

(a) Establishing the prospectively determined payment rates for routine services; and

(b) Explaining the basis on which the prospectively determined payment rates are calculated.

§ 413.321 Simplified cost report for SNFs.

SNFs electing to be paid under the prospectively determined payment rate system may file a simplified cost report. The cost report contains a simplified method of cost finding to be used in lieu of cost methods described in § 413.24(d). This method is specified in the instructions for Form HCFA-2540S, contained in sections 3000-3027.3 of Part 2 of the Provider Reimbursement Manual. This form may not be used by hospital-based SNFs or SNFs that are part of a health care complex. Those SNFs must file a cost report that reflects the shared services and administrative costs of the hospital and any other related facilities in the health care complex.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

Subpart A—General Provisions

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Subparts F–H—[Reserved]

AUTHORITY: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§ 414.1

42 CFR Ch. IV (10–1–96 Edition)

SOURCE: 55 FR 23441, June 8, 1990, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes affecting this part appear at 60 FR 50442, Sept. 29, 1995, and 60 FR 53877, Oct. 18, 1995.

Subpart A—General Provisions

SOURCE: 56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, unless otherwise noted.

§ 414.1 Basis and scope.

This part implements the indicated provisions of the following sections of the Act:

1833—Rules for payment for most Part B services.

1834(a) and (h)—Amounts and frequency of payments for durable medical equipment and for prosthetic devices and orthotics and prosthetics.

1848—Fee schedule for physician services.

1881(b)—Rules for payment for services to ESRD beneficiaries.

1887—Payment of charges for physician services to patients in providers.

[60 FR 50442, Sept. 29, 1995]

§ 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.

CF 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 HCFA Common Procedure Coding System.

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.

RVU stands for relative value unit.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63686, Dec. 2, 1993; 59 FR 63463, Dec. 8, 1994; 60 FR 63177, Dec. 8, 1995]

§ 414.4 Fee schedule areas.

(a) *General.* HCFA establishes physician fee schedule areas that generally conform to the geographic localities in existence before January 1, 1992.

(b) *Changes.* HCFA announces proposed changes to fee schedule areas in the FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, HCFA publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

§ 414.20 Formula for computing payment amounts.

Under the formula set forth in section 1848(b)(1) of the Act, the fee schedule payment amount for a service defined as a “physicians’ service” in section 1848(j)(3) of the Act is computed as the product of the following amounts:

(a) The relative value for the service.

(b) The geographic adjustment factor (GAF) for the fee schedule area.

(c) The conversion factor (CF).

§ 414.22 Relative value units (RVUs).

HCFA establishes RVUs for physician work, physician 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.* HCFA 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.

(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.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42493, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993]

§ 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) HCFA establishes interim RVUs for new services and for codes for which definitions have changed.

(2) HCFA 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, HCFA 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) HCFA 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.

(2) After considering public comments, HCFA publishes a final notice in the FEDERAL REGISTER to announce revisions to RVUs.

(3) The RVU revisions are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(c) *Values for local codes (HCPCS Level 3).* (1) Carriers establish relative values for local codes for services not included in HCPCS levels 1 or 2.

(2) Carriers must obtain prior approval from HCFA to establish local codes for services that meet the definition of "physician services" in § 414.2.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992]

§ 414.26 Determining the GAF.

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

(a) *Geographic indices.* HCFA 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) *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

value established under paragraph (a)(3) of this section.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992]

§ 414.28 Conversion factors.

HCFA establishes CFs in accordance with section 1848(d) of the Act.

(a) *Base-year CFs.* HCFA 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.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 60 FR 53877, Oct. 18, 1995; 60 FR 63177, Dec. 8, 1995]

§ 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.

[55 FR 23441, June 8, 1990, as amended at 60 FR 63177, Dec. 8, 1995; 61 FR 42385, Aug. 15, 1996]

§ 414.32 Determining payments for certain physician 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.

(b) *General rule.* If physician services of the type routinely furnished in physician offices are furnished in facility settings, the fee schedule amount for those services is determined by reducing the practice expense RVUs for the service by 50 percent.

(c) *Services covered by the reduction.* HCFA 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.

[58 FR 63687, Dec. 2, 1993, as amended at 60 FR 63177, Dec. 8, 1995]

§ 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.

(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) HCFA 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.

§ 414.38 Special rules for payment of low osmolar contrast media.

