§ 405.500 Basis.

Subpart E is based on the provisions of the following sections of the Act: Section 1814(b) provides for Part A payment on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1832 establishes the scope of benefits provided under the Part B supplementary medical insurance program. Section 1833(a) sets forth the amounts of payment for supplementary medical insurance services on the basis of the lesser of a provider's reasonable costs or customary charges. Section 1834(a) specifies how payments are made for the purchase or rental of new and used durable medical equipment for Medicare beneficiaries. Section 1834(b) provides for payment for radiologist services on a fee schedule basis. Section 1834(c) provides for payments and standards for screening mammography. Section 1842(b) sets forth the provisions for a carrier to enter into a contract with the Secretary and to make determinations with respect to Part B claims. Section 1842(h) sets forth the requirements for a physician or supplier to voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. Section 1842(i) sets forth the provisions for the payment of Part B claims. Section 1848 establishes a fee schedule for payment of physician services. Section 1861(b) sets forth the inpatient hospital services covered by the Medicare program. Section 1861(s) sets forth medical and other health services covered by the Medicare program. Section 1861(v) sets forth the general authority under which CMS may establish limits on provider costs recognized as reasonable in determining Medicare program payments. Section 1861(aa) sets forth the rural health clinic services and Federally qualified health center services covered by the Medicare program. Section 1861(jj) defines the term ''covered osteoporosis drug.'' Section 1862(a)(14) lists services that are excluded from coverage. Section 1866(a) specifies the terms for provider agreements. Section 1881 authorizes special rules for the coverage of and payment for services furnished to patients with end-stage renal disease. Section 1886 sets forth the requirements for payment to hospitals for inpatient hospital services. Section 1887 sets forth requirements for payment of provider-based physicians and payment under certain percentage arrangements. Section 1889 provides for Medicare and Medigap information by telephone.

[60 FR 63175, Dec. 8, 1995]

§ 405.501 Determination of reasonable charges.

(a) Except as specified in paragraphs (b), (c), and (d) of this section, Medicare pays no more for Part B medical and other health services than the ''reasonable charge'' for such service. The reasonable charge is determined by the carriers (subject to any deductible and coinsurance amounts as specified in §§ 410.152 and 410.160 of this chapter).

(b) Part B of Medicare pays on the basis of ''reasonable cost'' (see part 413 of this chapter) for certain institutional services, certain services furnished under arrangements with institutions, and services furnished by entities that elect to be paid on a cost basis (including health maintenance organizations, rural health clinics, FQHCs that are authorized to bill under a reasonable cost system, and end-stage renal disease facilities).

(c) Carriers will determine the reasonable charge on the basis of the criteria specified in § 405.502, and the customary and prevailing charge screens in effect when the service was furnished. (Also see §§ 415.55 through 415.70 and §§ 415.100 through 415.130 of this chapter, which pertain to the determination of reimbursement for services performed by hospital-based physicians.) However, when services are furnished more than 12 months before the beginning of the fee screen year (January 1 through December 30) in which a request for payment is made, payment is based on the customary and prevailing charge screens in effect for the fee screen year that ends immediately preceding the fee screen year in which the claim or request for payment is made.

(d) Payment under Medicare Part B for durable medical equipment and prosthetic and orthotic devices is determined in accordance with the provisions of subpart D of part 414 of this chapter.

[47 FR 63274, Dec. 31, 1981, as amended at 51 FR 34978, Oct. 1, 1986; 51 FR 37911, Oct. 27, 1986; 54 FR 9003, Mar. 2, 1989; 57 FR 24975, June 12, 1992; 57 FR 33896, July 31, 1992; 57 FR 57688, Dec. 7, 1992; 60 FR 63176, Dec. 8, 1995; 79 FR 25473, May 2, 2014]

§ 405.502 Criteria for determining reasonable charges.

(a) *Criteria.* The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for. The criteria for determining what charges are reasonable include:

(1) The customary charges for similar services generally made by the physician or other person furnishing such services.

(2) The prevailing charges in the locality for similar services.

(3) In the case of physicians' services, the prevailing charges adjusted to reflect economic changes as provided under § 405.504 of this subpart.

(4) In the case of medical services, supplies, and equipment that are reimbursed on a reasonable charge basis (excluding physicians' services), the inflation-indexed charge as determined under § 405.509.

(5) [Reserved]

(6) In the case of medical services, supplies, and equipment (including equipment servicing) that the Secretary judges do not generally vary significantly in quality from one supplier to another, the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality.

(7) Other factors that may be found necessary and appropriate with respect to a category of service to use in judging whether the charge is inherently reasonable. This includes special reasonable charge limits (which may be either upper or lower limits) established by CMS or a carrier if it determines that the standard rules for calculating reasonable charges set forth in this subpart result in the grossly deficient or excessive charges. The determination of these limits is described in paragraphs (g) and (h) of this section.

(8) In the case of laboratory services billed by a physician but performed by an outside laboratory, the payment levels established in accordance with the criteria stated in § 405.515.

(9) Except as provided in paragraph (a)(10) of this section, in the case of services of assistants-at-surgery as defined in § 405.580 in teaching and nonteaching settings, charges that are not more than 16 percent of the prevailing charge in the locality, adjusted by the economic index, for the surgical procedure performed by the primary surgeon. Payment is prohibited for the services of an assistant-at-surgery in surgical procedures for which CMS has determined that assistants-at-surgery on average are used in less than 5 percent of such procedures nationally.

(10) In the case of services of assistants at surgery that meet the exception under § 415.190(c)(2) or (c)(3) of this chapter because the physician is performing a unique, necessary, specialized medical service in the total care of a patient during surgery, reasonable charges consistent with prevailing practice in the carrier's service area rather than the special assistant at surgery rate.

(b) *Comparable services limitation.* The law also specifies that the reasonable charge cannot be higher than the charge applicable for a comparable service under comparable circumstances to the carriers' own policyholders and subscribers.

(c) *Application of criteria.* In applying these criteria, the carriers are to exercise judgment based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable.

(d) *Responsibility of Administration and carriers.* Determinations by carriers of reasonable charge are not reviewed on a case-by-case basis by the Centers for Medicare & Medicaid Services, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the