§ 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 (b)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.
1834(i)—Establishment of a fee schedule for ambulance services.
1834(m)—Rules for Medicare reimbursement for telehealth services.
1842(a)—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.
1887—Payment of charges for physician services to patients in providers.
1887(b)—Rules for payment for services to ESRD beneficiaries.

§ 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.
CP 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.
Health Professional Shortage Area (HPSA) means an area designated under section 332(a)(1)(A) of the Public Health Service Act as identified by the Secretary prior to the beginning of such year.

Major surgical procedure means a surgical procedure for which a 10-day or 90-day global period is used for payment under the physician fee schedule and section 1848(b) of the Act.

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.

§ 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.

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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.


§ 414.21 Medicare payment basis.

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


§ 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.

(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;

(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 practice expense RVUs applicable to services furnished in 1998 and 25 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2000, the practice expense RVUs are based on 50 percent of the practice expense RVUs applicable to services furnished in 1998 and 50 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2001, the practice expense RVUs are based on 25 percent of the...
practice expense RVUs applicable to services furnished in 1998 and 75 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

(i) Usually there are two levels of practice expense RVUs that correspond to each code.

(A) Facility practice expense RVUs. The facility PE RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center.

(B) Nonfacility practice expense RVUs. The nonfacility PE RVUs apply to services performed in a physician’s office, a patient’s home, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC.

(C) Outpatient therapy services. Outpatient therapy services billed under the physician fee schedule are paid using the non-facility practice expense RVU component.

(ii) Only one practice expense RVU per code can be applied for each of the following services: services that have only technical component practice expense RVUs or only professional component practice expense RVUs; evaluation and management services, such as hospital or nursing facility visits, that are furnished exclusively in one setting; and major surgical services.

(6)(i) CMS establishes criteria for supplemental surveys regarding specialty practice expenses submitted to CMS that may be used in determining practice expense RVUs.

(ii) Any CMS-designated specialty group may submit a supplemental survey.

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by March 1, 2004 to determine CY 2005 practice expense RVUs and by March 1, 2005 to determine CY 2006 practice expense RVUs.

(c) Malpractice insurance RVUs. (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:

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

(ii) Add all the products for all the specialties.

(3) For services furnished in the year 2000 and subsequent years, the malpractice RVUs are based on the relative malpractice insurance resources.

§ 414.24 Review, revision, and addition of RVUs for physician services.

(a) Interim values for new and revised HCPCS level 1 and level 2 codes. (1) CMS establishes interim RVUs for new services and for codes for which definitions have changed.

(2) CMS publishes a notice in the FEDERAL REGISTER to announce interim RVUs and seek public comment on them. The RVUs are effective prospectively for services furnished beginning on the effective date specified in the notice.

(3) After considering public comments, CMS revises, if necessary, the interim RVUs and announces those revisions in a final notice published in the FEDERAL REGISTER. Any revisions in the RVUs are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(b) Revision of RVUs for established HCPCS level 1 and level 2 codes. (1) CMS publishes a proposed notice in the FEDERAL REGISTER to announce changes in RVUs for established codes and provides an opportunity for public comment no less often than every 5 years.
§ 414.26 Determining the GAF.

CMS establishes a GAF for each service in each fee schedule area.

(a) Geographic indices. CMS uses the following indices to establish the GAF:

(1) An index that reflects one-fourth of the difference between the relative value of physicians’ work effort in each of the different fee schedule areas as determined under §414.22(a) and the national average of that work effort.

(2) An index that reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in each of the different fee schedule areas as determined under §414.22(b) compared to the national average of those costs.

(3) An index that reflects the relative costs of malpractice expenses in each of the different fee schedule areas as determined under §414.22(c) compared to the national average of those costs.

(b) Class-specific practice cost indices. If the application of a single index to different classes of services would be substantially inequitable because of differences in the mix of goods and services comprising practice expenses for the different classes of services, more than one index may be established under paragraph (a)(2) of this section.

(c) Adjusting the practice expense index to account for the Frontier State floor—

(1) General criteria. Effective on or after January 1, 2011, CMS will adjust the practice expense index for physicians’ services furnished in qualifying States to recognize the practice expense index floor established for Frontier States. A qualifying State must meet the following criteria:

(i) At least 50 percent of counties located within the State have a population density less than 6 persons per square mile.

(ii) The State does not receive a non-labor related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) Amount of adjustment. The practice expense value applied for physicians’ services furnished in a qualifying State will be not less than 1.00.

(3) Process for determining adjustment.

(i) CMS will use the most recent population estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will publish annually a listing of qualifying Frontier States receiving a practice expense index floor attributable to this provision.

(d) Computation of GAF. The GAF for each fee schedule area is the sum of the physicians’ work adjustment factor, the practice expense adjustment factor, and the malpractice cost adjustment factor, as defined in this section:

(1) The geographic physicians’ work adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the work component and the geographic physicians’ work index value established under paragraph (a)(1) of this section.

(2) The geographic practice expense adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the practice expense component, multiplied by the geographic practice cost index (GPCI) value established under paragraph (a)(2) of this section.

(3) The geographic malpractice adjustment factor for a service is the product of the proportion of the total relative value for the service that reflects the RVUs for the malpractice component, multiplied by the GPCI
§ 414.28 Conversion factors.
CMS establishes CFs in accordance with section 1848(d) of the Act.

(a) Base-year CFs. CMS established the CF for 1992 so that had section 1848 of the Act applied during 1991, it would have resulted in the same aggregate amount of payments for physician services as the estimated aggregate amount of these payments in 1991, adjusted by the update for 1992 computed as specified in §414.30.

(b) Subsequent CFs. For calendar years 1993 through 1995, the CF for each year is equal to the CF for the previous year, adjusted in accordance with §414.30. Beginning January 1, 1996, the CF for each calendar year may be further adjusted so that adjustments to the fee schedule in accordance with section 1848(c)(2)(B)(ii) of the Act do not cause total expenditures under the fee schedule to differ by more than $20 million from the amount that would have been spent if these adjustments had not been made.

§ 414.30 Conversion factor update.
Unless Congress acts in accordance with section 1848(d)(3) of the Act—

(a) General rule. The CF update for a CY equals the Medicare Economic Index increased or decreased by the number of percentage points by which the percentage increase in expenditures for physician services (or for a particular category of physician services, such as surgical services) in the second preceding FY over the third preceding FY exceeds the performance standard rate of increase established for the second preceding FY.

(b) Downward adjustment. The downward adjustment may not exceed the following:

(1) For CYs 1992 and 1993, 2 percentage points.