(a) *General.* Payment for low osmolar contrast media is included in the technical component payment for diagnostic procedures except as specified in paragraph (b) of this section.

(b) *Conditions for separate payment.* For diagnostic procedures furnished to beneficiaries who are neither inpatients nor outpatients of any hospital,

separate payment is made for low osmolar contrast media used in all intrathecal injections and in intravenous, and intra-arterial injections, if it is used for patients with one or more of the following characteristics:

(1) A history of a previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.

(2) A history of asthma or allergy.

(3) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.

(4) Generalized severe debilitation.

(5) Sickle cell disease.

(c) *Method of payment.* If one of the conditions of paragraph (b) of this section is met, payment is made for low osmolar contrast media as set forth in § 414.36 as a drug furnished incident to a physician's service, subject to paragraph (d) of this section.

(d) *Drug payment reduction.* If separate payment is made for low osmolar contrast media, the payment amount calculated in accordance with § 414.36 is reduced by 8 percent to account for the allowance for contrast media already included in the technical component of the diagnostic procedure code.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, 42493, Sept. 15, 1992]

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraph (b) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule.

(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 serv-

ice 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.

[59 FR 63463, Dec. 8, 1994; 60 FR 49, Jan. 3, 1995; 60 FR 36733, July 18, 1995]

§ 414.40 Coding and ancillary policies.

(a) *General rule.* HCFA establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes.

(b) *Specific types of policies.* HCFA establishes uniform national ancillary policies necessary to implement the fee schedule for physician services. These include, but are not limited to, the following policies:

(1) Global surgery policy (for example, post- and pre-operative periods and services, and intra-operative services).

(2) Professional and technical components (for example, payment for services, such as an EEG, which typically comprise a technical component (the taking of the test) and a professional component (the interpretation)).

(3) Payment modifiers (for example, assistant-at-surgery, multiple surgery, bilateral surgery, split surgical global services, team surgery, and unusual services).

§ 414.42 Adjustment for first 4 years of practice.

(a) *General rule.* For services furnished during CYs 1992 and 1993, except as specified in paragraph (b) of this section, the fee schedule payment amount or prevailing charge must be phased in as specified in paragraph (d) of this section for physicians, physical therapists (PTs), occupational therapists (OTs),

and all other health care practitioners who are in their first through fourth years of practice.

(b) *Exception.* The reduction required in paragraph (d) of this section does not apply to primary care services or to services furnished in a rural area as defined in section 1886(d)(2)(D) of the Act that is designated under section 332(a)(1)(A) of the Public Health Service Act as a Health Professional Shortage Area.

(c) *Definition of years of practice.* (1) The "first year of practice" is the first full CY during the first 6 months of which the physician, PT, OT, or other health care practitioner furnishes professional services for which payment may be made under Medicare Part B, plus any portion of the prior CY if that prior year does not meet the first 6 months test.

(2) The "second, third, and fourth years of practice" are the first, second, and third CYs following the first year of practice, respectively.

(d) *Amounts of adjustment.* The fee schedule payment for the service of a new physician, PT, OT, or other health care practitioner is limited to the following percentages for each of the indicated years:

- (1) First year—80 percent
- (2) Second year—85 percent
- (3) Third year—90 percent
- (4) Fourth year—95 percent

[57 FR 42493, Sept. 15, 1992, as amended at 58 FR 63687, Dec. 2, 1993]

§ 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 HCFA 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 estab-

lished 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.* HCFA 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 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(c) *Adjustment of 1992 payments for radiology services.* For radiology 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 109 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 109 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 pre-operative and post-operative visits, the administration of fluids and/or blood incident to anesthesia care, and monitoring services.

(2) *Time units* involve the continuous actual presence of the physician (or of the medically directed qualified anesthesiologist or resident) and start when he

or she begins to prepare the patient for anesthesia care and ends when the anesthesiologist (or medically directed CRNA) is no longer in personal attendance, that is, when the patient may be safely placed under post-operative care.

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

(1) The physician fee schedule amount for an anesthesia service is based on the product of the allowable base and time units and an anesthesia-specific CF.

(2) The allowable base units are determined by the uniform relative value guide based on 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. The uniform base units are identified in program operating instructions.

(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) HCFA 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) HCFA 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) HCFA 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. 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.

(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) *Physician medically supervises anesthesia services.* If the physician medically supervises more than four concurrent anesthesia services, HCFA 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.

