

§ 405.207

(1) The FDA notifies CMS, when it notifies the sponsor, that the device is categorized by FDA as non-experimental/investigational (Category B).

(2) CMS uses the categorization of the device as a factor in making Medicare coverage decisions.

(b) If the FDA becomes aware that a categorized device no longer meets the requirements of the exception at §411.15(o) of this chapter, the FDA notifies the sponsor and CMS and the procedures described in paragraph (a)(2) of this section apply.

§ 405.207 Services related to a non-covered device.

(a) *When payment is not made.* Medicare payment is not made for medical and hospital services that are related to the use of a device that is not covered because CMS determines the device is not “reasonable” and “necessary” under section 1862(a)(1)(A) of the Act or because it is excluded from coverage for other reasons. These services include all services furnished in preparation for the use of a noncovered device, services furnished contemporaneously with and necessary to the use of a noncovered device, and services furnished as necessary after-care that are incident to recovery from the use of the device or from receiving related noncovered services.

(b) *When payment is made.* Medicare payment may be made for—

(1) Covered services to treat a condition or complication that arises due to the use of a noncovered device or a noncovered device-related service; or

(2) Routine care services related to experimental/investigational (Category A) devices as defined in §405.201(b); and furnished in conjunction with an FDA-approved clinical trial. The trial must meet criteria established through the national coverage determination process; and if the trial is initiated before January 1, 2010, the device must be determined as intended for use in the diagnosis, monitoring or treatment of an immediately life-threatening disease or condition.

(3) Routine care services related to a non-experimental/investigational (Category B) device defined in §405.201(b)

42 CFR Ch. IV (10–1–07 Edition)

that is furnished in conjunction with an FDA-approved clinical trial.

[60 FR 48423, Sept. 19, 1995, as amended at 69 FR 66420, Nov. 15, 2004]

§ 405.209 Payment for a non-experimental/investigational (Category B) device.

Payment under Medicare for a non-experimental/investigational (Category B) device is based on, and may not exceed, the amount that would have been paid for a currently used device serving the same medical purpose that has been approved or cleared for marketing by the FDA.

§ 405.211 Procedures for Medicare contractors in making coverage decisions for a non-experimental/investigational (Category B) device.

(a) *General rule.* In their review of claims for payment, Medicare contractors are bound by the statute, regulations, and all CMS administrative issuances, including all national coverage decisions.

(b) *Potentially covered non-experimental/investigational (Category B) devices.* Medicare contractors may approve coverage for any device with an FDA-approved IDE categorized as a non-experimental/investigational (Category B) device if all other coverage requirements are met.

(c) *Other considerations.* Medicare contractors must consider whether any restrictions concerning site of service, indications for use, or any other list of conditions for coverage have been placed on the device’s use.

§ 405.213 Re-evaluation of a device categorization.

(a) *General rules.* (1) Any sponsor that does not agree with an FDA decision that categorizes its device as experimental/investigational (Category A) may request re-evaluation of the categorization decision.

(2) A sponsor may request review by CMS only after the requirements of paragraph (b) of this section are met.

(3) No reviews other than those described in paragraphs (b) and (c) of this section are available to the sponsor.

(4) Neither the FDA original categorization or re-evaluation (described in paragraph (b) of this section) nor