(2) For CY 1994, 2.5 percentage points.

(3) For CYs 1995 and thereafter, 5 percentage points.

§ 414.32 Determining payments for certain physicians’ services furnished in facility settings.

(a) Definition. As used in this section, facility settings include the following facilities:

(1) Hospital outpatient departments, including clinics and emergency rooms.

(2) Hospital inpatient departments.

(3) Comprehensive outpatient rehabilitation facilities.

(4) Comprehensive inpatient rehabilitation facilities.

(5) Inpatient psychiatric facilities.

(6) Skilled nursing facilities.

(b) General rule. If physicians’ services of the type routinely furnished in physicians’ offices are furnished in facility settings before January 1, 1999, the physician fee schedule amount for those services is determined by reducing the practice expense RVUs for the services by 50 percent. For services furnished on or after January 1, 1999, the practice expense RVUs are determined in accordance with §414.22(b)(5).

(c) Services covered by the reduction. CMS establishes a list of services routinely furnished in physicians’ offices nationally. Services furnished at least 50 percent of the time in physicians’ offices are subject to this reduction.

(d) Services excluded from the reduction. The reduction established under this section does not apply to the following:

(1) Rural health clinic services.

(2) Surgical services not on the ambulatory surgical center covered list of procedures published under §416.65(c) of this chapter when furnished in an ambulatory surgical center.

(3) Anesthesiology services and diagnostic and therapeutic radiology services.

§ 414.34 Payment for services and supplies incident to a physician’s service.

(a) Medical supplies. (1) Except as otherwise specified in this paragraph, office medical supplies are considered to be part of a physician’s practice expense, and payment for them is included in the practice expense portion of the payment to the physician for the medical or surgical service to which they are incidental.

(2) If physician services of the type routinely furnished in provider settings are furnished in a physician’s office, separate payment may be made for certain supplies furnished incident to that physician service if the following requirements are met:

(i) It is a procedure that can safely be furnished in the office setting in appropriate circumstances.

(ii) It requires specialized supplies that are not routinely available in physicians’ offices and that are generally disposable.

(iii) It is furnished before January 1, 1999.

(3) For the purpose of paragraph (a)(2) of this section, provider settings include only the following settings:

(i) Hospital inpatient and outpatient departments.

(ii) Ambulatory surgical centers.

(4) For the purpose of paragraph (a)(2) of this section, “routinely furnished in provider settings” means furnished in inpatient or outpatient hospital settings or ambulatory surgical centers more than 50 percent of the time.

(5) CMS establishes a list of services for which a separate supply payment may be made under this section.

(6) The fee schedule amount for supplies billed separately is not subject to a GPCI adjustment.

(b) Services of nonphysicians that are incident to a physician’s service. Services of nonphysicians that are covered as incident to a physician’s service are paid as if the physician had personally furnished the service.

§ 414.36 Payment for drugs incident to a physician’s service.

Payment for drugs incident to a physician’s service is made in accordance with §405.517 of this chapter.

§ 414.39 Special rules for payment of care plan oversight.

(a) General. Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

(b) Exception. Separate payment is made under the following conditions for physician care plan oversight services furnished to beneficiaries who receive HHA and hospice services that are covered by Medicare:

(1) The care plan oversight services require recurrent physician supervision of therapy involving 30 or more minutes of the physician’s time per month.

(2) Payment is made to only one physician per patient for services furnished during a calendar month period. The physician must have furnished a service requiring a face-to-face encounter with the patient at least once during the 6-month period before the month for which care plan oversight payment is first billed. The physician may not have a significant ownership interest in, or financial or contractual relationship with, the HHA in accordance with §424.22(d) of this chapter. The physician may not be the medical director or employee of the hospice and may not furnish services under an arrangement with the hospice.

(3) If a physician furnishes care plan oversight services during a post-operative period, payment for care plan oversight services is made if the services are documented in the patient’s medical record as unrelated to the surgery.

(c) Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare. (1) An NPP can furnish physician care plan oversight (but may not certify a patient as needing home health services) only if the physician who signs the
§ 414.44 Transition rules.

(a) Adjusted historical payment basis—

(1) All services other than radiology and nuclear medicine services. For all physician services other than radiology services, furnished in a fee schedule area,
the adjusted historical payment basis (AHPB) is the estimated weighted average prevailing charge applied in the fee schedule area for the service in CY 1991, as determined by CMS without regard to physician specialty and as adjusted to reflect payments for services below the prevailing charge, adjusted by the update established for CY 1992.

(2) Radiology services. For radiology services, the AHPB is the amount paid for the service in the fee schedule area in CY 1991 under the fee schedule established under section 1834(b), adjusted by the update established for CY 1992.

(3) Nuclear medicine services. For nuclear medicine services, the AHPB is the amount paid for the service in the fee schedule area in CY 1991 under the fee schedule established under section 6105(b) of Public Law 101–239 and section 4102(g) of Public Law 101–508, adjusted by the update established for CY 1992.

(4) Transition adjustment. CMS adjusts the AHPB for all services by 5.5 percent to produce budget-neutral payments for 1992.

(b) Adjustment of 1992 payments for physician services other than radiology services. For physician services furnished during CY 1992 the following rules apply:

(1) If the AHPB determined under paragraph (a) of this section is from 85 percent to 115 percent of the fee schedule amount for the area for services furnished in 1992, payment is at the fee schedule amount.

(2) If the AHPB determined under paragraph (a) of this section is less than 85 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB plus 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(3) If the AHPB determined under paragraph (a) of this section is greater than 115 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB minus 9 percent of the fee schedule amount is substituted for the fee schedule amount.

(d) Computation of payments for CY 1993. For physician services subject to the transition rules in CY 1992 and furnished during CY 1993, the fee schedule is equal to 75 percent of the amount that would have been paid in the fee schedule area under the 1992 transition rules, adjusted by the amount of the 1993 update, plus 25 percent of the 1993 fee schedule amount.

(e) Computation of payments for CY 1994. For physician services subject to the transition rules in CY 1993, and furnished during CY 1994, the fee schedule is equal to 67 percent of the amount that would have been paid in the fee schedule area under the 1993 transition rules, adjusted by the amount of the 1994 update, plus 33 percent of the 1994 fee schedule amount.

(f) Computation of payments for CY 1995. For physician services subject to the transition rules in CY 1994 and furnished during CY 1995, the fee schedule is equal to 50 percent of the amount that would have been paid in the fee schedule area under the 1994 transition rules, adjusted by the amount of the 1995 update, plus 50 percent of the 1995 fee schedule amount.