(f) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1) HCFA 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. HCFA 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) HCFA 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.

(g) *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.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 60 FR 63177, Dec. 8, 1995]

§414.48 Limits on actual charges of nonparticipating suppliers.

(a) *General rule.* A supplier, as defined in §400.202 of this chapter, who is nonparticipating and does not accept assignment may charge a beneficiary an amount up to the limiting charge described in paragraph (b) of this section.

(b) *Specific limits.* For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the fee schedule amount for nonparticipating suppliers. For items or services HCFA excludes from payment under the physician fee schedule (in accordance with section 1848 (j)(3) of the Act), the limiting charge is 115 percent of 95 percent of the payment basis applicable to participating suppliers.

[58 FR 63687, Dec. 2, 1993]

§414.50 Physician billing for purchased diagnostic tests.

(a) *General rule.* If a physician bills for a diagnostic test performed by an outside supplier, the payment to the physician less the applicable deductibles and coinsurance may not exceed the lowest of the following amounts:

- (1) The supplier's net charge to the physician.
- (2) The physician's actual charge.
- (3) The fee schedule amount for the test that would be allowed if the supplier billed directly.

(b) *Restriction on payment.* The physician must identify the supplier and indicate the supplier's net charge for the test. If the physician fails to provide this information, HCFA makes no payment to the physician and the physician may not bill the beneficiary.

(1) Physicians who accept Medicare assignment may bill beneficiaries for only the applicable deductibles and coinsurance.

(2) Physicians who do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

§414.52 Payment for physician assistants' services.

Allowed amounts for the services of a physician assistant furnished begin-

ning January 1, 1992, may not exceed the following limits:

(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.

§414.54 Payment for certified nurse-midwives' services.

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-midwife services may not exceed 65 percent of the physician fee schedule amount for the service.

§414.56 Payment for nurse practitioners' and clinical nurse specialists' services.

(a) *Rural areas.* For services furnished beginning January 1, 1992, allowed amounts for the services of a nurse practitioner or a clinical nurse specialist in 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, 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.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42493, Sept. 15, 1992]

§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 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, rural primary care 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]

Subparts B-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;
- (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" in paragraphs (a)(1) and (a)(2) of this section, respectively.

(b) *Payment rules.* (1) Subject to the limitation in paragraph (b)(3) of this section, payment for inexpensive and routinely purchased items is made on a rental basis or in a lump sum amount for purchase of the item based on the applicable fee schedule amount.

(2) Effective January 1, 1994, payment for ostomy supplies, tracheostomy supplies, urologicals, and surgical dressings not furnished as incident to a physician's professional service or furnished by an HHA is made using the methodology for the inexpensive and routinely purchased class.

(3) The total amount of payments made for an item may not exceed the fee schedule amount recognized for the purchase of that item.

(c) *Fee schedule amount for 1989 and 1990.* The fee schedule amount for payment of purchase or rental of inexpensive or routinely purchased items furnished in 1989 and 1990 is the local payment amount determined as follows:

(1) The carrier determines the average reasonable charge for inexpensive or routinely purchased items that were

furnished during the period July 1, 1986 through June 30, 1987 based on the mean of the carrier's allowed charges for the item. A separate determination of an average reasonable charge is made for rental equipment, new purchased equipment, and used purchased equipment.

(2) The carrier adjusts the amount determined under paragraph (c)(1) of this section by the change in the level of the CPI-U for the 6-month period ending December 1987.

(d) *Updating the local payment amounts for years after 1990.* For each year subsequent to 1990, the local payment amounts of the preceding year are increased or decreased by the covered item update. For 1991 and 1992, the covered item update is reduced by 1 percentage point.

(e) *Calculating the fee schedule amounts for years after 1990.* For years after 1990, the fee schedule amounts are equal to the national limited payment amount.

(f) *Calculating the national limited payment amount.* The national limited payment amount is computed as follows:

(1) The 1991 national limited payment amount is equal to:

(i) 100 percent of the local payment amount if the local payment amount is neither greater than the weighted average nor less than 85 percent of the weighted average of all local payment amounts;

(ii) The sum of 67 percent of the local payment amount plus 33 percent of the weighted average of all local payment amounts if the local payment amount exceeds the weighted average of all local payment amounts; or

(iii) The sum of 67 percent of the local payment amount plus 33 percent of 85 percent of the weighted average of all local payment amounts if the local payment amount is less than 85 percent of the weighted average of all local payment amounts.

