

most appropriate level of services is furnished.

(c) *Plan of care signature requirements.* The plan of care must be signed and dated by the ordering physician prior to submitting a claim for payment. The ordering physician must sign and date the plan of care upon any changes to the plan of care.

PAYMENT SYSTEM

§414.1550 Basis of payment.

(a) *General rule.* For home infusion therapy services furnished on or after January 1, 2021, 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 item or service, as determined in accordance with the provisions of this section.

(b) *Unit of single payment.* A unit of single payment is made for items and services furnished by a qualified home infusion therapy supplier per payment category for each infusion drug administration calendar day, as defined at §486.505 of this chapter.

(c) *Initial establishment of the payment amounts.* In calculating the initial single payment amounts for CY 2021, CMS determined such amounts using the equivalent to 5 hours of infusion services in a physician's office as determined by codes and units of such codes under the annual fee schedule issued under section 1848 of the Act as follows:

(1) *Category 1.* (i) Includes certain intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; chelation drugs; and other intravenous drugs as added to the durable Medicare equipment local coverage determination (DME LCD) for external infusion pumps.

(ii) Payment equals 1 unit of 96365 plus 4 units of 96366.

(2) *Category 2.* (i) Includes certain subcutaneous infusion drugs for therapy or prophylaxis, including certain subcutaneous immunotherapy infusions.

(ii) Payment equals 1 unit of 96369 plus 4 units of 96370.

(3) *Category 3.* (i) Includes intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.

(ii) Payment equals 1 unit of 96413 plus 4 units of 96415.

(4) *Initial visit.* (i) For each of the three categories listed in paragraphs (c)(1) through (3) of this section, the payment amounts are set higher for the first visit by the qualified home infusion therapy supplier to initiate the furnishing of home infusion therapy services in the patient's home and lower for subsequent visits in the patient's home. The difference in payment amounts is a percentage based on the relative payment for a new patient rate over an existing patient rate using the annual physician fee schedule evaluation and management payment amounts for a given year and calculated in a budget neutral manner.

(ii) The first visit payment amount is subject to the following requirements if a patient has previously received home infusion therapy services:

(A) The previous home infusion therapy services claim must include a patient status code to indicate a discharge.

(B) If a patient has a previous claim for HIT services, the first visit home infusion therapy services claim subsequent to the previous claim must show a gap of more than 60 days between the last home infusion therapy services claim and must indicate a discharge in the previous period before a HIT supplier may submit a home infusion therapy services claim for the first visit payment amount.

(d) *Required payment adjustments.* The single payment amount represents payment in full for all costs associated with the furnishing of home infusion therapy services and is subject to the following adjustments:

(1) An adjustment for a geographic wage index and other costs that may vary by region, using an appropriate wage index based on the site of service of the beneficiary.

(2) Beginning in 2022, an annual increase in the single payment amounts from the prior year by the percentage increase in the Consumer Price Index

(CPI) for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

(3)(i) An annual reduction in the percentage increase described in paragraph (d)(2) of this section by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(ii) The application of the paragraph (c)(3)(i) of this section may result in the both of the following:

(A) A percentage being less than zero for a year.

(B) Payment being less than the payment rates for the preceding year.

(e) *Medical review.* All payments under this system may be subject to a medical review adjustment reflecting the following:

(1) Beneficiary eligibility.

(2) Plan of care requirements.

(3) Medical necessity determinations.

Subpart Q—Payment for Lymphedema Compression Treatment Items

SOURCE: 88 FR 77876, Nov. 13, 2023, unless otherwise noted.

§ 414.1600 Purpose and definitions.

(a) *Purpose.* This subpart implements section 1834(z) of the Act and establishes procedures for making benefit category determinations and payment determinations for lymphedema compression treatment items.

(b) *Definitions.* For purposes of this subpart the following definitions apply:

Benefit category determination means a national determination regarding whether an item or service meets the Medicare definition of lymphedema compression treatment item at section 1861(mmm) of the Act and the rules of this subpart and is not otherwise excluded from coverage by statute.

Lymphedema compression treatment item means an item as described in § 410.2.

§ 414.1650 Payment basis for lymphedema compression treatment items.

(a) *General payment rule.* For items furnished on or after January 1, 2024, Medicare pays for lymphedema com-

pression treatment items on the basis of 80 percent of the lesser of—

(1) The actual charge for the item; or

(2) The payment amount for the item, as determined in accordance with paragraph (b) of this section.

(b) *Payment amounts.* The payment amounts for covered lymphedema compression treatment items paid for under this subpart are established based on one of the following:

(1) If payment amounts are available from Medicaid state plans, then 120 percent of the average of the Medicaid payment amounts.

(2) If payment amounts are not available from Medicaid state plans, then 100 percent of the average of average internet retail prices and payment amounts from TRICARE (Department of Defense).

(3) If payment amounts are not available from Medicaid state plans or TRICARE, then 100 percent of average internet retail prices.

(c) *Updates to payment amounts.* The payment amounts for covered lymphedema compression treatment items established in accordance with paragraph (b) of this section are increased on an annual basis beginning on January 1 of the year subsequent to the year in which the payment amounts are initially established based on the percent change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year.

§ 414.1660 Continuity of pricing when HCPCS codes are divided or combined.

(a) *General rule.* If HCPCS codes for lymphedema compression treatment items are divided or combined, the payment amounts for the old codes are mapped to the new codes to ensure continuity of pricing.

(b) *Mapping of payment amounts.* (1) If 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, then the payment amounts that applied to the single code continue to apply to each of the items described by the new codes.