§ 414.46 Additional rules for payment of anesthesia services.

(a) Definitions. For purposes of this section, the following definitions apply:
(1) **Base unit** means the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual preoperative and postoperative visits, the administration of fluids and blood incident to anesthesia care, and monitoring services.

(2) **Anesthesia practitioner**, for the purpose of anesthesia time, means a physician who performs the anesthesia service alone, a CRNA who is not medically directed who performs the anesthesia service alone, or a medically directed CRNA.

(3) **Anesthesia time** means the time during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

(b) **Determinations of payment amount—Basic rule.** For anesthesia services performed, medically directed, or medically supervised by a physician, CMS pays the lesser of the actual charge or the anesthesia fee schedule amount.

(1) The carrier bases the fee schedule amount for an anesthesia service on the product of the sum of allowable base and time units and an anesthesia-specific CF. The carrier calculates the time units from the anesthesia time reported by the anesthesia practitioner for the anesthesia procedure. The physician who fulfills the conditions for medical direction in §415.110 (Conditions for payment: Anesthesiology services) reports the same anesthesia time as the medically-directed CRNA.

(2) CMS furnishes the carrier with the base units for each anesthesia procedure code. The base units are derived from the 1988 American Society of Anesthesiologists’ Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units.

(3) Modifier units are not allowed. Modifier units include additional units charged by a physician or a CRNA for patient health status, risk, age, or unusual circumstances.

(c) **Physician personally performs the anesthesia procedure.** (1) CMS considers an anesthesia service to be personally performed under any of the following circumstances:

(i) The physician performs the entire anesthesia service alone.

(ii) The physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident and the service was furnished before January 1, 1994.

(iii) The physician establishes an attending physician relationship in one case involving an intern or resident and the service was furnished on or after January 1, 1994 but prior to January 1, 1996. For services on or after January 1, 1996, the physician must be the teaching physician as defined in §§415.170 through 415.184 of this chapter.

(iv) The physician and the CRNA or AA are involved in a single case and the services of each are found to be medically necessary.

(v) The physician is continuously involved in a single case involving a student nurse anesthetist.

(vi) The physician is continuously involved in a single case involving a CRNA or AA and the service was furnished prior to January 1, 1998.

(2) CMS determines the fee schedule amount for an anesthesia service personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(d) **Anesthesia services medically directed by a physician.** (1) CMS considers an anesthesia service to be medically directed by a physician if:
(i) The physician performs the activities described in §415.110 of this chapter.

(ii) The physician directs qualified individuals involved in two, three, or four concurrent cases.

(iii) Medical direction can occur for a single case furnished on or after January 1, 1998 if the physician performs the activities described in §415.110 of this chapter and medically directs a single CRNA or AA.

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician.

(i) If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(ii) For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical direction payment rules as specified in paragraph (e) of this section.

(3) Payment for medical direction is based on a specific percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. The following percentages apply for the years specified:

(i) CY 1994—60 percent of the payment allowance for personally performed procedures.

(ii) CY 1995—57.5 percent of the payment allowance for personally performed services.

(iii) CY 1996—55 percent of the payment allowance for personally performed services.

(iv) CY 1997—52.5 percent of the payment allowance for personally performed services.

(v) CY 1998 and thereafter—50 percent of the payment allowance for personally performed services.

(e) Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases. For physicians’ services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in §415.178 of this chapter. This special payment rule also applies if the teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under the medical direction payment rules.

(f) Physician medically supervises anesthesia services. If the physician medically supervises more than four concurrent anesthesia services, CMS bases the fee schedule amount on an anesthesia-specific CF and three base units. This represents payment for the physician’s involvement in the pre-surgical anesthesia services.

(g) Payment for medical or surgical services furnished by a physician while furnishing anesthesia services. (1) CMS allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. CMS makes payment for these services in accordance with the general physician fee schedule rules in §414.20. These services are described in program operating instructions.

(2) CMS makes no separate payment for other medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

(h) Physician involved in multiple anesthesia services. If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the
multiple services. The carrier makes payment for add-on anesthesia codes according to program operating instructions.

§ 414.50 Physician or other supplier billing for diagnostic tests performed or interpreted by a physician who does not share a practice with the billing physician or other supplier.

(a) General rules. (1) For services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(h)(5)(A) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act), if a physician or other supplier bills for the technical component (TC) or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control as described in §413.17 of this chapter) and the diagnostic test is performed by a physician who does not share a practice with the billing physician or other supplier, the payment to the billing physician or other supplier (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(i) The performing supplier’s net charge to the billing physician or other supplier. For purposes of this paragraph (a)(1) only, with respect to the TC, the performing supplier is the physician who supervised the TC, and with respect to the PC, the performing supplier is the physician who performed the PC.

(ii) The billing physician or other supplier’s actual charge.

(iii) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

(2) The following requirements are applicable for purposes of paragraph (a)(1) of this section:

(i) The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

(ii) A performing physician shares a practice with the billing physician or other supplier if he or she furnishes substantially all (which, for purposes of this section, means “at least 75 percent”) of his or her professional services through such billing physician or other supplier. The “substantially all” requirement will be satisfied if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that:

(A) For the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or

(B) The performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).
(iii) A physician will be deemed to share a practice with the billing physician or other supplier with respect to the performance of the TC or PC of a diagnostic test if the physician is an owner, employee or independent contractor of the billing physician or other supplier and the TC or PC is performed in the office of the billing physician or other supplier. The “office of the billing physician or other supplier” is any medical office space, regardless of number of locations, in which the ordering physician or other ordering supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the same building (as defined in §411.351) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in §411.351 of this chapter), the “office of the billing physician or other supplier” is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. The performance of the TC includes both the conducting of the TC as well as the supervision of the TC.

(b) Restriction on payment. (1) The billing physician or other supplier must identify the performing supplier and indicate the performing supplier’s net charge for the test. If the billing physician or other supplier fails to provide this information, CMS makes no payment to the billing physician or other supplier and the billing physician or other supplier may not bill the beneficiary.

(2) Physicians and other suppliers that accept Medicare assignment may bill beneficiaries for only the applicable deductibles and coinsurance.

(3) Physicians and other suppliers that do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

(42 CFR Ch. IV (10–1–11 Edition))

§414.52 Payment for physician assistants’ services.

Allowed amounts for the services of a physician assistant furnished beginning January 1, 1992 and ending December 31, 1997, may not exceed the limits specified in paragraphs (a) through (c) of this section. Allowed amounts for the services of a physician assistant furnished beginning January 1, 1998, may not exceed the limits specified in paragraph (d) of this section.