(2) The 1992 national limited payment amount is equal to:

(i) 100 percent of the local payment amount if the local payment amount is neither greater than the weighted average nor less than 85 percent of the weighted average of all local payment amounts;

(ii) The sum of 33 percent of the local payment amount plus 67 percent of the weighted average of all local payment amounts if the local payment amount exceeds the weighted average; or

(iii) The sum of 33 percent of the local payment amount plus 67 percent of 85 percent of the weighted average of all local payment amounts if the local payment amount is less than 85 percent of the weighted average.

(3) For 1993, the national limited payment amount is equal to one of the following:

(i) 100 percent of the local payment amount if the local payment amount is neither greater than the weighted average nor less than 85 percent of the weighted average of all local payment amounts.

(ii) 100 percent of the weighted average of all local payment amounts if the local payment amount exceeds the weighted average of all local payment amounts.

(iii) 85 percent of the weighted average of all local payment amounts if the local payment amount is less than 85 percent of the weighted average of all local payment amounts.

(4) For 1994 and subsequent years, the national limited payment amount is equal to one of the following:

(i) If the local payment amount is not in excess of the median, nor less than 85 percent of the median, of all local payment amounts—100 percent of the local payment amount.

(ii) If the local payment amount exceeds the median—100 percent of the median of all local payment amounts.

(iii) If the local payment amount is less than 85 percent of the median—85 percent of the median of all local payment amounts.

(g) *Payment for surgical dressings.* For surgical dressings furnished after December 31, 1993, the national limited payment amount is computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates for 1993 and 1994.

[57 FR 57689, Dec. 7, 1992, as amended at 60 FR 35497, July 10, 1995]

§ 414.222 Items requiring frequent and substantial servicing.

(a) *Definition.* Items requiring frequent and substantial servicing in order to avoid risk to the beneficiary's health are the following:

(1) Ventilators (except those that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices).

(2) Continuous and intermittent positive pressure breathing machines.

(3) Continuous passive motion machines.

(4) Other items specified in HCFA program instructions.

(5) Other items identified by the carrier.

(b) *Payment rule.* Rental payments for items requiring frequent and substantial servicing are made on a monthly basis, and continue until medical necessity ends.

(c) *Fee schedule amount for 1989 and 1990.* The fee schedule amount for items requiring frequent and substantial servicing is the local payment amount determined as follows:

(1) The carrier determines the average reasonable charge for rental of items requiring frequent and substantial servicing that were furnished during the period July 1, 1986 through June 30, 1987 based on the mean of the carrier's allowed charges for the item.

(2) The carrier adjusts the amounts determined under paragraph (c)(1) of this section by the change in the level of the CPI-U for the 6-month period ending December 1987.

(d) *Updating the fee schedule amounts for years after 1990.* For years after 1990, the fee schedules are determined using the methodology contained in paragraphs (d), (e), and (f) of § 414.220.

(e) *Transition to other payment classes.* For purposes of calculating the 15-month rental period, beginning January 1, 1994, if an item has been paid for under the frequent and substantial servicing class and is subsequently paid for under another payment class, the rental period begins with the first month of continuous rental, even if that period began before January 1, 1994. For example, if the rental period began on July 1, 1993, the carrier must use this date as beginning the first

month of rental. Likewise, for purposes of calculating the 10-month purchase option, the rental period begins with the first month of continuous rental without regard to when that period started. For example, if the rental period began in August 1993, the 10-month purchase option must be offered to the beneficiary in May 1994, the tenth month of continuous rental.

[57 FR 57690, Dec. 7, 1992, as amended at 60 FR 35497, July 10, 1995]

§ 414.224 Customized items.

(a) *Criteria for a customized item.* To be considered a customized item for payment purposes under paragraph (b) of this section, a covered item (including a wheelchair) must be uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of a physician and be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

(b) *Payment rule.* Payment is made on a lump sum basis for the purchase of a customized item based on the carrier's individual consideration and judgment of a reasonable payment amount for each customized item. The carrier's individual consideration takes into account written documentation on the costs of the item including at least the cost of labor and materials used in customizing an item.

[56 FR 65998, Dec. 20, 1991, as amended at 58 FR 34919, June 30, 1993]

§ 414.226 Oxygen and oxygen equipment.

