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changes from one stationary oxygen equipment modality to another or from one portable oxygen equipment modality to another.

(g) New supplier. If a beneficiary changes suppliers, a new period of continuous use does not begin.

(h) Oxygen equipment furnished after the 36-month rental period. A new period of continuous use does not begin under any circumstance in the case of oxygen equipment furnished after the 36-month rental period in accordance with §414.226(f) until the end of the reasonable useful lifetime established for such equipment in accordance with §414.210(f).

§ 414.232 Special payment rules for transcutaneous electrical nerve stimulators (TENS).

(a) General payment rule. Except as provided in paragraph (b) of this section, payment for TENS is made on a purchase basis with the purchase price determined using the methodology for purchase of inexpensive or routinely purchased items as described in §414.220. The payment amount for TENS computed under §414.220(c)(2) is reduced according to the following formula:

1. Effective April 1, 1990—the original payment amount is reduced by 15 percent.

2. Effective January 1, 1991—the reduced payment amount in paragraph (a)(1) is reduced by 15 percent.

3. Effective January 1, 1994—the reduced payment amount in paragraph (a)(1) is reduced by 45 percent.

(b) Exception. In order to permit an attending physician time to determine whether the purchase of the TENS is medically appropriate for a particular patient, two months of rental payments may be made in addition to the purchase price. The rental payments are equal to 10 percent of the purchase price.

[57 FR 57962, Dec. 7, 1992, as amended at 60 FR 35986, July 10, 1995]
Administrative services are physician services that are differentiated from routine professional services and other physician services because they are supervision, as described in the definition of “supervision of staff” of this section, or are not related directly to the care of an individual patient, but are supportive of the facility as a whole and of benefit to patients in general. Examples of administrative services include supervision of staff, staff training, participation in staff conferences and in the management of the facility, and advising staff on the procurement of supplies.

Dialysis session is the period of time that begins when the patient arrives at the facility and ends when the patient departs from the facility. In the case of home dialysis, the period begins when the patient prepares for dialysis and generally ends when the patient is disconnected from the machine. In this context, a dialysis facility includes only those parts of the building used as a facility. It does not include any areas used as a physician’s office.

Medical direction, in contrast to supervision of staff, is a routine professional service that entails substantial direct involvement and the physical presence of the physician in the delivery of services directly to the patient. Routine professional services include all physicians’ services furnished during a dialysis session and all services listed in paragraph (d) of this section that meet the following requirements:

1. They are personally furnished by a physician to an individual patient.
2. They contribute directly to the diagnosis or treatment of an individual patient.
3. They ordinarily must be performed by a physician.

Supervision of staff, in contrast to medical direction, is an administrative service that does not necessarily require the physician to be present at the dialysis session. It is a general activity primarily concerned with monitoring performance of and giving guidance to other health care personnel (such as nurses and dialysis technicians) who deliver services to patients.

Dialysis facility includes only those parts of the building used as a facility. It does not include any areas used as a physician’s office.

Medical direction, in contrast to supervision of staff, is a routine professional service that entails substantial direct involvement and the physical presence of the physician in the delivery of services directly to the patient. Routine professional services include all physicians’ services furnished during a dialysis session and all services listed in paragraph (d) of this section that meet the following requirements:

1. They are personally furnished by a physician to an individual patient.
2. They contribute directly to the diagnosis or treatment of an individual patient.
3. They ordinarily must be performed by a physician.

Supervision of staff, in contrast to medical direction, is an administrative service that does not necessarily require the physician to be present at the dialysis session. It is a general activity primarily concerned with monitoring performance of and giving guidance to other health care personnel (such as nurses and dialysis technicians) who deliver services to patients.

(d) Types of routine professional services. Routine professional services include at least all of the following services when medically appropriate:

1. Visits to the patient during dialysis, and review of laboratory test results, nurses’ notes and any other medical documentation, as a basis for—
   (i) Adjustment of the patient’s medication or diet, or the dialysis procedure;
   (ii) Prescription of medical supplies; and
   (iii) Evaluation of the patient’s psychosocial status and the appropriateness of the treatment modality.
2. Medical direction of staff in delivering services to a patient during a dialysis session.
3. Pre-dialysis and post-dialysis examinations, or examinations that could have been furnished on a pre-dialysis or post-dialysis basis.
4. Insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters.