(a) For assistant-at-surgery services, 65 percent of the amount that would be allowed under the physician fee schedule if the assistant-at-surgery service was furnished by a physician.

(b) For services (other than assistant-at-surgery services) furnished in a hospital, 75 percent of the physician fee schedule amount for the service.

(c) For all other services, 85 percent of the physician fee schedule amount for the service.

(d) For services (other than assistant-at-surgery services) furnished beginning January 1, 1998, 85 percent of the physician fee schedule amount for the service. For assistant-at-surgery services, 85 percent of the physician fee schedule amount that would be allowed under the physician fee schedule if the assistant-at-surgery service were furnished by a physician.


§414.54 Payment for certified nurse-midwives’ services.

(a) For services furnished after December 31, 1991, allowed amounts under the fee schedule established under section 1833(a)(1)(K) of the Act for the payment of certified nurse-midwifery services may not exceed 65 percent of the physician fee schedule amount for the service.

(b) For certified nurse-midwife services furnished on or after January 1, 2011, allowed amounts may not exceed 100 percent of the physician fee schedule amount that would be paid to a physician for the services.

[75 FR 73616, Nov. 29, 2010]
§ 414.56 Payment for nurse practitioners' and clinical nurse specialists' services.

(a) Rural areas. For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a rural area (as described in section 1861(s)(2)(K)(iii) of the Act) may not exceed the following limits:

1. For services furnished in a hospital (including assistant-at-surgery services), 75 percent of the physician fee schedule amount for the service.
2. For all other services, 85 percent of the physician fee schedule amount for the service.

(b) Non-rural areas. For services furnished beginning January 1, 1992 and ending December 31, 1997, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed 85 percent of the physician fee schedule amount for the service.

(c) Beginning January 1, 1998. For services (other than assistant-at-surgery services) furnished beginning January 1, 1998, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in a nursing facility may not exceed 85 percent of the physician fee schedule amount for the service.

[63 FR 58911, Nov. 2, 1998]

§ 414.58 Payment of charges for physician services to patients in providers.

(a) Payment under the physician fee schedule. In addition to the special conditions for payment in §§415.100 through 415.130, and §415.190 of this chapter, CMS establishes payment for physician services to patients in providers under the physician fee schedule in accordance with §§414.1 through 414.48.

(b) Teaching hospitals. Services furnished by physicians in teaching hospitals may be made on a reasonable cost basis set forth in §415.162 of this chapter if the hospital exercises the election described in §415.160 of this chapter.


§ 414.60 Payment for the services of CRNAs.

(a) Basis for payment. The allowance for the anesthesia service furnished by a CRNA, medically directed or not medically directed, is based on allowable base and time units as defined in §414.46(a). Beginning with CY 1994—

1. The allowance for an anesthesia service furnished by a medically directed CRNA is based on a fixed percentage of the allowance recognized for the anesthesia service personally performed by the physician alone, as specified in §414.46(d)(3); and
2. The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

(b) To whom payment may be made. Payment for an anesthesia service furnished by a CRNA may be made to the CRNA or to any individual or entity (such as a hospital, critical access hospital, physician, group practice, or ambulatory surgical center) with which the CRNA has an employment or contract relationship that provides for payment to be made to the individual or entity.

(c) Condition for payment. Payment for the services of a CRNA may be made only on an assignment related basis, and any assignment accepted by a CRNA is binding on any other person presenting a claim or request for payment for the service.


§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) Basis for payment. Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:

1. The teaching CRNA, who is not under medical direction of a physician,
(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) Level of payment. The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in §414.46(c) of this subpart.

§414.62 Fee schedule for clinical psychologist services.

The fee schedule for clinical psychologist services is set at 100 percent of the amount determined for corresponding services under the physician fee schedule.


§414.63 Payment for outpatient diabetes self-management training.

(a) Payment under the physician fee schedule. Except as provided in paragraph (d) of this section, payment for outpatient diabetes self-management training is made under the physician fee schedule in accordance with §§414.1 through 414.48.

(b) To whom payment may be made. Payment may be made to an entity approved by CMS to furnish outpatient diabetes self-management training in accordance with part 410, subpart H of this chapter.

(c) Limitation on payment. Payment may be made for training sessions actually attended by the beneficiary and documented on attendance sheets.

(d) Payments made to those not paid under the physician fee schedule. Payments may be made to other entities not routinely paid under the physician fee schedule, such as hospital outpatient departments, ESRD facilities, and DME suppliers. The payment equals the amounts paid under the physician fee schedule.

(e) Other conditions for fee-for-service payment. The beneficiary must meet the following conditions:

(1) Has not previously received initial training for which Medicare payment was made under this benefit.

(2) Is not receiving services as an inpatient in a hospital, SNF, hospice, or nursing home.

(3) Is not receiving services as an outpatient in an RHC or FQHC.

[65 FR 83153, Dec. 29, 2000]

§414.64 Payment for medical nutrition therapy.

(a) Payment under the physician fee schedule. Medicare payment for medical nutrition therapy is made under the physician fee schedule in accordance with subpart B of this part. Payment to non-physician professionals, as specified in paragraph (b) of this section, is the lesser of the actual charges or 80 percent of 85 percent of the physician fee schedule amount.

(b) To whom payment may be made. Payment may be made to a registered dietician or nutrition professional qualified to furnish medical nutrition therapy in accordance with part 410, subpart G of this chapter.

(c) Effective date of payment. Medicare pays suppliers of medical nutrition therapy on or after the effective date of enrollment of the supplier at the carrier.

(d) Limitation on payment. Payment is made only for documented nutritional therapy sessions actually attended by the beneficiary.

(e) Other conditions for fee-for-service payment. Payment is made only if the beneficiary:

(1) Is not an inpatient of a hospital, SNF, nursing home, or hospice.

(2) Is not receiving services in an RHC, FQHC or ESRD dialysis facility.

[66 FR 55332, Nov. 1, 2001]
§ 414.65 Payment for telehealth services.

(a) Professional service. Medicare payment for the professional service via an interactive telecommunications system is made according to the following limitations:

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth subsequent hospital care service every 3 days), subsequent nursing facility care services (not including the Federally-mandated periodic visits under § 483.40(c) and with the limitation of one telehealth nursing facility care service every 30 days), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one “hands on” visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training (DSMT) services (except for 1 hour of in-person DSMT services to be furnished in the year following the initial DSMT service to ensure effective injection training), and individual and group health and behavior assessment and intervention furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(2) Only the physician or practitioner at the distant site may bill and receive payment for the professional service via an interactive telecommunications system.

