Subpart M—Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) Services

§ 414.1100 Basis and scope.

This subpart implements sections 1834(k)(1) and (k)(3) of the Act by specifying the payment methodology for comprehensive outpatient rehabilitation facility services covered under Part B of Title XVIII of the Act that are described at section 1861(cc)(1) of the Act.

§ 414.1105 Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) services.

(a) Payment under the physician fee schedule. Except as otherwise specified under paragraphs (b), (c), (d), and (e) of this section payment for CORF services, as defined under § 410.100 of this chapter, is paid the lesser of 80 percent of:

(1) The actual charge for the item or service; or

(2) The nonfacility amount determined under the physician fee schedule established under section 1848(b) of the Act for the item or service.

(b) Payment for physician services. No separate payment for physician services that are CORF services under § 410.100(a) of this chapter will be made.

(c) Payment for supplies and durable medical equipment, prosthetic and orthotic devices, and drugs and biologicals. Supplies and durable medical equipment that are CORF services under § 410.100(l) of this chapter, prosthetic device services that are CORF services under § 410.100(f), orthotic device services that are CORF services under § 410.100(g) of this chapter and drugs and biologicals that are CORF services under § 410.100(k) of this chapter are paid the lesser of 80 percent of the following:

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (d); or

(2) The amount determined under the DMEPOS fee schedule established under part 414 subparts D and F for the item or the single payment amount established under the DMEPOS competitive bidding program provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (d).

(d) Payment for drugs and biologicals. Drugs and biologicals that are CORF services under § 410.100(j) of this chapter, are paid the lesser of 80 percent of the following:

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (c); or

(2) The amount determined using the same methodology for drugs (as defined in § 414.704 of this chapter) described in section 1842(o)(1) of the Act provided that payment for such drug is not included in the payment amount for other CORF services paid under paragraphs (a) or (c).

(e) Payment for CORF services when no fee schedule amount for the service. If there is no fee schedule amount established for a CORF service, payment for the item or service will be the lesser of 80 percent of:

(1) The actual charge for the service provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

(2) The amount determined under the fee schedule established for a comparable service as specified by the Secretary provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.
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(concerning compensation of owners), §415.60 (concerning allocation of physician compensation costs), and §415.162 (concerning payment for physician services furnished to beneficiaries in teaching hospitals), costs a provider incurs for services of physicians are allowable only if the following conditions are met:

1. The services do not meet the conditions in §415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.

2. The services include a surgeon’s supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.

3. The provider has incurred a cost for salary or other compensation it furnished the physician for the services.

4. The costs incurred by the provider for the services meet the requirements in §413.9 of this chapter regarding costs related to patient care.

5. The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in §415.160, or any other costs incurred in connection with an approved GME program that are payable under §§413.75 through 413.83 of this chapter.

(b) Allocation of allowable costs. The provider must follow the rules in §415.60 regarding allocation of physician compensation costs to determine its costs of services.

(c) Allowable physician compensation costs. Only costs allocated to payable physician services to the provider (as described in §415.55) are allowable costs to the provider under this subpart.

(d) Allocation of all compensation to services to the provider. Generally, the total physician compensation received by a physician is allocated among all services furnished by the physician, unless:

1. The provider certifies that the compensation is attributable solely to the physician services furnished to the provider; and

2. The physician bills all patients for the physician services he or she furnishes to them and personally receives the payment from or on behalf of the patients. If returned directly or indirectly to the provider or an organization related to the provider within the meaning of §413.17 of this chapter, these payments are not compensation for physician services furnished to the provider.

(e) Assumed allocation of all compensation to beneficiary services. If the provider and physician agree to accept the assumed allocation of all the physician services to direct services to beneficiaries as described under §415.102(a), CMS does not require a written allocation agreement between the physician and the provider.

(f) Determination and payment of allowable physician compensation costs. Except as provided under paragraph (e)
of this section, the intermediary pays the provider for these costs only if—

(i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and

(ii) The compensation is reasonable in terms of the time devoted to these services.

(2) In the absence of a written allocation agreement, the intermediary assumes, for purposes of determining reasonable costs of the provider, that 100 percent of the physician compensation cost is allocated to services to beneficiaries as specified in paragraph (b)(2) of this section.

