

Centers for Medicare & Medicaid Services, HHS

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AUTHORITY: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

SOURCE: 55 FR 23441, June 8, 1990, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes affecting this part appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

Subpart A—General Provisions

§414.1 Basis and scope.

This part implements the following provisions of the Act:

1802—Rules for private contracts by Medicare beneficiaries.

1833—Rules for payment for most Part B services.

1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.

1834(l)—Establishment of a fee schedule for ambulance services.

1834(m)—Rules for Medicare reimbursement for telehealth services.

1848—Fee schedule for physician services.

1881(b)—Rules for payment for services to ESRD beneficiaries.

1887—Payment of charges for physician services to patients in providers.

[67 FR 9132, Feb. 27, 2002]

§414.2 Definitions.

As used in this part, unless the context indicates otherwise—

AA stands for anesthesiologist assistant.

AHPB stands for adjusted historical payment basis.

CF stands for conversion factor.

CRNA stands for certified registered nurse anesthetist.

CY stands for calendar year.

FY stands for fiscal year.

GAF stands for geographic adjustment factor.

GPCI stands for geographic practice cost index.

HCPCS stands for CMS Common Procedure Coding System.

Physician services means the following services to the extent that they are covered by Medicare:

(1) Professional services of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors.

(2) Supplies and services covered “incident to” physician services (excluding drugs as specified in §414.36).

(3) Outpatient physical and occupational therapy services if furnished by a person or an entity that is not a Medicare provider of services as defined in §400.202 of this chapter.

(4) Diagnostic x-ray tests and other diagnostic tests (excluding diagnostic laboratory tests paid under the fee schedule established under section 1833(h) of the Act).

(5) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

(6) Antigens, as described in section 1861(s)(2)(G) of the Act.

(7) Bone mass measurement.

RVU stands for relative value unit.

(8) Screening mammography services.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63686, Dec. 2, 1993; 59 FR 63463, Dec. 8, 1994; 60 FR 63177, Dec. 8, 1995; 63 FR 34328, June 24, 1998; 66 FR 55322, Nov. 1, 2001]

§414.4 Fee schedule areas.

(a) *General.* CMS establishes physician fee schedule areas that generally conform to the geographic localities in existence before January 1, 1992.

(b) *Changes.* CMS announces proposed changes to fee schedule areas in the

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FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, CMS publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

Subpart B—Physicians and Other Practitioners

SOURCE: 56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, unless otherwise noted.

§ 414.20 Formula for computing fee schedule amounts.

(a) *Participating supplier.* The fee schedule amount for a participating supplier for a physician service as defined in § 414.2 is computed as the product of the following amounts:

- (1) The RVUs for the service.
- (2) The GAF for the fee schedule area.
- (3) The CF.

(b) *Nonparticipating supplier.* The fee schedule amount for a nonparticipating supplier for a physician service as defined in § 414.2 is 95 percent of the fee schedule amount as calculated in paragraph (a) of this section.

[62 FR 59101, Oct. 31, 1997]

§ 414.21 Medicare payment basis.

Medicare payment is based on the lesser of the actual charge or the applicable fee schedule amount.

[62 FR 59101, Oct. 31, 1997]

§ 414.22 Relative value units (RVUs).

CMS establishes RVUs for physicians' work, practice expense, and malpractice insurance.

(a) *Physician work RVUs*—(1) *General rule.* Physician work RVUs are established using a relative value scale in which the value of physician work for a particular service is rated relative to the value of work for other physician services.

(2) *Special RVUs for anesthesia and radiology services*—(i) *Anesthesia services.* The rules for determining RVUs for anesthesia services are set forth in § 414.46.

(ii) *Radiology services.* CMS bases the RVUs for all radiology services on the relative value scale developed under section 1834(b)(1)(A) of the Act, with

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appropriate modifications to ensure that the RVUs established for radiology services that are similar or related to other physician services are consistent with the RVUs established for those similar or related services.

(b) *Practice expense RVUs.* (1) Practice expense RVUs are computed for each service or class of service by applying average historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average practice expense percentage for a service or class of services is computed as follows:

(i) Multiply the average practice expense percentage for each specialty by the proportion of a particular service or class of service performed by that specialty.

(ii) Add the products for all specialties.

(3) For services furnished beginning calendar year (CY) 1994, for which 1994 practice expense RVUs exceed 1994 work RVUs and that are performed in office settings less than 75 percent of the time, the 1994, 1995, and 1996 practice expense RVUs are reduced by 25 percent of the amount by which they exceed the number of 1994 work RVUs. Practice expense RVUs are not reduced to less than 128 percent of 1994 work RVUs.

(4) For services furnished beginning January 1, 1998, practice expense RVUs for certain services are reduced to 110 percent of the work RVUs for those services. The following two categories of services are excluded from this limitation:

(i) The service is provided more than 75 percent of the time in an office setting; or

(ii) The service is one described in section 1848(c)(2)(G)(v) of the Act, codified at 42 U.S.C. 1395w-4(c)(2)(G). Section 1848(c)(2)(G)(v) of the Act refers to the 1998 proposed resource-based practice expense RVUs (as specified in the June 18, 1997 physician fee schedule proposed rule (62 FR 33158)) for the specific site, either in-office or out-of-office, increased from its 1997 practice expense RVUs.)

(5) For services furnished beginning January 1, 1999, the practice expense RVUs are based on 75 percent of the