

services furnished by nonparticipating physicians.

(b) *Prohibited billing.* The beneficiary may not be billed for any telephone line charges or any facility fees.

(c) *Assignment required for nonphysician practitioners.* Payment to nonphysician practitioners is made only on an assignment-related basis.

(d) *Who may bill for the consultation.* Only the consultant practitioner may bill for the consultation.

(e) *Sharing of payment.* The consultant practitioner must provide to the referring practitioner 25 percent of any payments he or she receives for the consultation, including any applicable deductible or coinsurance amounts.

(f) *Sanctions.* A practitioner may be subject to the applicable sanctions provided for in chapter V, parts 1001, 1002, and 1003 of this title if he or she—

(1) Knowingly and willfully bills or collects for services in violation of the limitations of this section on a repeated basis; or

(2) Fails to timely correct excess charges by reducing the actual charge billed for the service to an amount that does not exceed the limiting charge for the service or fails to timely refund excess collections.

[63 FR 58911, Nov. 2, 1998]

### Subpart C [Reserved]

### 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:

*Covered item update* means the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) for the 12-month

period ending with June of the previous year.

*Durable medical equipment* means equipment, furnished by a supplier or a home health agency that—

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to an individual in the absence of an illness or injury; and
- (4) Is appropriate for use in the home. (See § 410.38 of this chapter for a description of when an institution qualifies as a home.)

*Prosthetic and orthotic devices* means—

- (1) Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies;
- (2) One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens; and
- (3) Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the beneficiary's physical condition.

The following are neither prosthetic nor orthotic devices—

- (1) Parenteral and enteral nutrients, supplies, and equipment;
- (2) Intraocular lenses;
- (3) Medical supplies such as catheters, catheter supplies, ostomy bags, and supplies related to ostomy care that are furnished by an HHA as part of home health services under § 409.40(e) of this chapter;
- (4) Dental prostheses.

*Region* means those carrier service areas administered by HCFA regional offices.

[57 FR 57689, Dec. 7, 1992]

#### § 414.210 General payment rules.

(a) *General rule.* For items furnished on or after January 1, 1989, except as provided in paragraphs (c) and (d) of this section, Medicare pays for durable medical equipment, prosthetics and orthotics, including a separate payment for maintenance and servicing of the items as described in paragraph (e) of this section, on the basis of 80 percent of the lesser of—

- (1) The actual charge for the item;

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(2) The fee schedule amount for the item, as determined in accordance with the provisions of §§ 414.220 through 414.232.

(b) *Payment classification.* (1) The carrier determines fee schedules for the following classes of equipment and devices:

(i) Inexpensive or routinely purchased items, as specified in § 414.220.

(ii) Items requiring frequent and substantial servicing, as specified in § 414.222.

(iii) Certain customized items, as specified in § 414.224.

(iv) Oxygen and oxygen equipment, as specified in § 414.226.

(v) Prosthetic and orthotic devices, as specified in § 414.228.

(vi) Other durable medical equipment (capped rental items), as specified in § 414.229.

(vii) Transcutaneous electrical nerve stimulators (TENS), as specified in § 414.232.

(2) HCFA designates the items in each class of equipment or device through its program instructions.

(c) *Exception for certain HHAs.* Public HHAs and HHAs that furnish services or items free-of-charge or at nominal prices to a significant number of low-income patients, as defined in § 413.13(a) of this chapter, are paid on the basis of 80 percent of the fee schedule amount determined in accordance with the provision of §§ 414.220 through 414.230.

(d) *Prohibition on special limits.* For items furnished on or after January 1, 1989 and before January 1, 1991, neither HCFA nor a carrier may establish a special reasonable charge for items covered under this subpart on the basis of inherent reasonableness as described in § 405.502(g) of this chapter.

(e) *Maintenance and servicing.* (1) *General rule.* Except as provided in paragraph (e)(2) of this section, the carrier pays the reasonable and necessary charges for maintenance and servicing of purchased equipment. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. Payment is made, as needed, in a lump sum based on the carrier's consideration of the item. Payment is not made for maintenance and servicing of a rented item other

than the maintenance and servicing fee for other durable medical equipment, as described in § 414.229(e).

(2) *Exception.* For items purchased on or after June 1, 1989, no payment is made under the provisions of paragraph (e)(1) of this section for the maintenance and servicing of:

(i) Items requiring frequent and substantial servicing, as defined in § 414.222(a);

(ii) Capped rental items, as defined in § 414.229(a), that are not purchased in accordance with § 414.229(d); and

(iii) Oxygen equipment, as defined in § 414.226.

(f) *Replacement of equipment.* Except as provided in § 414.229(g), if a purchased item of DME or a prosthetic or orthotic device paid for under this subpart has been in continuous use by the patient for the equipment's reasonable useful lifetime or if the carrier determines that the item is lost or irreparably damaged, the patient may elect to obtain a new piece of equipment.

(1) The reasonable useful lifetime of DME or prosthetic and orthotic devices is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment.

(2) If the beneficiary elects to obtain replacement equipment, payment is made on a purchase basis.

[57 FR 57689, Dec. 7, 1992]

### § 414.220 Inexpensive or routinely purchased items.

(a) *Definitions.* (1) *Inexpensive equipment* means equipment the average purchase price of which did not exceed \$150 during the period July 1986 through June 1987.

(2) *Routinely purchased equipment* means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987.

(3) *Accessories.* Effective January 1, 1994, accessories used in conjunction with a nebulizer, aspirator, or ventilator excluded from § 414.222 meet the definitions of "inexpensive equipment" and "routinely purchased equipment"