(g) Recordkeeping requirements. Except for services furnished in accordance with the assumed allocation under paragraph (e) of this section, each provider that claims payment for services of physicians under this subpart must meet all of the following requirements:

(1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier.

(2) Report the information on which the physician compensation allocation is based to services to beneficiaries as specified in paragraph (b)(2) of this section.

(3) Retain each physician compensation allocation, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.

§ 415.70 Limits on compensation for physician services in providers.

(a) Principle and scope. (1) Except as provided in paragraphs (a)(2) and (a)(3) of this section, CMS establishes reasonable compensation equivalency limits on the amount of compensation paid to physicians by providers. These limits are applied to a provider’s costs incurred in compensating physicians for services to the provider, as described in § 415.55(a).

(2) Limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective payment system implemented under part 412 of this chapter or to costs of physician compensation attributable to approved GME programs that are payable under §§ 413.75 through 413.83 of this chapter.

(b) Methodology for establishing limits. CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty and type of location using the best available data.

(c) Application of limits. If the level of compensation exceeds the limits established under paragraph (b) of this section, Medicare payment is based on the level established by the limits.

(d) Adjustment of the limits. The intermediary may adjust limits established under paragraph (b) of this section to account for costs incurred by the physician or the provider related to malpractice insurance, professional memberships, and continuing medical education.

(1) For the costs of membership in professional societies and continuing medical education, the intermediary may adjust the limit by the lesser of—

(i) The actual cost incurred by the provider or the physician for these activities; or

(ii) Five percent of the appropriate limit.

(2) For the cost of malpractice expenses incurred by either the provider or the physician, the intermediary may adjust the reasonable compensation equivalency limit by the cost of the malpractice insurance expense related to the physician service furnished to patients in providers.

(e) Exception to limits. An intermediary may grant a provider an exception to the limits established under
§ 415.100 Scope.

This subpart implements section 1887(a)(1)(A) of the Act by providing general conditions that must be met in order for services furnished by physicians to beneficiaries in providers to be paid for on the basis of the physician fee schedule under part 414 of this chapter. Section 415.102 sets forth the conditions for fee schedule payment for physician services to beneficiaries in providers. Section 415.105 sets forth general requirements for determining the amounts of payment for services that meet the conditions of this section. Sections 415.120 and 415.130 set forth additional conditions for payment for physician services in the specialties of radiology and pathology (laboratory services).

§ 415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

(a) General rule. If the physician furnishes services to beneficiaries in providers, the carrier pays on a fee schedule basis provided the following requirements are met:

(1) The services are personally furnished for an individual beneficiary by a physician.

(2) The services contribute directly to the diagnosis or treatment of an individual beneficiary.

(3) The services ordinarily require performance by a physician.

(4) In the case of radiology or laboratory services, the additional requirements in § 415.120 or § 415.130, respectively, are met.

(b) Exception. If a physician furnishes services in a provider that do not meet the requirements in paragraph (a) of this section, but are related to beneficiary care furnished by the provider, the intermediary pays for those services, if otherwise covered. The intermediary follows the rules in §§ 415.55 and 415.60 for payment on the basis of reasonable cost or PPS, as appropriate.

(c) Effect of billing charges for physician services to a provider. (1) If a physician furnishes services that may be paid under the reasonable cost rules in §§ 415.55 or 415.60, and paid by the intermediary, or would be paid under those rules except for the PPS rules in part 412 of this chapter, and under the payment rules for GME established by §§ 413.75 through 413.83 of this chapter, neither the provider nor the physician may seek payment from the carrier, beneficiary, or another insurer.

(2) If a physician furnishes services to an individual beneficiary that do not meet the applicable conditions in §§ 415.120 (concerning conditions for payment for radiology services) and 415.130 (concerning conditions for payment for physician pathology services), the carrier does not pay on a fee schedule basis.

(3) If the physician, the provider, or another entity bills the carrier or the beneficiary or another insurer for physician services furnished to the provider, as described in § 415.55(a), CMS considers the provider to which the services are furnished to have violated...
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§ 415.110 Conditions for payment: Medically directed anesthesia services.

