

§414.58

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(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 clinical nurse specialist may not exceed 85 percent of the physician fee schedule amount for the service. For assistant-at-surgery services, allowed amounts for the services of a nurse practitioner or clinical nurse specialist may not exceed 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.

[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, HCFA 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.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 60 FR 63189, Dec. 8, 1995]

§414.60 Payment for the services of CRNAs.

(a) *Basis for payment.* Beginning with CY 1994—

(1) The allowance for an anesthesia service furnished by a medically directed CRNA is based on a fixed per-

centage 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.

[60 FR 63178, Dec. 8, 1995, as amended at 62 FR 46037, Aug. 29, 1997]

§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.

[62 FR 59102, Oct. 31, 1997]

§414.65 Payment for consultations via interactive telecommunications systems.

(a) *Limitations on payment.* Medicare payment for a professional consultation conducted via interactive telecommunications systems is subject to the following limitations:

(1) The payment may not exceed the current fee schedule amount applicable to the consulting practitioner for the health care service provided.

(2) The payment may not include reimbursement for any telephone line charges or any facility fees.

(3) The payment is subject to the coinsurance and deductible requirements of sections 1833(a)(1) and (b) of the Act.

(4) The payment differential of section 1848(a)(3) of the Act applies to

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;