(a) *Payment rules.* (1) Payment for rental of oxygen equipment and purchase of oxygen contents is made based on a monthly fee schedule amount.

(2) Monthly fee schedule payments continue until medical necessity ends.

(b) *Monthly fee schedule amount.* (1) Monthly fee schedule amounts are separately calculated for the following items:

(i) Stationary oxygen equipment and oxygen contents (stationary and portable oxygen contents).

(ii) Portable oxygen equipment only.

(iii) Stationary and portable oxygen contents only.

(iv) Portable oxygen contents only.

(2) For 1989 and 1990, the monthly fee schedule amounts are the local payment amounts determined as follows:

(i) The carrier determines the base local average monthly payment rate equal to the total reasonable charges for the item for the 12-month period ending December 1986 divided by the total number of months for all beneficiaries receiving the item for the same period. In determining the local average monthly payment rate, the following limitations apply:

(A) Purchase charges for oxygen systems are not included as items classified under paragraph (b)(1)(i) of this section.

(B) Purchase charges for portable equipment are not included as items classified under paragraph (b)(1)(ii) of this section.

(ii) The carrier determines the local monthly payment amount equal to 0.95 times the base local average monthly payment amount adjusted by the change in the CPI-U for the six-month period ending December 1987.

(3) For years after 1990, the fee schedule amounts are determined using the methodology contained in § 414.220 (d), (e), and (f).

(c) *Application of monthly fee schedule amounts.* (1) The fee schedule amount for items described in paragraph (b)(1)(i) of this section is paid when the beneficiary rents a stationary oxygen system.

(2) Subject to the limitation set forth in paragraph (d)(2) of this section, the fee schedule amount for items described in paragraph (b)(1)(ii) of this section is paid when the beneficiary rents a portable oxygen system.

(3) The fee schedule amount for items described in paragraph (b)(1)(iii) of this section is paid when the beneficiary owns a stationary gaseous or liquid oxygen system.

(4) The fee schedule amount for items described in paragraph (b)(1)(iv) of this section is paid when the beneficiary owns or rents a portable gaseous or portable liquid oxygen system and uses either a stationary oxygen concentrator or no stationary oxygen system.

(d) *Volume adjustments:* (1) The fee schedule amount for an item described

in paragraph (b)(1)(i) of this section is adjusted as follows:

(i) If the attending physician prescribes an oxygen flow rate exceeding four liters per minute, the fee schedule amount is increased by 50 percent, subject to the limit in paragraph (d)(2) of this section.

(ii) If the attending physician prescribes an oxygen flow rate of less than one liter per minute, the fee schedule amount is decreased by 50 percent.

(2) If portable oxygen equipment is used and the prescribed oxygen flow rate exceeds four liters per minute, the total fee schedule amount recognized for payment is limited to the higher of—

(i) The sum of the monthly fee schedule amount for the items described in paragraphs (b)(1)(i) and (ii) of this section; or

(ii) The adjusted fee schedule amount described in paragraph (d)(1)(i) of this section.

(3) In establishing the volume adjustment for those beneficiaries whose physicians prescribe varying flow rates, the following rules apply:

(i) If the prescribed flow rate is different for stationary oxygen equipment than for portable oxygen equipment, the flow rate for the stationary equipment is used.

(ii) If the prescribed flow rate is different for the patient at rest than for the patient at exercise, the flow rate for the patient at rest is used.

(iii) If the prescribed flow rate is different for nighttime use and daytime use, the average of the two flow rates is used.

[57 FR 57690, Dec. 7, 1992]

§ 414.228 Prosthetic and orthotic devices.

(a) *Payment rule.* Payment is made on a lump-sum basis for prosthetic and orthotic devices subject to this subpart.

(b) *Fee schedule amounts.* The fee schedule amount for prosthetic and orthotic devices is determined as follows:

(1) The carrier determines a base local purchase price equal to the average reasonable charge for items purchased during the period July 1, 1986 through June 30, 1987 based on the

mean of the carrier's allowed charges for the item.

(2) The carrier determines a local purchase price equal to the following:

(i) For 1989 and 1990, the base local purchase price is adjusted by the change in the level of the CPI-U for the 6-month period ending December 1987.

