

§ 414.94

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

42 CFR Ch. IV (10–1–24 Edition)

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