

(c) May make payment to a physician or practitioner who furnishes emergency or urgent care services to a beneficiary who has not previously entered into a private contract with the physician or practitioner in accordance with § 405.440.

### Subpart E—Criteria for Determining Reasonable Charges

**AUTHORITY:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

**SOURCE:** 32 FR 12599, Aug. 31, 1967, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

#### § 405.500 Basis.

Subpart E is based on the provisions of the following sections of the Act: Section 1814(b) provides for Part A payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1832 establishes the scope of benefits provided under the Part B supplementary medical insurance program. Section 1833(a) sets forth the amounts of payment for supplementary medical insurance services on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1834(a) specifies how payments are made for the purchase or rental of new and used durable medical equipment for Medicare beneficiaries. Section 1834(b) provides for payment for radiologist services on a fee schedule basis. Section 1834(c) provides for payments and standards for screening mammography. Section 1842(b) sets forth the provisions for a carrier to enter into a contract with the Secretary and to make determinations with respect to Part B claims. Section 1842(h) sets forth the requirements for a physician or supplier to voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. Section 1842(i) sets forth the provisions for the payment of Part B claims. Section 1848 establishes a fee schedule for payment of physician services. Section 1861(b) sets forth the inpatient hospital services covered by the Medicare program. Section 1861(s) sets forth medical and other health services covered by the Medicare program. Section 1861(v) sets forth the general authority under which CMS

may establish limits on provider costs recognized as reasonable in determining Medicare program payments. Section 1861(aa) sets forth the rural health clinic services and Federally qualified health center services covered by the Medicare program. Section 1861(jj) defines the term "covered osteoporosis drug." Section 1862(a)(14) lists services that are excluded from coverage. Section 1866(a) specifies the terms for provider agreements. Section 1881 authorizes special rules for the coverage of and payment for services furnished to patients with end-stage renal disease. Section 1886 sets forth the requirements for payment to hospitals for inpatient hospital services. Section 1887 sets forth requirements for payment of provider-based physicians and payment under certain percentage arrangements. Section 1889 provides for Medicare and Medigap information by telephone.

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#### § 405.501 Determination of reasonable charges.

(a) Except as specified in paragraphs (b), (c), and (d) of this section, Medicare pays no more for Part B medical and other health services than the "reasonable charge" for such service. The reasonable charge is determined by the carriers (subject to any deductible and coinsurance amounts as specified in §§ 410.152 and 410.160 of this chapter).

(b) Part B of Medicare pays on the basis of "reasonable cost" (see part 413 of this chapter) for certain institutional services, certain services furnished under arrangements with institutions, and services furnished by entities that elect to be paid on a cost basis (including health maintenance organizations, rural health clinics, Federally qualified health centers and end-stage renal disease facilities).

(c) Carriers will determine the reasonable charge on the basis of the criteria specified in § 405.502, and the customary and prevailing charge screens in effect when the service was furnished. (Also see §§ 415.55 through 415.70 and §§ 415.100 through 415.130 of this chapter, which pertain to the determination of reimbursement for services