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data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) *Informal review.* Eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (e) of this section, group practices) did not meet the requirements for the 2012 and 2013 incentives or the 2013 and 2014 payment adjustments.

(1) To request an informal review for the 2012 and 2013 incentives, an eligible professional or group practice must submit a request to CMS via email within 90 days of the release of the feedback reports. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) To request an informal review for the 2013 and 2014 payment adjustments, an eligible professional or group practices must submit a request to CMS via email by February 28 of the year in which the eligible professional is receiving the applicable payment adjustment. The request must be submitted in writing and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(3) CMS will provide a written response of CMS' determination.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(h) *Public reporting of an eligible professional's or group practice's Electronic Prescribing Incentive Program data.* For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (e) of this

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section, group practices) who are successful electronic prescribers.

[75 FR 73620, Nov. 29, 2010, as amended at 76 FR 54968, Sept. 6, 2011; 76 FR 73472, Nov. 28, 2011; 77 FR 69368, Nov. 16, 2012; 80 FR 71379, Nov. 16, 2015]

§ 414.94 [Reserved]

Subpart C—Fee Schedules for Parenteral and Enteral Nutrition (PEN) Nutrients, Equipment and Supplies, Splints, Casts, and Certain Intraocular Lenses (IOLs)

SOURCE: 66 FR 45176, Aug. 28, 2001, unless otherwise noted.

§ 414.100 Purpose.

This subpart implements fee schedules for PEN items and services, splints and casts, and IOLs inserted in a physician's office as authorized by section 1842(s) of the Act.

[78 FR 72252, Dec. 2, 2013]

§ 414.102 General payment rules.

(a) *General rule.* For PEN items and services furnished on or after January 1, 2002, and for splints and casts and IOLs inserted in a physician's office on or after April 1, 2014, Medicare pays for the items and services as described in paragraph (b) of this section on the basis of 80 percent of the lesser of—

(1) The actual charge for the item or service; or

(2) The fee schedule amount for the item or service, as determined in accordance with §§ 414.104 thru 414.108.

(b) *Payment classification.* (1) CMS or the carrier determines fee schedules for parenteral and enteral nutrition (PEN) nutrients, equipment, and supplies, splints and casts, and IOLs inserted in a physician's office, as specified in §§ 414.104 thru 414.108.

(2) CMS designates the specific items and services in each category through program instructions.

(c) *Updating the fee schedule amounts.* For the years 2003 through 2010 for PEN items and services, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI-U for the 12-month period ending with June of the preceding year. For

each year subsequent to 2010 for PEN items and services and for each year subsequent to 2014 for splints and casts, and IOLs inserted in a physician's office, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI-U for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

[66 FR 45176, Aug. 28, 2001, as amended at 78 FR 72252, Dec. 2, 2013]

§414.104 PEN Items and Services.

(a) *Payment rules.* Payment for PEN items and services is made in a lump sum for nutrients and supplies that are purchased and on a monthly basis for equipment that is rented.

(b) *Fee schedule amount.* The fee schedule amount for payment for an item or service furnished in 2002 is the lesser of—

(i) The reasonable charge from 1995; or

(ii) The reasonable charge that would have been used in determining payment for 2002.

§414.105 Application of competitive bidding information.

For enteral nutrients, equipment and supplies furnished on or after January 1, 2011, the fee schedule amounts may be adjusted based on information on the payment determined as part of implementation of the programs under subpart F using the methodologies set forth at §414.210(g).

[79 FR 66262, Nov. 6, 2014]

§414.106 Splints and casts.

(a) *Payment rules.* Payment is made in a lump sum for splints and casts.

(b) *Fee schedule amount.* The fee schedule amount for payment for an item or service furnished in 2014 is the reasonable charge amount for 2013, updated by the percentage increase in the CPI-U for the 12-month period ending with June of 2013.

[78 FR 72253, Dec. 2, 2013]

§414.108 IOLs inserted in a physician's office.

(a) *Payment rules.* Payment is made in a lump sum for IOLs inserted in a physician's office.

(b) *Fee schedule amount.* The fee schedule amount for payment for an IOL furnished in 2014 is the national average allowed charge for the IOL furnished from in calendar year 2012, updated by the percentage increase in the CPI-U for the 24-month period ending with June of 2013.

[78 FR 72253, Dec. 2, 2013]

§414.110 Continuity of pricing when HCPCS codes are divided or combined.

(a) *General Rule.* If a new HCPCS code is added, CMS or contractors make every effort to determine whether the item and service has a fee schedule pricing history. If there is a fee schedule pricing history, the previous fee schedule amounts for the old code(s) are mapped to the new code(s) to ensure continuity of pricing.

(b) *Mapping fee schedule amounts based on different kinds of coding changes.* When the code for an item is divided into several codes for the components of that item, the total of the separate fee schedule amounts established for the components must not be higher than the fee schedule amount for the original item. When there is a single code that describes two or more distinct complete items (for example, two different but related or similar items), and separate codes are subsequently established for each item, the fee schedule amounts that applied to the single code continue to apply to each of the items described by the new codes. When the codes for the components of a single item are combined in a single global code, the fee schedule amounts for the new code are established by totaling the fee schedule amounts used for the components (that is, use the total of the fee schedule amounts for the components as the fee schedule amount for the global code). When the codes for several different 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

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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 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]

§ 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.

Region means, for the purpose of implementing § 414.210(g), geographic areas defined by the Bureau of Economic Analysis in the United States