 81 FR 41098, June 23, 2016]

§ 414.2 Definitions.

As used in this part, unless the context indicates otherwise—

AA stands for anesthesiologist assistant.

AHPB stands for adjusted historical payment basis.

CF stands for conversion factor.

CRNA stands for certified registered nurse anesthetist.

CY stands for calendar year.

FY stands for fiscal year.

GAF stands for geographic adjustment factor.

GPCI stands for geographic practice cost index.

HCPCS stands for CMS Common Procedure Coding System.

Health Professional Shortage Area (HPSA) means an area designated under section 332(a)(1)(A) of the Public Health Service Act as identified by the Secretary prior to the beginning of such year.

Major surgical procedure means a surgical procedure for which a 10-day or 90-day global period is used for payment under the physician fee schedule and section 1848(b) of the Act.

Physician services means the following services to the extent that they are covered by Medicare:

(1) Professional services of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors.

(2) Supplies and services covered “incident to” physician services (excluding drugs as specified in § 414.36).

(3) Outpatient physical and occupational therapy services if furnished by a person or an entity that is not a Medicare provider of services as defined in § 400.202 of this chapter.

42 CFR Ch. IV (10–1–24 Edition)

Centers for Medicare & Medicaid Services, HHS

§ 414.5

(4) Diagnostic x-ray tests and other diagnostic tests (excluding diagnostic laboratory tests paid under the fee schedule established under section 1833(h) of the Act).

(5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

(6) Antigens, as described in section 1861(s)(2)(G) of the Act.

(7) Bone mass measurement.

RVU stands for relative value unit.

(8) Screening mammography services.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63686, Dec. 2, 1993; 59 FR 63463, Dec. 8, 1994; 60 FR 63177, Dec. 8, 1995; 63 FR 34328, June 24, 1998; 66 FR 55322, Nov. 1, 2001; 75 FR 73616, Nov. 29, 2010]

§ 414.4 Fee schedule areas.

(a) *General.* CMS establishes physician fee schedule areas that generally conform to the geographic localities in existence before January 1, 1992.

(b) *Changes.* CMS announces proposed changes to fee schedule areas in the FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, CMS publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

§ 414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

(a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

(1) Services described in § 419.21(a) of this chapter that do not require an outpatient status.

(2) Physical therapy services, speech-language pathology services, and occupational therapy services.

(3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.

(4) Except as provided in § 419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.

(5) Except as provided in § 419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.

(6) Clinical diagnostic laboratory services.

(7)(i) Effective December 8, 2003, screening mammography services; and

(ii) Effective January 1, 2005, diagnostic mammography services.

(8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

(b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) of this chapter or § 485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in § 412.2(c)(5), § 412.405, § 412.540, or § 412.604(f) of this chapter or § 413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).

(c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in § 424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

Subpart B—Physicians and Other Practitioners

SOURCE: 56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, unless otherwise noted.