(3) Payments made to the physician or practitioner at the distant site, including deductible and coinsurance, for the professional service may not be shared with the referring practitioner or telepresenter.

(b) Originating site facility fee. For telehealth services furnished on or after October 1, 2001:

(1) For services furnished on or after October 1, 2001 through December 31, 2002, the payment amount to the originating site is the lesser of the actual charge or the originating site facility fee of $20. For services furnished on or after January 1 of each subsequent year, the facility fee for the originating site will be updated by the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act.

(2) Only the originating site may bill for the originating site facility fee and only on an assignment-related basis. The distant site physician or practitioner may not bill for or receive payment for facility fees associated with the professional service furnished via an interactive telecommunications system.

(c) Deductible and coinsurance apply. The payment for the professional service and originating site facility fee is subject to the coinsurance and deductible requirements of sections 1833(a)(1) and (b) of the Act.

(d) Assignment required for physicians, practitioners, and originating sites. Payment to physicians, practitioners, and originating sites is made only on an assignment-related basis.

(e) Sanctions. A distant site practitioner or originating site facility may be subject to the applicable sanctions provided for in chapter IV, part 402 and chapter V, parts 1001, 1002, and 1003 of this title if he or she does any of the following:

(1) Knowingly and willfully bills or collects for services in violation of the limitation of this section.

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service in an amount that does not exceed the limiting charge for
§ 414.66 Incentive payments for physician scarcity areas.

(a) Definition. As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians’ services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

§ 414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) Health Professional Shortage Area (HPSA) physician bonus program. A HPSA, physician incentive payment will be made subject to the following:

1. HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

2. HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

3. Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

4. Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are included must use the AQ modifier to receive the HPSA physician bonus payment.

(b) HPSA surgical incentive payment program. A HPSA surgical incentive payment will be made subject to the following:

1. A major surgical procedure as defined in § 414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

2. Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (b)(1) of this section, in addition to the amount the physician would otherwise be paid.

3. Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made should report HCPCS modifier -AQ to receive the HPSA surgical incentive payment.
(4) The payment described in paragraph (b)(2) of this section is made to the surgeon or, where the surgeon has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

[75 FR 73617, Nov. 29, 2010]

§ 414.68 Imaging accreditation.

(a) Scope and purpose. Section 1834(e) of the Act requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) Definitions. As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.
(ii) Computed tomography.
(iii) Nuclear medicine.
(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act.

(c) Application and reapplication procedures for accreditation organizations. An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(i) A detailed description of how the organization’s accreditation criteria satisfy the statutory standards authorized by section 1834(e)(3) of the Act, specifically—

(ii) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(iii) Qualifications and responsibilities of medical directors and supervising physicians (who may be the same person), such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iv) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier, including a thorough evaluation of equipment performance and safety;

(v) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

(vi) Procedures to assist the beneficiary in obtaining the beneficiary’s imaging records on request; and

(vii) Procedures to notify the accreditation organization of any changes to the modalities subsequent to the organization’s accreditation decision.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements authorized by section 1834(e) of the Act. The accreditation organization must maintain or adopt standards that are equal to, or more stringent than, those of Medicare.

(3) Information that demonstrates the accreditation organization’s knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization’s proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization’s survey process, including the following:

(i) Type and frequency of the surveys performed.
(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organization’s national capacity.

(iii) Description of the organization’s audit procedures, including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance for the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization’s survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for surveys.

(B) The education, employment, and experience requirements surveyors must meet.

(C) The content and length of the orientation program.

(ix) The frequency and types of in-service training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(xi) The policies and procedures regarding an individual’s participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization’s data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization’s procedures for responding to and for the investigation of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization’s policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization’s standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of Medicare facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier’s current accreditation.

(12) A written presentation that demonstrates the organization’s ability to furnish CMS with electronic data in ASCII comparable code.

(13) A resource analysis that demonstrates that the organization’s staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(14) A statement acknowledging that, as a condition for approval of designation, the organization agrees to carry out the following activities:

(i) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(ii) Notify CMS, in writing, of any Medicare supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.
(iii) Notify all accredited suppliers within 10 calendar days of the organization’s removal from the list of designated accreditation organizations.

(iv) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any significant proposed changes in its accreditation requirements.

(v) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(vi) Notify CMS, in writing (electronically or hard copy), within 2 business days of a deficiency identified in any accreditation supplier from any source where the deficiency poses an immediate jeopardy to the supplier’s beneficiaries or a hazard to the general public.

(vii) Provide, on an annual basis, summary data specified by CMS that relates to the past year’s accreditations and trends.

(viii) Attest that the organization will not perform any accreditation surveys of Medicare-participating suppliers with which it has a financial relationship in which it has an interest.

(ix) Conform accreditation requirements to changes in Medicare requirements.

(x) If CMS withdraws an accreditation organization’s approved status, work collaboratively with CMS to direct suppliers to the remaining accreditation organizations within a reasonable period of time.

\(\text{Determination of whether additional information is needed.}\)

If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization’s application for designation, the organization must be notified and afforded an opportunity to provide the additional information.

\(\text{Visits to the organization’s office.}\)

CMS may visit the organization’s offices to verify representations made by the organization in its application, including, but not limited to, reviewing documents and interviewing the organization’s staff.

\(\text{Formal notice from CMS.}\)

The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and re-application procedures.

\(\text{Ongoing responsibilities of a CMS-approved accreditation organization.}\)

An accreditation organization approved by CMS must carry out the following activities on an ongoing basis:

(1) Provide CMS with all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about all accredited suppliers against which the accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier’s accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS’ approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days after a change in CMS requirements, the accreditation organization must submit an acknowledgment of receipt of CMS’ notification to CMS.

(3) The accreditation organization must permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 business days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, the accreditation organization must provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS’ notice to a CMS-approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, the accreditation organization must provide written notice
of the withdrawal to all of the organization’s accredited suppliers.

(6) The organization must provide, on an annual basis, summary data specified by CMS that relate to the past year’s accreditation activities and trends.

(b) Continuing Federal oversight of approved accreditation organizations. This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS-approved accreditation organization.

(1) Validation audits. (i) CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations for the TC of advanced diagnostic imaging services.

(ii) The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards.

(A) When conducted on a representative sample basis, the audit is comprehensive and addresses all of the standards, or may focus on a specific standard in issue.

(B) When conducted in response to an allegation, CMS audits any standards that CMS determines are related to the allegations.

