

## § 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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AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 60 FR 63178, Dec. 8, 1995, unless otherwise noted.

### Subpart A—General Provisions

#### § 415.1 Basis and scope.

(a) *Basis.* This part is based on the provisions of the following sections of the Act: Section 1848 establishes a fee schedule for payment for physician services. Section 1861(q) specifies what is included in the term “physician services” covered under Medicare. Section 1862(a)(14) sets forth the exclusion of nonphysician services furnished to hospital patients under Part B of Medicare. Section 1886(d)(5)(B) provides for a payment adjustment under the prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983, to account for the indirect costs of medical education. Section 1886(h) establishes the methodology for Medicare payment of the cost of direct GME activities.

(b) *Scope.* This part sets forth rules for fiscal intermediary payments to providers for physician services, Part B carrier payments for physician services to beneficiaries in providers, physician services in teaching settings, and services of residents.

### Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

#### § 415.50 Scope.

This subpart sets forth rules for payment by fiscal intermediaries to providers for services furnished by physicians. Payment for covered services is made either under the prospective payment system (PPS) to PPS-participating providers in accordance with part 412 of this chapter or under the reasonable cost method to non-PPS participating providers in accordance with part 413 of this chapter.

#### § 415.55 General payment rules.

(a) *Allowable costs.* Except as specified otherwise in §§ 413.102 of this chapter (concerning compensation of owners), 415.60 (concerning allocation of physician compensation costs), and 415.162 (concerning payment for physician services furnished to beneficiaries in teaching hospitals), costs a provider incurs for services of physicians are allowable only if the following conditions are met:

(1) The services do not meet the conditions in § 415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.

(2) The services include a surgeon’s supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.

(3) The provider has incurred a cost for salary or other compensation it furnished the physician for the services.

(4) The costs incurred by the provider for the services meet the requirements in § 413.9 of this chapter regarding costs related to patient care.

(5) The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in § 415.160, or any other costs incurred in connection with an approved GME program that are payable under §§ 413.75 through 413.83 of this chapter.

(b) *Allocation of allowable costs.* The provider must follow the rules in § 415.60 regarding allocation of physician compensation costs to determine its costs of services.

(c) *Limits on allowable costs.* The intermediary must apply the limits on compensation set forth in § 415.70 to determine its payments to a provider for the costs of services.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

#### § 415.60 Allocation of physician compensation costs.

(a) *Definition.* For purposes of this subpart, *physician compensation costs* means monetary payments, fringe benefits, deferred compensation, and any