(e) Payment for routine professional services. Beginning August 7, 1990, routine professional services furnished by physicians may be paid under either the “initial method” of payment described in §414.313, (if all of the physicians at the facility elect the initial method) or under the “physician MCP method” described in §414.314. Physician services furnished after July 31, 1983 and before August 6, 1990, are payable only under the MCP method described in §414.314.

§ 414.313 Initial method of payment.

(a) Basic rule. Under this method, the intermediary pays the facility for routine professional services furnished by physicians. Payment is in the form of an add-on to the facility’s composite rate payment, which is described in part 413, subpart H of this subchapter.

(b) Services for which payment is not included in the add-on payment. (1) Physician administrative services are considered to be facility services and are paid for as part of the facility’s composite rate.

2. The carrier pays the physician or the beneficiary (as appropriate) under the reasonable charge criteria set forth in subpart E of part 405 of this chapter for the following services:

1. Physician services that must be furnished at a time other than during
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the dialysis session (excluding pre-dialysis and post-dialysis examinations and examinations that could have been furnished on a pre-dialysis or post-dialysis basis), such as monthly and semi-annual examinations to review health status and treatment.

(ii) Physician surgical services other than insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters.

(iii) Physician services furnished to hospital inpatients who were not admitted solely to receive maintenance dialysis.

(iv) Administration of hepatitis B vaccine.

(c) Physician election of the initial method. (1) Each physician in a facility must submit to the appropriate carrier and intermediary that serve the facility a statement of election of the initial method of payment for all the ESRD facility patients that he or she attends.

(2) The initial method of payment applies to dialysis services furnished beginning with the second calendar month after the month in which all physicians in the facility elect the initial method and continues until the effective date of a termination of the election described in paragraph (d) of this section.

(d) Termination of the initial method. (1) Physicians may terminate the initial method of payment by written notice to the carrier(s) that serve each physician and to the intermediary that serves the facility.

(2) If the notice terminating the initial method is received by the carrier(s) and intermediary—

(i) On or before November 1, the effective date of the termination is January 1 of the following calendar year in which the termination notice is received by the carrier(s) and intermediary; or

(ii) After November 1, the effective date of the termination is January 1 of the second year after the calendar year in which the notice is received by the carrier(s) and intermediary.

(e) Determination of payment amount. The factors used in determining the add-on amount are related to program experience. They are re-evaluated periodically and may be adjusted, as determined necessary by CMS, to maintain the payment at a level commensurate with the prevailing charges of other physicians for comparable services.

(f) Publication of payment amount. Revisions to the add-on amounts are published in the FEDERAL REGISTER in accordance with the Department’s established rulemaking procedures.


§414.314 Monthly capitation payment method.

(a) Basic rules. (1) Under the monthly capitation payment (MCP) method, the carrier pays an MCP amount for each patient, to cover all professional services furnished by the physician, except those listed in paragraph (b) of this section.

(2) The carrier pays the MCP amount, subject to the deductible and coinsurance provisions, either to the physician if the physician accepts assignment or to the beneficiary if the physician does not accept assignment.

(3) The MCP method recognizes the need of maintenance dialysis patients for physician services furnished periodically over relatively long periods of time, and the capitation amounts are consistent with physicians’ charging patterns in their localities.

(4) Payment of the capitation amount for any particular month is contingent upon the physician furnishing to the patient all physician services required by the patient during the month, except those listed in paragraph (b) of this section.

(5) Payment for physician administrative services (§414.310) is made to the dialysis facility as part of the facility’s composite rate (part 413, subpart H of this subchapter) and not to the physician under the MCP.

(b) Services not included in the MCP. (1) Services that are not included in the MCP and which may be paid in accordance with the reasonable charge rules set forth in subpart E of part 405 of this chapter are limited to the following:

(i) Administration of hepatitis B vaccine.