(a) General payment rule. Medicare pays for the physician’s medical direction of anesthesia services for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in §415.102(a) and the following additional conditions:

(1) For each patient, the physician—
   (i) Performs a pre-anesthetic examination and evaluation;
   (ii) Prescribes the anesthesia plan;
   (iii) Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;
   (iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions;
   (v) Monitors the course of anesthesia administration at frequent intervals;
   (vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and
   (vii) Provides indicated post-anesthesia care.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in §414.46(c) of this chapter apply (Physician personally performs the anesthesia procedure).
§ 415.120  Conditions for payment: Radiology services.

(a) Services to beneficiaries. The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in §415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient’s medical record maintained by the hospital.

(b) Services to providers. The carrier does not pay on a fee schedule basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the x-ray films or other items that are interpreted by the radiologist. However, the intermediary pays the provider for these services in accordance with §415.55 for provider costs; §415.102(d)(2) for costs incurred by a physician, such as under a lease or concession agreement; or part 412 of this chapter for payment under PPS.

§ 415.130  Conditions for payment: Physician pathology services.

(a) Definitions. The following definitions are used in this section.

(1) Covered hospital means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for this technical component directly to a Medicare carrier.

(2) Fee-for-service Medicare beneficiaries means those beneficiaries who are entitled to benefits under Part A or are enrolled under Part B of Title XVIII of the Act or both and are not enrolled in any of the following:

(i) A Medicare+Choice plan under Part C of Title XVIII of the Act;

(ii) A plan offered by an eligible organization under section 1876 of the Act;

(iii) A program of all-inclusive care for the elderly (PACE) under 1894 of the Act; or

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

(b) Physician pathology services. The carrier pays for pathology services furnished by a physician to an individual beneficiary on a fee schedule basis only if the services meet the conditions for payment in §415.102(a) and are one of the following services:

(1) Surgical pathology services.

(2) Specific cytopathology, hematology, and blood banking services that have been identified to require performance by a physician and are listed in program operating instructions.

(3) Clinical consultation services that meet the requirements in paragraph (c) of this section.

(4) Clinical laboratory interpretative services that meet the requirements of paragraphs (c)(1), (c)(3), and (c)(4) of this section and that are specifically listed in program operating instructions.

(c) Clinical consultation services. For purposes of this section, clinical consultation services must meet the following requirements:

(1) Be requested by the beneficiary’s attending physician.

(2) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the beneficiary.

(3) Result in a written narrative report included in the beneficiary’s medical record.
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(4) Require the exercise of medical judgment by the consultant physician.

(d) **Physician pathology services furnished by an independent laboratory.**

The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before December 31, 2010, may be paid to the laboratory by the contractor under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section.

(2) For services furnished after December 31, 2010, an independent laboratory may not bill the Medicare contractor for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

(3) For services furnished on or after January 1, 2008, the date of service policy in § 414.510 of this chapter applies to the TC of specimens for physician pathology services.


Subpart D—Physician Services in Teaching Settings

§ 415.150 Scope.

This subpart sets forth the rules governing payment for the services of physicians in teaching settings and the criteria for determining whether the payments are made as one of the following:

(a) Services to the hospital under the reasonable cost election in §§ 415.160 through 415.164.

(b) Provider services through the direct GME payment mechanism in §§ 413.75 through 413.83 of this chapter.

(c) Physician services to beneficiaries under the physician fee schedule as set forth in part 414 of this chapter.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 415.152 Definitions.

As used in this subpart—

*Approved graduate medical education (GME) program* means one of the following:

(1) A residency program approved by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

(2) A program otherwise recognized as an “approved medical residency program” under § 413.75(b) of this chapter.

*Direct medical and surgical services* means services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the cost election described in §§ 415.160 through 415.162.

*Nonprovider setting* means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. These include, but are not limited to, family practice or multispecialty clinics and physician offices.

*Resident* means one of the following:

(1) An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry.

(2) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, for example, individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. For purposes of this subpart, the term *resident* is synonymous with the terms *intern* and *fellow*.

*Teaching hospital* means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

*Teaching physician* means a physician (other than another resident) who involvement residents in the care of his or her patients.