(2) Notice of intent to withdraw approval. (i) If, during the audit specified in paragraph (b)(1) of this section, CMS identifies any accreditation programs for which validation audit results indicate—

(A) A 10 percent or greater rate of disparity between findings by the accreditation organization and findings by CMS on standards that do not constitute immediate jeopardy to patient health and safety if unmet; or

(B) Any disparity between findings by the accreditation organization and findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet; or

(C) Irrespective of the rate of disparity, widespread or systemic problems in an organization’s accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements; then CMS will give the organization written notice of its intent to withdraw approval as specified in paragraph (h)(3) of this section.

(ii) CMS may also provide the organization written notice of its intent to withdraw approval if an equivalency review, onsite observation, or CMS’ daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) Withdrawal of approval. CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(1) Reconsideration. An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsider any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) Filing requirements. (i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time.
before the issuance of a reconsideration determination.

(2) CMS response to a filing request. In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) Hearing requirements and rules. (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(1) Authorized representatives;

(2) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(3) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though such evidence may be inadmissible under the Federal Rules of Civil Procedure.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer’s decision is final.

[74 FR 62006, Nov. 25, 2009]
the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

[75 FR 73617, Nov. 29, 2010]

§ 414.90 Physician Quality Reporting System.

(a) Basis and scope. This section implements the following provisions of the Act:

1. 1848(a)—Payment Based on Fee Schedule.
2. 1848(k)—Quality Reporting System.
3. 1848(m)—Incentive Payments for Quality Reporting.

(b) Definitions. As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Eligible professional means any of the following:

(i) A physician.
(ii) A practitioner described in section 1842(b)(18)(C) of the Act.
(iii) A physical or occupational therapist or a qualified speech-language pathologist.
(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a single Taxpayer Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician’s practice that—

(i) Includes an initial assessment of an eligible professional’s practice that is designed to demonstrate the physician’s use of evidence-based medicine;

(ii) Includes a survey of patient experience with care; and

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of four or more Physician Quality Reporting System measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

Physician Quality Reporting System means the physician reporting system under section 1848(k) of the Act for the reporting by eligible professionals of data on quality measures and the incentive payment associated with this physician reporting system.
Performance rate means the percentage of a defined population who receives a particular process of care or achieve a particular outcome for a particular quality measure.

Reporting rate means the percentage of patients that the eligible professional indicated a quality action was or was not performed divided by the total number of patients in the denominator of the measure.

Qualified registry means a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the Physician Quality Reporting System qualification requirements specified by CMS for that program year. The registry may act as a data submission vendor, which has the requisite legal authority to provide Physician Quality Reporting System data (as specified by CMS) on behalf of an eligible professional to CMS.

Qualified electronic health record product means an electronic health record vendor's product and version that, with respect to a particular program year, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate the product's compliance with the Physician Quality Reporting System qualification requirements specified by CMS for a program year. The requirements and process for an electronic health record product to be qualified for the purpose of the Physician Quality Reporting System is separate from the standards, implementation specifications, and certification criteria established for the EHR Incentive Program specified in part 495.

(c) Incentive payments. With respect to covered professional services furnished during a reporting period by an eligible professional, if—

(1) There are any quality measures that have been established under the Physician Quality Reporting System that are applicable to any such services furnished by such professional (or in the case of a group practice under paragraph (g) of this section, such group practice) for such reporting period; and

(2) The eligible professional (or in the case of a group practice under paragraph (g) of this section, the group practice) successfully submits (as determined under paragraph (f) of this section for eligible professionals and paragraph (g) of this section for group practices) to the Secretary data on such quality measures in accordance with the Physician Quality Reporting System for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act or, in the case of a group practice under paragraph (g) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable quality percent (as specified in paragraph (c)(3) of this section) of the eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (g) of this section, by the group practice) during the applicable reporting period. For purposes of this paragraph,

(i) The eligible professional's (or, in the case of a group practice under paragraph (g) of this section, the group practice's) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (g) of this section, by the group practice) during the applicable reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;

(ii) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately determined for each practice based on claims submitted for the eligible professional for each practice;

(iii) Incentive payments earned by an eligible professional (or in the case of a group practice under paragraph (g) of this section, by a group practice) for a particular program year will be paid as
a single consolidated payment to the TIN holder of record.

(3) Applicable quality percent. The applicable quality percent is as follows:

(i) For 2011, 1.0 percent; and

(ii) For 2012, 2013, and 2014, 0.5 percent.

(d) Additional incentive payment. (1) Through 2014, if an eligible professional meets the requirements described in paragraph (d)(2) of this section, the applicable percent for such year, as described in paragraphs (c)(3)(i) and (ii) of this section, must be increased by 0.5 percentage points.

(2) In order to qualify for the additional incentive payment described in paragraph (d)(1) of this section, an eligible professional must meet the following requirements:

(i) The eligible professional must—

(A) Satisfactorily submit data on quality measures for purposes of this section for a year; and

(B) Have such data submitted on their behalf through a Maintenance of Certification program (as defined in paragraph (b) of this section) that meets:

(1) The criteria for a registry (as specified by CMS); or

(2) An alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(A) Participates in a maintenance of certification program (as defined in paragraph (b) of this section) for a year; and

(B) Successfully completes a qualified maintenance of certification program practice assessment (as defined in paragraph (b) of this section) for such year.

(iii) A Maintenance of Certification Program submits to the Secretary, on behalf of the eligible professional, information—

(A) In a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of paragraph (d)(2)(ii) of this section, which may be in the form of a structural measure;

(B) If requested by the Secretary, on the survey of patient experience with care (as described in paragraph (b) of this section); and

(C) As the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(e) Use of consensus-based quality measures. For each program year, CMS will publish the final list of measures and the final detailed measure specifications for all quality measures selected for inclusion in the Physician Quality Reporting System quality measure set for a given program year on a CMS Web site by no later than December 31 of the prior year.

(1) General rule. Subject to paragraph (e)(2) of this section, for purposes of reporting data on quality measures for covered professional services furnished during a year, subject to paragraph (f) of this section, the quality measures specified under this paragraph must be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act.

(2) Exception. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

(3) Opportunity to provide input on measures. For each quality measure adopted by the Secretary under this paragraph, the Secretary ensures that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of quality measures applicable to services they furnish.

