specified in paragraph (b) of this section, is 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charges or 85 percent of the physician fee schedule amount.

(b) *To whom payment may be made.* Payment may be made to a registered dietician or nutrition professional qualified to furnish medical nutrition therapy in accordance with part 410, subpart G of this chapter.

(c) *Effective date of payment.* Medicare pays suppliers of medical nutrition therapy on or after the effective date of enrollment of the supplier at the carrier.

(d) *Limitation on payment.* Payment is made only for documented nutritional therapy sessions actually attended by the beneficiary.

(e) *Other conditions for fee-for-service payment.* Payment is made only if the beneficiary:

(1) Is not an inpatient of a hospital, SNF, nursing home, or hospice.

(2) Is not receiving services in an RHC, FQHC or ESRD dialysis facility.

[66 FR 55332, Nov. 1, 2001, as amended at 86 FR 65668, Nov. 19, 2021]

§ 414.65 Payment for telehealth services.

(a) *Professional service.* The Medicare payment amount for telehealth services described under §410.78 of this chapter is equal to the current fee schedule amount applicable for the service of the physician or practitioner, subject to paragraphs (a)(1) and (2) of this section, but must be made in accordance with the following limitations:

(1) Only the physician or practitioner at the distant site may bill and receive payment for the professional service via an interactive telecommunications system.

(2) Payments made to the physician or practitioner at the distant site, including deductible and coinsurance, for the professional service may not be shared with the referring practitioner or telepresenter.

(b) *Originating site facility fee.* For telehealth services furnished on or after October 1, 2001:

(1) For services furnished on or after October 1, 2001 through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act.

(2) Only the originating site may bill for the originating site facility fee and only on an assignment-related basis. The distant site physician or practitioner may not bill for or receive payment for facility fees associated with the professional service furnished via an interactive telecommunications system.

(3) No originating site facility fee payment is made to an originating site described in §410.78(b)(3)(x), (xi), or (xii); or to an originating site for services furnished under the exception at §410.78(b)(4)(iv)(A) or (B) of this chapter.

(c) *Deductible and coinsurance apply.* The payment for the professional service and originating site facility fee is subject to the coinsurance and deductible requirements of sections 1833(a)(1) and (b) of the Act.

(d) *Assignment required for physicians, practitioners, and originating sites.* Payment to physicians, practitioners, and originating sites is made only on an assignment-related basis.

(e) *Sanctions.* A distant site practitioner or originating site facility may be subject to the applicable sanctions provided for in chapter IV, part 402 and chapter V, parts 1001, 1002, and 1003 of this title if he or she does any of the following:

(1) Knowingly and willfully bills or collects for services in violation of the limitation of this section.

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service in an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

(3) Fails to submit a claim on a standard form for services provided for

which payment is made on a fee schedule basis.

(4) Imposes a charge for completing and submitting the standard claims form.

[66 FR 55332, Nov. 1, 2001, as amended at 67 FR 80041, Dec. 31, 2003; 69 FR 66424, Nov. 15, 2004; 70 FR 70332, Nov. 21, 2005; 72 FR 66401, Nov. 27, 2007; 73 FR 69936, Nov. 19, 2008; 74 FR 62006, Nov. 25, 2009; 75 FR 73617, Nov. 29, 2010; 76 FR 73471, Nov. 28, 2011; 77 FR 69363, Nov. 16, 2012; 78 FR 74812, Dec. 10, 2013; 83 FR 60074, Nov. 23, 2018]

§ 414.66 Incentive payments for physician scarcity areas.

(a) *Definition.* As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

[69 FR 66424, Nov. 15, 2004]

§ 414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) *Health Professional Shortage Area (HPSA) physician bonus program.* A HPSA physician incentive payment will be made subject to the following:

(1) HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

(2) HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

(3) Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(4) Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made must use the AQ modifier to receive the HPSA physician bonus payment.

(b) *HPSA surgical incentive payment program.* A HPSA surgical incentive payment will be made subject to the following:

(1) A major surgical procedure as defined in § 414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

(2) Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (b)(1) of this section, in addition to the amount the physician would otherwise be paid.

(3) Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made should report HCPCS modifier -AQ to receive the HPSA surgical incentive payment.

(4) The payment described in paragraph (b)(2) of this section is made to