(ii) Covered physician services furnished by another physician when the patient is not available to receive, or
§ 414.320 Determination of reasonable charges for physician renal transplantation services.

(a) Comprehensive payment for services furnished during a 60-day period. (1) The comprehensive payment is subject to the deductible and coinsurance provisions and is for all surgeon services furnished during a period of 60 days in connection with a renal transplantation, including the usual preoperative and postoperative care, and for immunosuppressant therapy if supervised by the transplant surgeon.

(2) Additional sums, in amounts established on the basis of program experience, may be included in the comprehensive payment for other surgery performed concurrently with the transplant operation.

(3) The amount of the comprehensive payment may not exceed the lower of the following:

(i) The actual charges made for the services.

(ii) Overall national payment levels established under the ESRD program and adjusted to give effect to variations in physician’s charges throughout the nation. (These adjusted amounts are the maximum allowances in a carrier’s service area for renal transplantation surgery and related services by surgeons.)

(4) Maximum allowances computed under these instructions are revised at the beginning of each calendar year to

§ 414.316 Payment for physician services to patients in training for self-dialysis and home dialysis.

(a) For each patient, the carrier pays a flat amount that covers all physician services required to create the capacity for self-dialysis and home dialysis.

(b) CMS determines the amount on the basis of program experience and reviews it periodically.

(c) The payment is made at the end of the training course, is subject to the deductible and coinsurance provisions, and is in addition to any amounts payable under the initial or MCP methods set forth in § 414.313 and 414.314, respectively.

(d) If the training is not completed, the payment amount is proportionate to the time spent in training.

§ 414.316 Payment for physician services to patients in training for self-dialysis and home dialysis.

(a) For each patient, the carrier pays a flat amount that covers all physician services required to create the capacity for self-dialysis and home dialysis.

(b) CMS determines the amount on the basis of program experience and reviews it periodically.

(c) The payment is made at the end of the training course, is subject to the deductible and coinsurance provisions, and is in addition to any amounts payable under the initial or MCP methods set forth in § 414.313 and 414.314, respectively.

(d) If the training is not completed, the payment amount is proportionate to the time spent in training.

§ 414.320 Determination of reasonable charges for physician renal transplantation services.

(a) Comprehensive payment for services furnished during a 60-day period. (1) The comprehensive payment is subject to the deductible and coinsurance provisions and is for all surgeon services furnished during a period of 60 days in connection with a renal transplantation, including the usual preoperative and postoperative care, and for immunosuppressant therapy if supervised by the transplant surgeon.

(2) Additional sums, in amounts established on the basis of program experience, may be included in the comprehensive payment for other surgery performed concurrently with the transplant operation.

(3) The amount of the comprehensive payment may not exceed the lower of the following:

(i) The actual charges made for the services.

(ii) Overall national payment levels established under the ESRD program and adjusted to give effect to variations in physician’s charges throughout the nation. (These adjusted amounts are the maximum allowances in a carrier’s service area for renal transplantation surgery and related services by surgeons.)

(4) Maximum allowances computed under these instructions are revised at the beginning of each calendar year to

the attending physician is not available to furnish the outpatient services as usual (see paragraph (b)(3) of this section).

(iii) Covered physician services furnished to hospital inpatients, including services related to inpatient dialysis, by a physician who elects not to continue to receive the MCP during the period of inpatient stay.

(iv) Surgical services, including declotting of shunts, other than the insertion of catheters for patients on maintenance peritoneal dialysis who do not have indwelling catheters.

(v) Needed physician services that are—

(A) Furnished by the physician furnishing renal care or by another physician;

(B) Not related to the treatment of the patient’s renal condition; and

(C) Not furnished during a dialysis session or an office visit required because of the patient’s renal condition.

(2) For the services described in paragraph (b)(1)(v) of this section, the following rules apply:

(i) The physician must provide documentation to show that the services are not related to the treatment of the patient’s renal condition and that additional visits are required.

(ii) The carrier’s medical staff, acting on the basis of the documentation and appropriate medical consultation obtained by the carrier, determines whether additional payment for the additional services is warranted.