*Teaching setting* means any provider, hospital-based provider, or nonprovider settings in which Medicare payment for the services of residents is made under the direct GME payment provisions of §§ 413.75 through 413.83, or on a reasonable-cost basis under the provisions of § 409.26 or § 409.40(f) for resident.
§ 415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.

(a) Scope. A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services.

(b) Conditions. A teaching hospital may elect to receive these payments only if—

1. The hospital notifies its intermediary in writing of the election and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;

2. All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or

3. All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.

(c) Effect of election. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—

1. Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and

2. The intermediary pays the hospital for those services on a reasonable cost basis under the rules in §415.162. (Payment for other physician compensation costs related to approved GME programs is made as described in §413.78 of this chapter.)

(d) Election declined. If the teaching hospital does not make this election, payment is made—

1. For requirements services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and

2. For the supervision of interns and residents as described in §§413.75 through 413.83.

§ 415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.

(a) General rule. Payments for direct medical and surgical services of physicians furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries is made by Medicare on the basis of reasonable cost if the hospital exercises the election as provided for in §415.160. If this election is made, the following occurs:

1. Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries are paid on a reasonable-cost basis, as provided for in paragraph (b) of this section.

2. Payment for certain medical school costs may be made as provided for in paragraph (c) of this section.

3. Payments for services donated by volunteer physicians to beneficiaries are made to a fund designated by the organized medical staff of the teaching hospital or medical school as provided for in paragraph (d) of this section.

(b) Reasonable cost of physician services and supervision of interns and residents. (1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis.

(2) For purposes of this paragraph, reasonable cost is defined as the direct salary paid to these physicians, plus applicable fringe benefits.

(3) The costs must be allocated to the services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section.

(4) Other allowable costs incurred by the provider related to the services described in this paragraph are payable subject to the requirements applicable to all other provider services.
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(c) Reasonable costs for the services furnished by a medical school or related organization in a hospital. An amount is payable to the hospital by CMS under the Medicare program provided that the costs would be payable if incurred directly by the hospital rather than under the arrangement. The amount must not be in excess of the reasonable costs (as defined in paragraphs (c)(1) and (c)(2) of this section) incurred by a teaching hospital for services furnished by a medical school or organization as described in § 413.17 of this chapter for certain costs to the medical school (or a related organization) in furnishing services in the hospital.

(1) Reasonable costs of physician services—(i) When the medical school and the hospital are related organizations. If the medical school (or organization related to the medical school) and the hospital are related by common ownership or control as described in § 413.17 of this chapter—

(A) The costs of these services are allowable costs to the hospital under the provisions of § 413.17 of this chapter; and

(B) The reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital.

(ii) When the medical school and the hospital are not related organizations. (A) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school for the costs of those services furnished to all patients, payment is made by Medicare to the hospital for the reasonable cost incurred by the hospital for its payments to the medical school for services furnished to beneficiaries.

(B) Costs incurred under an arrangement must be allocated to the full range of services furnished to the hospital by the medical school physicians on the same basis as provided for under paragraph (j) of this section, and costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided for under paragraph (g) of this section.

(C) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school only for the costs of those services furnished to beneficiaries, costs of the medical school not to exceed 105 percent of the sum of physician direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation paid by the medical school or an organization related to the medical school may be recognized as allowable costs of the medical school.

(D) These allowable medical school costs must be allocated to the full range of services furnished by the physicians of the medical school or organization related as provided by paragraph (j) of this section.

(E) Costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided by paragraph (g) of this section.

(2) Reasonable costs of other than direct medical and surgical services. These costs are determined in accordance with paragraph (c)(1) of this section except that—

(i) If the hospital makes payment to the medical school for other than direct medical and surgical services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries, these payments are subject to the required cost-finding and apportionment methods applicable to the cost of other hospital services (except for direct medical and surgical services furnished to beneficiaries); or

(ii) If the hospital makes payment to the medical school only for these services furnished to beneficiaries, the cost of these services is not subject to cost-finding and apportionment as otherwise provided by this subpart, and the reasonable cost paid by Medicare must be determined on the basis of the health insurance ratio(s) used in the apportionment of all other provider costs (excluding physician direct medical and surgical services furnished to beneficiaries) applied to the allowable
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medical school costs incurred by the medical school for the services furnished to all patients of the hospital.