(ii) For 1991 through 1993, the local purchase price for the preceding year is adjusted by the applicable percentage increase for the year. The applicable percentage increase is equal to 0 percent for 1991. For 1992 and 1993, the applicable percentage increase is equal to the percentage increase in the CPI-U for the 12-month period ending with June of the previous year.

(iii) For 1994 and 1995, the applicable percentage increase is 0 percent.

(iv) For all subsequent years the applicable percentage increase is equal to the percentage increase in the CPI-U for the 12-month period ending with June of the previous year.

(3) HCFA determines the regional purchase price equal to the following:

(i) For 1992, the average (weighted by the relative volume of all claims among carriers) of the local purchase prices for the carriers in the region.

(ii) For 1993 and subsequent years, the regional purchase price for the preceding year adjusted by the applicable percentage increase for the year.

(4) HCFA determines a purchase price equal to the following:

(i) For 1989, 1990 and 1991, 100 percent of the local purchase price.

(ii) For 1992, 75 percent of the local purchase price plus 25 percent of the regional purchase price.

(iii) For 1993, 50 percent of the local purchase price plus 50 percent of the regional purchase price.

(iv) For 1994 and subsequent years, 100 percent of the regional purchase price.

(5) For 1992 and subsequent years, HCFA determines a national average purchase price equal to the unweighted average of the purchase prices determined under paragraph (b)(4) of this section for all carriers.

(6) HCFA determines the fee schedule amount equal to 100 percent of the purchase price determined under paragraph (b)(4) of this section, subject to the following limitations:

(i) For 1992, the amount cannot be greater than 125 percent nor less than 85 percent of the national average purchase price determined under paragraph (b)(5) of this section.

(ii) For 1993 and subsequent years, the amount cannot be greater than 120 percent of the national average nor less than 90 percent of the national average purchase price determined under paragraph (b)(5) of this section.

[57 FR 57691, Dec. 7, 1992, as amended at 60 FR 35498, July 10, 1995]

§ 414.229 Other durable medical equipment—capped rental items.

(a) *General payment rule.* Subject to the limitation set forth in paragraph (b) of this section, payment is made on a rental or purchase option basis for other durable medical equipment that is not subject to the payment provisions set forth in §§ 414.220 through 414.228.

(b) *Fee schedule amounts for rental.* (1) For 1989 and 1990, the monthly fee schedule amount for rental of other covered durable medical equipment equals 10 percent of the purchase price recognized as determined under paragraph (c) of this section subject to the following limitation: For 1989 and 1990, the fee schedule amount cannot be greater than 115 percent nor less than 85 percent of the prevailing charge, as determined under § 405.504 of this chapter, established for rental of the item in January 1987, as adjusted by the change in the level of the CPI-U for the 6-month period ending December 1987.

(2) For 1991 and subsequent years, the monthly fee schedule amount for rental of other covered durable medical equipment equals 10 percent of the purchase price recognized as determined under paragraph (c) of this section for each of the first 3 months and 7.5 percent of the purchase price for each of the remaining months.

(c) *Determination of purchase price.* The purchase price of other covered durable medical equipment is determined as follows:

(1) For 1989 and 1990. (i) The carrier determines a base local purchase price amount equal to the average of the purchase prices submitted on an assignment-related basis of new items

supplied during the 6-month period ending December 1986.

(ii) The purchase price is equal to the base local purchase price adjusted by the change in the level of the CPI-U for the 6-month period ending December 1987.

(2) For 1991. (i) The local payment amount is the purchase price for the preceding year adjusted by the covered item update for 1991 and decreased by the percentage by which the average of the reasonable charges for claims paid for all other items described in § 414.229, is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988.

(ii) The purchase price for 1991 is the national limited payment amount as determined using the methodology contained in § 414.220(f).

(3) For years after 1991. The purchase price is determined using the methodology contained in paragraphs (d) through (f) of § 414.220.

(d) *Purchase option.* Suppliers must offer a purchase option to beneficiaries during the 10th continuous rental month and, for power-driven wheelchairs, the purchase option must also be made available at the time the equipment is initially furnished.

(1) Suppliers must offer beneficiaries the option of purchasing power-driven wheelchairs at the time the supplier first furnishes the item. Payment must be on a lump-sum fee schedule purchase basis if the beneficiary chooses the purchase option. The purchase fee is the amount established in § 414.229(c).

