

(2) If the codes for several different items are combined into a single code, then the payment amounts for the new code are established using the average (arithmetic mean), weighted by allowed services, of the payment amounts for the formerly separate codes.

§414.1670 Procedures for making benefit category determinations and payment determinations for new lymphedema compression treatment items.

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 paid for in accordance with this subpart are as follows:

(a) At the start of a HCPCS coding cycle, CMS performs an analysis to determine if the item is statutorily excluded from coverage under Medicare under section 1862 of the Act.

(1) If not excluded by statute, then CMS determines whether the item is a lymphedema compression treatment item as defined under section 1861(mmm) of the Act.

(2) If excluded by statute, the analysis is concluded.

(b) If a preliminary determination is made that the item is a lymphedema compression treatment item, CMS makes a preliminary payment determination for the item or service.

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

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

§414.1680 Frequency limitations.

(a) *General rule.* With the exception of replacements of items that are lost, stolen, or irreparably damaged, or if needed due to a change in the patient's medical or physical condition, no payment may be made for gradient com-

pression garments or wraps with adjustable straps furnished other than at the frequencies established in paragraphs (b) and (c) of this section.

(b) *Initial furnishing of lymphedema compression treatment items.* The following frequency limitations apply to items initially furnished to the beneficiary if determined to be reasonable and necessary for the treatment of lymphedema:

(1) Three units of daytime gradient compression garments or wraps with adjustable straps per affected extremity or part of the body.

(2) Two garments for nighttime use per affected extremity or part of the body.

(c) *Replacements of lymphedema compression treatment items.* The following frequency limitations apply to replacements of lymphedema compression treatment items if determined to be reasonable and necessary for the treatment of lymphedema:

(1) Payment for the replacement of gradient compression garments or wraps with adjustable straps per each affected extremity or part of the body can be made once every 6 months.

(2) Payment for the replacement of nighttime garments per each affected extremity or part of the body can be made once every 2 years.

(d) *Replacements of lymphedema compression bandaging systems or supplies.* Specific frequency limitations are not established for these items. Determinations regarding the quantity of compression bandaging supplies needed by each beneficiary are made by the DME MAC that processes the claims for the supplies.

§414.1690 Application of competitive bidding information.

The payment amounts for lymphedema compression treatment items under §414.1650(b) may be adjusted using information on the payment determined as part of implementation of the programs under subpart F using the methodologies set forth at §414.210(g).

§ 414.1700

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

SOURCE: 88 FR 77877, Nov. 13, 2023, unless otherwise noted.

§ 414.1700 Basis of payment.

(a) *General rule.* For home intravenous immunoglobulin (IVIG) items or services furnished on or after January 1, 2024, Medicare payment is made on the basis of 80 percent of the lesser of the following:

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

(2) The fee schedule amount for the items and services, as determined in accordance with the provisions of this section.

(b) *Per visit amount.* A single payment amount is made for items and services furnished by a DME supplier per visit.

(c) *Initial establishment of the payment amount.* In establishing the initial per visit IVIG items and services payment amount for CY 2024, CMS used the CY 2023 bundled payment rate under the IVIG Demonstration updated by the home health payment percentage update for CY 2024.

(d) *Annual payment adjustment.* The per visit payment amount represents payment in full for all costs associated with the furnishing of home IVIG items and services and is subject to the following adjustment:

(1) Beginning in 2025, an annual increase in the per-visit payment amount from the prior year by the home health update percentage increase for the current calendar year.

(2) [Reserved]

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

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Subpart E—Services of Residents

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