(3) The MCP is reduced in proportion to the number of days the patient is—

(i) Hospitalized and the physician elects to bill separately for services furnished during hospitalization; or

(ii) Not attended by the physician or his or her substitute for any reason, including when the physician is not available to furnish patient care or when the patient is not available to receive care.

(c) Determination of payment amount. The amount of payment for the MCP is determined under the Medicare physician fee schedule described in this part 414.

§ 414.330 Payment for home dialysis equipment, supplies, and support services.

(a) Equipment and supplies—(1) Basic rule. Except as provided in paragraph (a)(2) of this section, Medicare pays for home dialysis equipment and supplies only under the prospective payment rates established at § 413.210.

(2) Exception for equipment and supplies furnished prior to January 1, 2011. If the conditions in subparagraphs (a)(2) (i) through (iv) of this section are met, Medicare pays for home analysis equipment and supplies on a reasonable charge basis in accordance with part 405, but the amount of payment may not exceed the limit for equipment and supplies in paragraph (c)(2) of this section.

(i) The patient elects to obtain home dialysis equipment and supplies from a supplier that is not a Medicare approved dialysis facility.

(ii) The patient certifies to CMS that he or she has only one supplier for all home dialysis equipment and supplies. This certification is made on Form 382 (the “ESRD Beneficiary Selection” form).

(iii) In writing, the supplier—

(A) Agrees to receive Medicare payment for home dialysis supplies and equipment only on an assignment-related basis; and

(B) Certifies to CMS that it has a written agreement with one Medicare approved dialysis facility or, if the beneficiary is also entitled to military or veteran’s benefits, one military or Veterans Administration hospital, for each patient. (See part 494 of this chapter for the requirements for a Medicare approved dialysis facility.) Under the agreement, the facility or military or VA hospital agrees to the following:

(1) To furnish all home dialysis support services for each patient in accordance with part 494 (Conditions for Coverage for End-Stage Renal Disease Facilities) of this chapter. (§ 410.52 sets forth the scope and conditions for Medicare Part B coverage of home dialysis services, supplies, and equipment.)

(2) To furnish institutional dialysis services and supplies. (§ 410.50 sets forth the scope and conditions for Medicare Part B coverage of institutional dialysis services and supplies.)

(3) To furnish dialysis-related emergency services.

(4) To arrange for a Medicare approved laboratory to perform dialysis-related laboratory tests that are covered under the composite rate established at § 413.170 and to arrange for the laboratory to seek payment from the facility. The facility then includes these laboratory services in its claim for payment for home dialysis support services.

(5) To arrange for a Medicare approved laboratory to perform dialysis-related laboratory tests that are not covered under the composite rate established at § 413.170 and for which the laboratory files a Medicare claim directly.

(6) To furnish all other necessary dialysis services and supplies (that is, those which are not home dialysis equipment and supplies).

(7) To satisfy all documentation, recordkeeping and reporting requirements in part 494 (Conditions for Coverage for End-Stage Renal Disease Facilities) of this chapter. This includes maintaining
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a complete medical record of ESRD-related items and services furnished by other parties. The facility must report, on the forms required by CMS or the ESRD network, all data for each patient in accordance with subpart U.

(iv) The facility with which the agreement is made must be located within a reasonable distance from the patient’s home (that is, located so that the facility can actually furnish the needed services in a practical and timely manner, taking into account variables like the terrain, whether the patient’s home is located in an urban or rural area, the availability of transportation, and the usual distances traveled by patients in the area to obtain health care services).

(C) Agrees to report to the ESRD facility providing support services, at least every 45 days, all data (meaning information showing what supplies and services were provided to the patient and when each was provided) for each patient regarding services and items furnished to the patient in accordance with §494.100(c)(2) of this chapter.

(b) Support services—(1) Basic rule. Except as provided in paragraph (b)(2) of this section, Medicare pays for support services only under the prospective payment rates established in §413.210 of this chapter.