(d) “Salary equivalent” payments for direct medical and surgical services furnished by physicians on the voluntary staff of the hospital. (1) CMS makes payments under the Medicare program to a fund as defined in §415.164 for direct medical and surgical services furnished to beneficiaries on a regularly scheduled basis by physicians on the unpaid voluntary medical staff of the hospital (or medical school under arrangement with the hospital).

(i) These payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a payable basis.

(ii) Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time, salaried physicians (other than interns and residents) on the hospital staff or, if the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area.

(iii) This “salary equivalent” is a single hourly rate covering all physicians regardless of specialty and is applied to the actual regularly scheduled time contributed by the physicians in furnishing direct medical and surgical services to beneficiaries including supervision of interns and residents in that care.

(iv) A physician who receives any compensation from the hospital or a medical school related to the hospital by common ownership or control (within the meaning of §413.17 of this chapter) for direct medical and surgical services furnished to any patient in the hospital is not considered an unpaid voluntary physician for purposes of this paragraph.

(v) If, however, a physician receives compensation from the hospital or related medical school or organization only for services that are other than direct medical and surgical services, a salary equivalent payment for the physician’s regularly scheduled direct medical and surgical services to beneficiaries in the hospital may be imputed. However, the sum of the imputed value for volunteer services and the physician’s actual compensation from the hospital and the related medical school (or organization) may not exceed the amount that would have been imputed if all of the physician’s hospital and medical school services (compensated and volunteer) had been volunteer services, or paid at the rate of $30,000 per year, whichever is less.

(2) The following examples illustrate how the allowable imputed value for volunteer services is determined. In each example, it has been assumed that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician’s compensated services.

Example No. 1. Dr. Jones received $3,000 a year from Hospital X for services other than direct medical services to all patients, for example, utilization review and administrative services. Dr. Jones also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to $10,000 for the cost reporting period. The full imputed value of Dr. Jones’ volunteer direct medical services would be allowed since the total amount of the imputed value ($10,000) and the compensated services ($3,000) does not exceed $30,000.

Example No. 2. Dr. Smith received $25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to $10,000. Only $5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value ($30,000) and the compensated services ($25,000) exceeds the $30,000 maximum amount allowable for all of Dr. Smith’s services.

Computation:

Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation $30,000

Less compensation received from Hospital X for other than direct medical services to individual patients $25,000

Allowable amount of imputed value for the volunteer services furnished by Dr. Smith $5,000

Example No. 3. Dr. Brown is not compensated by Hospital X for any services furnished in the hospital. Dr. Brown voluntarily
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furnished direct surgical services to beneficiaries for a period of 6 months, and the imputed value of these services amounted to $20,000. The allowable amount of the imputed value for volunteer services furnished by Dr. Brown would be limited to $15,000 ($30,000 × 6/12).

(3) The amount of the imputed value for volunteer services applicable to beneficiaries and payable to a fund is determined in accordance with the aggregate per diem method described in paragraph (g) of this section.

(4) Medicare payments to a fund must be used by the fund solely for improvement of care of hospital patients or for educational or charitable purposes (which may include but are not limited to medical and other scientific research).

(i) No personal financial gain, either direct or indirect, from benefits of the fund may inure to any of the hospital staff physicians, medical school faculty, or physicians for whom Medicare imputes costs for purposes of payment into the fund.

(ii) Expenses met from contributions made to the hospital from a fund are not included as a reimbursable cost when expended by the hospital, and depreciation expense is not allowed with respect to equipment or facilities donated to the hospital by a fund or purchased by the hospital from monies in a fund.

(e) Requirements for payment—(1) Physicians on the hospital staff. The requirements under which the costs of physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries are the same as those applicable to the cost of all other covered provider services except that the costs of these services are separately determined as provided by this section and are not subject to cost-finding as described in §413.24 of this chapter.

(2) Physicians on the medical school faculty. Payment is made to a hospital for the costs of services of physicians on the medical school faculty, provided that if the medical school is not related to the hospital (within the meaning of §413.17 of this chapter, concerning cost to related organizations), the hospital does not make payment to the medical school for services furnished to all patients and the following requirements are met: If the hospital makes payment to the medical school for services furnished to all patients, these requirements do not apply. (See paragraph (c)(1)(ii) of this section.)