(2) Suppliers must offer beneficiaries the option of converting capped rental items (including power-driven wheelchairs not purchased when initially furnished) to purchased equipment during their 10th continuous rental month. Beneficiaries have one month from the date the supplier makes the offer to accept the purchase option.

(i) If the beneficiary does not accept the purchase option, payment continues on a rental basis not to exceed a period of continuous use of longer than 15 months. After 15 months of rental payments have been paid, the supplier must continue to provide the item without charge, other than a charge for maintenance and servicing fees, until medical necessity ends or Medicare

coverage ceases. A period of continuous use is determined under the provisions in § 414.230.

(ii) If the beneficiary accepts the purchase option, payment continues on a rental basis not to exceed a period of continuous use of longer than 13 months. On the first day after 13 continuous rental months during which payment is made, the supplier must transfer title to the equipment to the beneficiary.

(e) *Payment for maintenance and servicing.* (1) The carrier establishes a reasonable fee for maintenance and servicing for each rented item of other durable medical equipment. The fee may not exceed 10 percent of the purchase price recognized as determined under paragraph (c) of this section.

(2) Payment of the fee for maintenance and servicing of other durable medical equipment that is rented is made only for equipment that continues to be used after 15 months of rental payments have been made and is limited to the following:

(i) For the first 6-month period, no payments are to be made.

(ii) For each succeeding 6-month period, payment may be made during the first month of that period.

(3) Payment for maintenance and servicing of DME purchased in accordance with paragraphs (d)(1) and (d)(2)(ii) of this section, is made on the basis of reasonable and necessary charges.

(f) *Transition to the fee schedules.* For purposes of computing the 10-month or 15-month period of continuous use for other durable medical equipment, as described in § 414.230, the carrier counts the first month that the beneficiary continuously rented the equipment without regard to whether that month occurred before January 1, 1989 or after. If a beneficiary's 15-month rental period ends prior to January 1, 1989, no further purchase or rental payments are to be made except for maintenance and servicing of equipment as described in paragraph (e) of this section.

(g) *Replacement of equipment.* If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, or if the carrier determines that the item is lost or ir-

reparably 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 rental or purchase basis in accordance with paragraph (a) of this section or on a lump-sum purchase basis if a purchase agreement had been entered into in accordance with paragraph (d) of this section.

[57 FR 57691, Dec. 7, 1992, as amended at 60 FR 35498, July 10, 1995]

§ 414.230 Determining a period of continuous use.

(a) *Scope.* This section sets forth the rules that apply in determining a period of continuous use for rental of durable medical equipment.

(b) *Continuous use.* A period of continuous use begins with the first month of medical need and lasts until a beneficiary's medical need for a particular item of durable medical equipment ends.

(c) *Temporary interruption.* (1) A period of continuous use allows for temporary interruptions in the use of equipment.

(2) An interruption of not longer than 60 consecutive days plus the days remaining in the rental month in which use ceases is temporary, regardless of the reason for the interruption.

(3) Unless there is a break in medical necessity that lasts longer than 60 consecutive days plus the days remaining in the rental month in which use ceases, medical necessity is presumed to continue.

(d) *Criteria for a new rental period.* If an interruption in the use of equipment continues for more than 60 consecutive days plus the days remaining in the rental month in which use ceases, a new rental period begins if the supplier submits all of the following information—

- (1) A new prescription.
- (2) New medical necessity documentation.
- (3) A statement describing the reason for the interruption and demonstrating that medical necessity in the prior episode ended.

(e) *Beneficiary moves.* A permanent or temporary move made by a beneficiary does not constitute an interruption in the period of continuous use.

(f) *New equipment.* If a beneficiary changes equipment or requires additional equipment based on a physician's prescription, and the new or additional equipment is found to be necessary, a new period of continuous use begins for the new or additional equipment. A new period of continuous use does not begin for base equipment that is modified by an addition.

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

[56 FR 50823, Oct. 9, 1991, as amended at 57 FR 57111, Dec. 3, 1992]

§ 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 57692, Dec. 7, 1992, as amended at 60 FR 35498, July 10, 1995]

Subpart E—Determination of Reasonable Charges Under the ESRD Program

§ 414.300 Scope of subpart.

This subpart sets forth criteria and procedures for payment of the following services furnished to ESRD patients:

(a) Physician services related to renal dialysis.

(b) Physician services related to renal transplantation.

(c) Home dialysis equipment, supplies, and support services.

