CDSMs. This application must be received by CMS by January 1 of the 5th year after the most recent approval date.

(h) *Identification of non-adherence to requirements for qualified CDSMs.* (1) If a qualified CDSM is found non-adherent to the requirements in paragraph (g)(1) of this section, CMS may terminate its qualified status or may consider this information during requalification.

(i) *Exceptions.* Consulting and reporting requirements are not required for orders for applicable imaging services made by ordering professionals under the following circumstances:

(1) Emergency services when provided to individuals with emergency medical conditions as defined in section 1867(e)(1) of the Act.

(2) For an inpatient and for which payment is made under Medicare Part A.

(3) Significant hardships for ordering professionals who experience any of the following:

(i) Insufficient internet access.

(ii) EHR or CDSM vendor issues.

(iii) Extreme and uncontrollable circumstances.

(j) *Consulting.* (1) Except as specified in paragraphs (i) and (j)(2) of this section, ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2020.

(2) Ordering professionals may delegate the consultation with specified applicable AUC required under paragraph (j)(1) of this section to clinical staff acting under the direction of the ordering professional.

(k) *Reporting.* The following information must be reported on Medicare claims for advanced diagnostic imaging services furnished in an applicable setting, paid for under an applicable payment system defined in paragraph (b) of this section, and ordered on or after January 1, 2020:

(1) The qualified CDSM consulted by the ordering professional.

(2) Information indicating:

(i) Whether the service ordered would adhere to specified applicable AUC;

(ii) Whether the service ordered would not adhere to specified applicable AUC; or

(iii) Whether the specified applicable AUC consulted was not applicable to the service ordered.

(3) The NPI of the ordering professional who consulted specified applicable AUC as required in paragraph (j) of this section, if different from the furnishing professional.

[80 FR 71380, Nov. 16, 2015, as amended at 80 FR 80554, Nov. 15, 2016; 82 FR 53363, Nov. 15, 2017; 83 FR 60074, Nov. 23, 2018]

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