

§ 405.535

(2) The amount established for the technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(3) The technical component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

[55 FR 53521, Dec. 31, 1990, as amended at 59 FR 49833, Sept. 30, 1994; 66 FR 55328, Nov. 1, 2001]

§ 405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are physician services pursuant to § 414.2 of this chapter paid under the physician fee schedule. If screening mammography services are furnished to a beneficiary by a nonparticipating physician or supplier that does not accept assignment, a limiting charge applies to the charges billed to the beneficiary. The limiting charge is the lesser of the following:

(a) 115 percent of the payment limit set forth in § 405.534(b)(3), (c)(3), and (d)(3) (limitations on the global service, professional component, and technical component of screening mammography services, respectively).

(b) The limiting charge for the global service, professional component, and technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services set forth at § 414.48(b) of this chapter.

[59 FR 49833, Sept. 30, 1994, as amended at 62 FR 59098, Oct. 31, 1997; 66 FR 55328, Nov. 1, 2001]

Subpart F [Reserved]

Subpart G—Reconsiderations and Appeals Under Medicare Part A

AUTHORITY: Secs. 1102, 1155, 1869(b), 1871, 1872, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c-4, 1395ff(b), 1395hh, 1395ii, and 1395pp).

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SOURCE: 37 FR 5814, Mar. 22, 1972, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.701 Basis, purpose and definitions.

(a) This subpart implements section 1869 of the Social Security Act. Section 1869(a) provides that the Secretary will make determinations about the following matters, and section 1869(b) provides for a hearing for an individual who is dissatisfied with the Secretary's determination as to:

(1) Whether the individual is entitled to hospital insurance (part A) or supplementary medical insurance (part B) under title XVIII of the Act; or

(2) The amount payable under hospital insurance.

(b) This subpart establishes the procedures governing initial determinations, reconsidered determinations, hearings, and final agency review, and the reopening of determinations and decisions that are applicable to matters arising under paragraph (a) of this section.

(c) Subparts J and R of 20 CFR part 404 (dealing with determinations, the administrative review process and representation of parties) are also applicable to matters arising under paragraph (a) of this section, except to the extent that specific provisions are contained in this subpart.

(d) *Definitions.* As used in subpart G of this part, the term—

Appellant designates the beneficiary, provider or other person or entity that has filed an appeal concerning a particular determination of benefits under Medicare part A. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Common issues of law and fact, with respect to the aggregation of claims by two or more appellants to meet the minimum amount in controversy needed for a hearing, occurs when the claims sought to be aggregated are denied or reduced for similar reasons and arise from a similar fact pattern material to the reason the claims are denied.

Delivery of similar or related services, with respect to the aggregation of claims by two or more provider appellants to meet the minimum amount in