(d) Epoetin (EPO) furnished by a supplier of home dialysis equipment and supplies to a home dialysis patient for use in the home.

[55 FR 23441, June 8, 1990, as amended at 56 FR 43710, Sept. 4, 1991; 59 FR 1285, Jan. 10, 1994]

§ 414.310 Determination of reasonable charges for physician services furnished to renal dialysis patients.

(a) *Principle.* Physician services furnished to renal dialysis patients are subject to payment if the services are otherwise covered by the Medicare program and if they are considered reasonable and medically necessary in accordance with section 1862(a)(1)(A) of the Act.

(b) *Scope and applicability—(1) Scope.* This section pertains to physician services furnished to the following patients:

(i) Outpatient maintenance dialysis patients who dialyze—

(A) In an independent or hospital-based ESRD facility, or

(B) At home.

(ii) Hospital inpatients for which the physician elects to continue payment under the monthly capitation payment (MCP) method described in § 414.314.

(2) *Applicability.* These provisions apply to routine professional services of physicians. They do not apply to administrative services performed by physicians, which are paid for as part of a prospective payment for dialysis

services made to the facility under § 413.170 of this chapter.

(c) *Definitions.* For purposes of this section, the following definitions apply:

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.

(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 § 413.170 of this chapter.

(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:

(i) Physician services that must be furnished at a time other than during 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 serves 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 year following the 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 HCFA, 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 (§413.170) 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.

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(ii) Covered physician services furnished by another physician when the patient is not available to receive, or 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 physi-

cian fee schedule described in this part 414.

[55 FR 23441, June 8, 1990, as amended at 59 FR 63463, Dec. 8, 1994]

§ 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) HCFA 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 extent permitted by the lesser of the following:

(i) Changes in the economic index as described in §405.504(a)(3)(i) of this chapter.

(ii) Percentage changes in the weighted average of the carrier's prevailing charges (before adjustment by the economic index) for—

(A) A unilateral nephrectomy; or

(B) Another medical or surgical service designated by HCFA for this purpose.

(b) *Other payments.* Payments for covered medical services furnished to the transplant recipient by other specialists, as well as for services by the transplant surgeon after the 60-day period covered by the comprehensive payment, are made under the reasonable charge criteria set forth in §405.502 (a) through (d) of this chapter. The payments for physicians' services in connection with renal transplantations are changed on the basis of program experience and the expected advances in the medical art for this operation.

§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 §413.170.

(2) *Exception.* 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 subpart E (Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians) of 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 HCFA that he or she has only one supplier for all home dialysis equipment and supplies. This certification is made on HCFA 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 HCFA 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 subpart U of part 405 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 subpart U (Conditions for Coverage of Suppliers of ESRD Services) of this chapter. (§410.52 sets forth the scope and conditions of 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 subpart U (Conditions for Coverage of Suppliers of ESRD Services) of this chapter. This includes maintaining a complete medical record of ESRD related items and services furnished by other parties. The facility must report, on the forms required by HCFA 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).

(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 § 413.170 of this chapter.

(2) *Exceptions*. 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)(iii)(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*—(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 HCFA, plus the median cost per treatment for all dialysis facilities for laboratory tests included under the composite rate, as determined by HCFA, 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 HCFA 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]

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

(a) 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.

(b) Payment is made in accordance with the rules set forth in § 413.170 of this chapter.

[56 FR 43710, Sept. 4, 1991]

Subparts F–H—[Reserved]**PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS****Subpart A—General Provisions**

Sec.

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 60 FR 63178, Dec. 8, 1995, unless otherwise noted.

Subpart A—General Provisions**§ 415.1 Basis and scope.**

(a) *Basis.* This part is based on the provisions of the following sections of the Act: Section 1848 establishes a fee schedule for payment for physician services. Section 1861(q) specifies what is included in the term “physician services” covered under Medicare. Section 1862(a)(14) sets forth the exclusion of nonphysician services furnished to hospital patients under Part B of Medicare. Section 1886(d)(5)(B) provides for a payment adjustment under the prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983, to account for the indirect costs of medical education. Section 1886(h) establishes the methodology for Medicare payment of the cost of direct GME activities.

(b) *Scope.* This part sets forth rules for fiscal intermediary payments to providers for physician services, Part B carrier payments for physician services to beneficiaries in providers, physician services in teaching settings, and services of residents.