

§ 414.1

42 CFR Ch. IV (10–1–06 Edition)

Subpart G [Reserved]

Subpart H—Fee Schedule for Ambulance Services

- 414.601 Purpose.
- 414.605 Definitions.
- 414.610 Basis of payment.
- 414.615 Transition to the ambulance fee schedule.
- 414.617 Transition from regional to national ambulance fee schedule.
- 414.620 Publication of the ambulance fee schedule.
- 414.625 Limitation on review.

Subpart I—Payment for Drugs and Biologicals

- 414.701 Purpose.
- 414.704 Definitions.
- 414.707 Basis of payment.

Subpart J—Submission of Manufacturer’s Average Sales Price Data

- 414.800 Purpose.
- 414.802 Definitions.
- 414.804 Basis of payment.
- 414.806 Penalties associated with the failure to submit timely and accurate ASP data.

Subpart K—Payment for Drugs and Biologicals Under Part B

- 414.900 Basis and scope.
- 414.902 Definitions.
- 414.904 Average sales price as the basis for payment.
- 414.906 Competitive acquisition program as the basis for payment.
- 414.908 Competitive acquisition program.
- 414.910 Bidding process.
- 414.912 Conflicts of interest.
- 414.914 Terms of contract.
- 414.916 Dispute resolution for vendors and beneficiaries.
- 414.917 Dispute resolution and process for suspension or termination of approved CAP contract.
- 414.918 Assignment.
- 414.920 Judicial review.

Subpart L—Supplying and Dispensing Fees

- 414.1000 Purpose.
- 414.1001 Basis of Payment.

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 to part 414 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.
 - 1842(o)—Rules for payment of certain drugs and biologicals.
 - 1847(a) and (b)—Competitive bidding for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
 - 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, as amended at 69 FR 1116, Jan. 7, 2004; 71 FR 48409, Aug. 18, 2006]

§ 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 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 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.