(f) Requirements for individual eligible professionals to qualify to receive an incentive payment. In order to qualify to earn a Physician Quality Reporting System incentive payment for a particular program year, an individual eligible professional, as identified by a
unique TIN/NPI combination, must meet the criteria for satisfactory reporting specified by CMS for such year by reporting on either individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups identified by CMS during a reporting period specified in paragraph (f)(1) of this section and using one of the reporting mechanisms specified in paragraph (f)(2) of this section. Although an eligible professional may attempt to qualify for the Physician Quality Reporting System incentive payment by reporting on both individual Physician Quality Reporting System quality measures and measures groups, using more than one reporting mechanism (as specified in paragraph (f)(2) of this section), or reporting for more than one reporting period, he or she will receive only one Physician Quality Reporting System incentive payment per TIN/NPI combination for a program year.

(i) Reporting periods. For purposes of this paragraph, the reporting period with respect to program year 2011 is—

(i) The 12-month period from January 1 through December 31 of such program year; or

(ii) The 6-month period from July 1 through December 31 of such program year.

(2) Exceptions. In program year 2011, the 6-month reporting period is not available for EHR-based reporting of individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(3) Reporting mechanisms. For program year 2011, an eligible professional who wishes to participate in the Physician Quality Reporting System must report information on the individual Physician Quality Reporting System quality measures or for reporting by group practices under the process described in paragraph (g) of this section.

(i) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional’s Medicare Part B claims for covered professional services furnished during the applicable reporting period.

(ii) Reporting the individual Physician Quality Reporting System quality measures or Physician Quality Reporting System measures groups to a qualified registry (as specified in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the applicable reporting period to CMS on the eligible professional’s behalf; or

(iii) Reporting the individual Physician Quality Reporting System quality measures to CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified EHR product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the applicable reporting period. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified EHR product selected by the eligible professional using a secure data submission method, as required by CMS.

(g) Requirements for group practices to qualify to receive an incentive payment. A group practice (as defined in paragraph (b) of this section) will be treated as satisfactorily submitting data on quality measures under Physician Quality Reporting System for covered professional services for a reporting period, if, in lieu of reporting Physician Quality Reporting System measures, the group practice—

(1) Meets the participation requirements specified by CMS for the Physician Quality Reporting System group practice reporting option or is a group practice of any size (including solo practitioners) or comprised of multiple TINs participating in a Medicare approved demonstration project that is
§414.92

42 CFR Ch. IV (10–1–11 Edition)

(1) The determination of measures applicable to services furnished by eligible professionals under the Physician Quality Reporting System;
(2) The determination of the payment limitation; and
(3) The determination of any Physician Quality Reporting System incentive payment and the Physician Quality Reporting System payment adjustment.

(i) Informal review. Eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) may seek an informal review of the determination that an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) did not satisfactorily submit data on quality measures under the Physician Quality Reporting System.

(1) To request an informal review, an eligible professional (or in the case of reporting under paragraph (g) of this section, group practices) must submit a request to CMS within 90 days of the release of the feedback reports. The request must be submitted in writing or via e-mail and summarize the concern(s) and reasons for requesting an informal review and may also include information to assist in the review.

(2) CMS will provide a written response within 60 days of the receipt of the original request.

(i) All decisions based on the informal review will be final.

(ii) There will be no further review or appeal.

(j) Public reporting of an eligible professional’s or group practice’s Physician Quality Reporting System data. For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (g) of this section, group practices) who satisfactorily submitted Physician Quality Reporting System quality measures.

(75 FR 73617, Nov. 29, 2010)

§414.92 Electronic Prescribing Incentive Program.

(a) Basis and scope. This section implements the following provisions of the Act:
(1) Section 1848(a)—Payment Based on Fee Schedule.
(2) Section 1848(m)—Incentive Payments for Quality Reporting.

(b) Definitions. As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule which are furnished by an eligible professional.

Electronic Prescribing Incentive Program means the incentive payment program established under section 1848(m) of the Act for the adoption and use of electronic prescribing technology by eligible professionals.

Eligible professional means any of the following healthcare professionals who have prescribing authority:

(i) A physician.
(ii) A practitioner described in section 1842(b)(18)(C) of the Act.
(iii) A physical or occupational therapist or a qualified speech-language pathologist.
(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a group practice that is—

(i) Defined at § 414.90(b), that is participating in the Physician Quality Reporting System; or
(ii) (A) In a Medicare approved demonstration project that is deemed to be participating in the Physician Quality Reporting System group practice reporting option; and
(B) Has indicated its desire to participate in the electronic prescribing group practice option.

Qualified electronic health record product means an electronic health record product and version that, with respect to a particular program year, is designated by CMS as a qualified electronic health record product for the purpose of the Physician Quality Reporting System (as described in § 414.90) and the product’s vendor has indicated a desire to have the product qualified for purposes of the product’s users to submit information related to the electronic prescribing measure.

Qualified registry means a medical registry or a Maintenance of Certification Program operated by a specialty body of the American Board of Medical Specialties that, with respect to a particular program year, is designated by CMS as a qualified registry for the purpose of the Physician Quality Reporting System (as described in § 414.90) and that has indicated its desire to be qualified to submit the electronic prescribing measure on behalf of eligible professionals for the purposes of the Electronic Prescribing Incentive Program.

(c) Incentive payments and payment adjustments. (1) Incentive payments. Subject to paragraph (c)(3) of this section, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under section 1848 of the Act, there also must be paid to the eligible professional (or to an employer or facility in the cases described in section 1842(b)(6)(A) of the Act) or, in the case of a group practice under paragraph (e) of this section, to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Act an amount equal to the applicable electronic prescribing percent (as specified in paragraph (c)(1)(ii) of this section) of the eligible professional’s (or, in the case of a group practice under paragraph (e) of this section, the group practice’s) total estimated allowed charges for all covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (e) of this section, by the group practice) during the applicable reporting period.

(i) For purposes of paragraph (c)(1) of this section,
(A) The eligible professional’s (or, in the case of a group practice under paragraph (e) of this section, the group practice’s) total estimated allowed charges for covered professional services furnished during a reporting period are determined based on claims processed in the National Claims History (NCH) no later than 2 months after the end of the applicable reporting period;
(B) In the case of an eligible professional who furnishes covered professional services in more than one practice, incentive payments are separately
§414.92  Incentive payments for electronic prescribing

(d) Requirements for individual eligible professionals to qualify to receive an incentive payment. In order to be considered a successful electronic prescriber and qualify to earn an electronic prescribing incentive payment (subject to paragraph (c)(3) of this section), an individual eligible professional, as identified by a unique TIN/NPI combination, must meet the criteria for successful electronic prescriber under paragraph 1848(m)(3)(B) of the Act and as specified by CMS during the reporting period specified in paragraph (d)(1) of this section and using one of the reporting mechanisms specified in paragraph (d)(2) of this section. Although an eligible professional may attempt to qualify for the electronic prescribing incentive payment using more than one reporting mechanism (as specified in paragraph (d)(2) of this section), the eligible professional will receive only one electronic prescribing incentive payment per TIN/NPI combination for a program year.