(2) Exception for home support services furnished prior to January 1, 2011. If the patient elects to obtain home dialysis equipment and supplies from a supplier that is not an approved ESRD facility, Medicare pays for support services other than support services furnished by military or VA hospitals referred to in paragraph (a)(2)(i)(B) of this section, under paragraphs (b)(2)(i) and (ii) of this section but in no case may the amount of payment exceed the limit for support services in paragraph (c)(1) of this section:

(i) For support services furnished by a hospital-based ESRD facility, Medicare pays on a reasonable cost basis in accordance with part 413 of this chapter.

(ii) For support services furnished by an independent ESRD facility, Medicare pays on the basis of reasonable charges that are related to costs and allowances that are reasonable when the services are furnished in an effective and economical manner.

(c) Payment limits for support services, equipment and supplies, and notification of changes to the payment limits apply prior to January 1, 2011 as follows:

(1) Support services. The amount of payment for home dialysis support services is limited to the national average Medicare-allowed charge per patient per month for home dialysis support services, as determined by CMS, plus the median cost per treatment for all dialysis facilities for laboratory tests included under the composite rate, as determined by CMS, multiplied by the national average number of treatments per month.

(2) Equipment and supplies. Payment for home dialysis equipment and supplies is limited to an amount equal to the result obtained by subtracting the support services payment limit in paragraph (c)(1) of this section from the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent) of the national median payment as determined by CMS that would have been made under the prospective payment rates established in §413.170 of this chapter for hospital-based facilities.

(3) Notification of changes to the payment limits. Updated data are incorporated into the payment limits when the prospective payment rates established at §413.170 of this chapter are updated, and changes are announced by notice in the FEDERAL REGISTER without a public comment period. Revisions of the methodology for determining the limits are published in the FEDERAL REGISTER in accordance with the Department’s established rulemaking procedures. [57 FR 54187, Nov. 17, 1992, as amended at 73 FR 20474, Apr. 15, 2008; 75 FR 49202, Aug. 12, 2010]

§ 414.335 Payment for EPO furnished to a home dialysis patient for use in the home.

(a) Prior to January 1, 2011, payment for EPO used at home by a home dialysis patient is made only to either a Medicare approved ESRD facility or a supplier of home dialysis equipment and supplies. Effective January 1, 2011, payment for EPO used at home by a
§ 414.400 Purpose and basis.

This subpart implements competitive bidding programs for certain DMEPOS items as required by sections 1847(a) and (b) of the Act.

[72 FR 18084, Apr. 10, 2007]

§ 414.402 Definitions.

For purposes of this subpart, the following definitions apply:

Affected party means a contract supplier that has been notified that their DMEPOS CBP contract will be terminated for a breach of contract.

Bid means an offer to furnish an item for a particular price and time period that includes, where appropriate, any services that are directly related to the furnishing of the item.

Breach of contract means any deviation from contract requirements, including a failure to comply with a governmental agency or licensing organization requirements, constitutes a breach of contract.

Competitive bidding area (CBA) means an area established by the Secretary under this subpart.

Competitive bidding program means a program established under this subpart within a designated CBA.

Composite bid means the sum of a supplier’s weighted bids for all items within a product category for purposes of allowing a comparison across bidding suppliers.

Contract supplier means an entity that is awarded a contract by CMS to furnish items under a competitive bidding program.

Corrective action plan (CAP) means a contract supplier’s written document with supporting information that describes the actions the contract supplier will take within a specified timeframe to remedy a breach of contract.

Covered document means a financial, tax, or other document required to be submitted by a bidder as part of an original bid submission under a competitive acquisition program in order to meet the required financial standards.

Covered document review date means the later of—

(1) The date that is 30 days before the final date for the closing of the bid window; or

(2) The date that is 30 days after the opening of the bid window.

DMEPOS stands for durable medical equipment, prosthetics, orthotics, and supplies.

Grandfathered item means all rented items within a product category for which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220 of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

Grandfathered supplier means a non-contract supplier that chooses to continue to furnish grandfathered items to a beneficiary in a CBA.

Hospital has the same meaning as in section 1861(e) of the Act.