

§ 405.503

proposed and final notices of a special payment limit before it adopts the limit. The notice sets forth the criteria and circumstances, if any, under which a carrier may grant an exception to the limit for the category of items or services.

(i) *Proposed notice.* The proposed notice—

(A) Explains the factors and data that CMS considered in determining that the payment amount for a category of items or services is grossly excessive or deficient;

(B) Specifies the proposed payment amount or methodology to be established with respect to a category of items or services;

(C) Explains the factors and data that CMS considered in determining the payment amount or methodology, including the economic justification for a uniform fee or payment limit if it is proposed;

(D) Explains the potential impacts of a limit on a category of items or services as described in paragraph (h)(1) of this section; and

(E) Allows no less than 60 days for public comment on the proposed payment limit for the category of items or services.

(ii) *Final notice.* The final notice—

(A) Explains the factors and data that CMS considered, including the economic justification for any uniform fee or payment limit established; and

(B) Responds to the public comments.

(i) *Paramedic intercept ambulance services.* (1) CMS establishes its payment allowance on a carrier-wide basis by using the median allowance from all localities within an individual carrier's jurisdiction.

(2) CMS's payment allowance is equal to the advanced life support rate minus 40 percent of the basic life support rate.

(3) CMS bases payment on the lower of the actual charge or the amount described in paragraph (i)(1) and (i)(2) of this section.

(Secs. 1102, 1814(b), 1833(a), 1842(b), and (h), and 1871, 1903(i)(1) of the Social Security Act; 49 Stat. 647, as amended, 79 Stat. 296, 302, 310, 331; 86 Stat. 1395, 1454; 42 U.S.C. 1302, 1395u(b), 1395hh, 1396b(i)(1).

[32 FR 12599, Aug. 31, 1967]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 405.502, see the List of CFR

42 CFR Ch. IV (10-1-02 Edition)

Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

§ 405.503 Determining customary charges.

(a) *Customary charge defined.* The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in § 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

(b) *Variation of charges.* If the individual physician or other person varies his charges for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a "customary charge" for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or midpoint of his charges, excluding token and substandard charges as well as exceptional charges on the high side. A significant clustering of charges in the vicinity of the median amount might indicate that a point of such clustering should be taken as the physician's or other person's "customary" charge. Use of

relative value scales will help in arriving at a decision in such instances.

(c) *Use of relative value scales.* If, for a particular medical procedure or service, the carrier is unable to determine the customary charge on the basis of reliable statistical data (for example, because the carrier does not yet have sufficient data or because the performance of the particular medical procedure or service by the physician or other person is infrequent), the carrier may use appropriate relative value scales to determine the customary charge for such procedure or service in relation to customary charges of the same physician or person for other medical procedures and services.

(d) *Revision of customary charge.* A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. If the new customary charge is not above the top of the range of prevailing charges (see § 405.504(a)), it should be deemed to be reasonable by the carrier, subject to the provisions of § 405.508.

§ 405.504 Determining prevailing charges.

(a) *Ranges of charges.* (1) In the case of physicians' services furnished beginning January 1, 1987, the prevailing charges for a nonparticipating physician as defined in this paragraph will be no higher than the same level that was set for services furnished during the previous calendar year for a physician who was a participating physician during that year. A nonparticipating physician is a physician who has not entered into an agreement with the Medicare program to accept payment on an assignment-related basis (in accordance with § 424.55 of this chapter)

for all items and services furnished to individuals enrolled under Part B of Medicare during a given calendar year.

(2) No charge for Part B medical or other health services may be considered to be reasonable if it exceeds the higher of:

(i) The prevailing charge for similar services in the same locality in effect on December 31, 1970, provided such prevailing charge had been found acceptable by CMS; or

(ii) The prevailing charge that, on the basis of statistical data and methodology acceptable to CMS, would cover:

(A) 75 percent of the customary charges made for similar services in the same locality during the 12-month period of July 1 through June 30 preceding the fee screen year (January 1 through December 31) in which the service was furnished; or

(B) In the case of services furnished more than 12 months before the beginning of the fee screen year (January 1 through December 31) in which the claim or request for payment is submitted, 75 percent of the customary charges made for similar services in the same locality during the 12 month period of July 1 through June 30 preceding the fee screen year that ends immediately preceding the fee screen year in which the claim or request for payment is submitted.

(3)(i) In the case of physicians' services, furnished before January 1, 1992, each prevailing charge in each locality may not exceed the prevailing charge determined for the FY ending June 30, 1973 (without reference to the adjustments made in accordance with the economic stabilization program then in effect), except on the basis of appropriate economic index data that demonstrate the higher prevailing charge level is justified by:

(A) Changes in general earnings levels of workers that are attributable to factors other than increases in their productivity; and

(B) changes in expenses of the kind incurred by physicians in office practice. The office-expense component and the earnings component of such index shall be given the relative weights shown in data on self-employed physicians' gross incomes.