42 CFR Ch. IV (10–1–11 Edition)
Centers for Medicare & Medicaid Services, HHS \section*{§414.92}

(1) \textbf{Reporting period.} For purposes of this paragraph in 2011, the reporting period with respect to a program year is the entire calendar year.

(2) \textbf{Reporting mechanisms.} For program year 2011, an eligible professional who wishes to participate in the Electronic Prescribing Incentive Program must report information on the electronic prescribing measure identified by CMS to—

(i) CMS, by no later than 2 months after the end of the applicable reporting period, on the eligible professional's Medicare Part B claims for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section;

(ii) A qualified registry (as defined in paragraph (b) of this section) in the form and manner and by the deadline specified by the qualified registry selected by the eligible professional. The selected qualified registry will submit information, as required by CMS, for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section to CMS on the eligible professional's behalf; or

(iii) CMS by extracting clinical data using a secure data submission method, as required by CMS, from a qualified electronic health record product (as defined in paragraph (b) of this section) by the deadline specified by CMS for covered professional services furnished by the eligible professional during the reporting period specified in paragraph (d)(1) of this section. Prior to actual data submission for a given program year and by a date specified by CMS, the eligible professional must submit a test file containing real or dummy clinical quality data extracted from the qualified electronic health record product selected by the eligible professional using a secure data submission method, as required by CMS.

(e) \textbf{Requirements for group practices to qualify to receive an incentive payment.} (1) A group practice (as defined in paragraph (b) of this section) will be treated as a successful electronic prescriber for covered professional services for a reporting period if the group practice meets the criteria for successful electronic prescriber specified by CMS in the form and manner and at the time specified by CMS.

(2) \textbf{No double payments.} Payments to a group practice under this paragraph must be in lieu of the payments that would otherwise be made under the Electronic Prescribing Incentive Program to eligible professionals in the group practice for being a successful electronic prescriber.

(i) If an eligible professional, as identified by an individual NPI, has reassigned his or her Medicare billing rights to a TIN selected to participate in the electronic prescribing group practice reporting option for a program year, then for that program year the eligible professional must participate in the Electronic Prescribing Incentive Program via the group practice reporting option. For any program year in which the TIN is selected to participate in the Electronic Prescribing Incentive Program group practice reporting option, the eligible professional cannot individually qualify for an electronic prescribing incentive payment by meeting the requirements specified in paragraph (d) of this section.

(ii) If, for the program year, the eligible professional participates in the Electronic Prescribing Incentive Program under another TIN that is not selected to participate in the Electronic Prescribing Incentive Program group practice reporting option for that program year, then the eligible professional may individually qualify for an electronic prescribing incentive by meeting the requirements specified in paragraph (d) of this section under that TIN.

(f) \textbf{Public reporting of an eligible professional's or group practice's Electronic Prescribing Incentive Program data.} For each program year, CMS will post on a public Web site, in an easily understandable format, a list of the names of eligible professionals (or in the case of reporting under paragraph (e) of this section, group practices) who are successful electronic prescribers.

[75 FR 73620, Nov. 29, 2010]

\textbf{Effective Date Note:} At 76 FR 54968, Sept. 6, 2011, §414.92 was amended by revising paragraph (c)(2)(ii), effective October 6, 2011. For the convenience of the user, the revised text is set forth as follows:
§ 414.100

§ 414.92 Electronic Prescribing Incentive Program.

* * * * *

(c) * * *

(2) * * *

(ii) Significant hardship exception. CMS may, on a case-by-case basis, exempt an eligible professional (or in the case of a group practice under paragraph (e) of this section, a group practice) from the application of the payment adjustment under paragraph (c)(2) of this section if, CMS determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship. Eligible professionals (or, in the case of a group practice under paragraph (e) of this section, a group practice) may request consideration for a significant hardship exemption from the 2012 eRx payment adjustment if one of the following circumstances apply:

(A) The practice is located in a rural area without high speed internet access.

(B) The practice is located in an area without sufficient available pharmacies for electronic prescribing.

(C) Registration to participate in the Medicare or Medicaid EHR Incentive Program and adoption of Certified EHR Technology.

(D) Inability to electronically prescribe due to local, State or Federal law or regulation.

(E) Limited prescribing activity.

(F) Insufficient opportunities to report the eRx measure due to limitations of the measure’s denominator.

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Subpart C—Fee Schedules for Parenteral and Enteral Nutrition (PEN) Nutrients, Equipment and Supplies

Source: 66 FR 45176, Aug. 28, 2001, unless otherwise noted.

§ 414.100 Purpose.

This subpart implements fee schedules for PEN items and services as authorized by section 1842(s) of the Act.

§ 414.102 General payment rules.

(a) General rule. For items and services furnished on or after January 1, 2002, Medicare pays for the items and services as described in paragraph (b) of this section on the basis of 80 percent of the lesser of—

(1) The actual charge for the item or service; or

(b) The fee schedule amount for the item or service, as determined in accordance with §414.104.

(b) Payment classification. (1) CMS or the carrier determines fee schedules for Parenteral and enteral nutrition (PEN) nutrients, equipment, and supplies, as specified in §414.104.

(2) CMS designates the specific items and services in each category through program instructions.

(c) Updating the fee schedule amounts. For each year subsequent to 2002, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI-U for the 12-month period ending with June of the preceding year.

§ 414.104 PEN Items and Services.

(a) Payment rules. Payment for PEN items and services is made in a lump sum for nutrients and supplies that are purchased and on a monthly basis for equipment that is rented.

(b) Fee schedule amount. The fee schedule amount for payment for an item or service furnished in 2002 is the lesser of—

(i) The reasonable charge from 1995; or

(ii) The reasonable charge that would have been used in determining payment for 2002.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

§ 414.200 Purpose.

This subpart implements sections 1834 (a) and (h) of the Act by specifying how payments are made for the purchase or rental of new and used durable medical equipment and prosthetic and orthotic devices for Medicare beneficiaries.

[57 FR 57689, Dec. 7, 1992]

§ 414.202 Definitions.

For purposes of this subpart, the following definitions apply:

Complex rehabilitative power-driven wheelchair means a power-driven wheelchair that is classified as—

(1) Group 2 power wheelchair with power options that can accommodate