(i) There is a written agreement between the hospital and the medical school or organization, specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay to the medical school an amount at least equal to the reasonable cost (as defined in paragraph (c) of this section) of furnishing the services to beneficiaries.

(ii) The costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were furnished is due to CMS.

(iii) Payment for the services furnished under an arrangement would have been made to the hospital had the services been furnished directly by the hospital.

(3) Physicians on the voluntary staff of the hospital (or medical school under arrangement with the hospital). If the conditions for payment to a fund outlined in §415.164 are met, payments are made on a “salary equivalent” basis (as defined in paragraph (d) of this section) to a fund.

(f) Requirements for payment for medical school faculty services other than physician direct medical and surgical services. If the requirements for payment for physician direct medical and surgical services furnished in a teaching hospital are met, payment is made to a hospital for the costs of medical school faculty services other than physician direct medical and surgical services furnished in a teaching hospital.

(g) Aggregate per diem methods of apportionment—(1) For the costs of physician direct medical and surgical services. The cost of physician direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined on the basis of an average cost per diem as defined in paragraph (h)(1) of this section for physician direct medical and surgical services to all patients (see §§415.172 through 415.184) for each of the following categories of physicians:
(i) Physicians on the hospital staff.

(ii) Physicians on the medical school faculty.

(2) For the imputed value of physician volunteer direct medical and surgical services. The imputed value of physician direct medical and surgical services furnished to beneficiaries in a teaching hospital is determined on the basis of an average per diem, as defined in paragraph (h)(1) of this section, for physician direct medical and surgical services to all patients except that the average per diem is derived from the imputed value of the physician volunteer direct medical and surgical services furnished to all patients.

(h) Definitions. (1) Average cost per diem for physician direct medical and surgical services (including supervision of interns and residents) furnished in a teaching hospital to patients in each category of physician services described in paragraph (g)(1) of this section means the amount computed by dividing total reasonable costs of these services in each category by the sum of—

(i) Inpatient days (as defined in paragraph (h)(2) of this section); and

(ii) Outpatient visit days (as defined in paragraph (h)(3) of this section).

(2) Inpatient days are determined by counting the day of admission as 3.5 days and each day after a patient’s day of admission, except the day of discharge, as 1 day.

(3) Outpatient visit days are determined by counting only one visit day for each calendar day that a patient visits an outpatient department or multiple outpatient departments.

(i) Application. (1) The following illustrates how apportionment based on the aggregate per diem method for costs of physician direct medical and surgical services furnished in a teaching hospital to patients is determined.

**Teaching Hospital Y**

Statistical and financial data:

Total inpatient days as defined in paragraph (h)(2) of this section and outpatient visit days as defined in paragraph (h)(3) of this section ........................................ 75,000

Total inpatient Part A days .......... 20,000

Total inpatient Part B days where Part A coverage is not available ........................................ 1,000

Total outpatient Part B visit days ......................................... 5,000

Total cost of direct medical and surgical services furnished to all patients by physicians on the hospital staff as determined in accordance with paragraph (i) of this section ........................................ $1,500,000

Total cost of direct medical and surgical services furnished to all patients by physicians on the medical school faculty as determined in accordance with paragraph (i) of this section ........ 1,650,000

Computation of cost applicable to program for physicians on the hospital staff:

Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff: $1,500,000 ÷ 75,000 = $20 per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $20 per diem × 20,000 ........................................ $400,000

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $20 per diem × 1,000 ........................................ $20,000

Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $20 per diem × 5,000 ........................................ $100,000

Computation of cost applicable to program for physicians on the medical school faculty:

Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty: $1,650,000 ÷ 75,000 = $22 per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $22 per diem × 20,000 ........................................ $440,000

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $20 per diem × 1,000 ........................................ $22,000

Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $22 per diem × 5,000 ........................................ $110,000

(2) The following illustrates how the imputed value of physician volunteer direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined.

**Example:** The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in furnishing direct medical
and surgical services to patients of the hospital during a cost reporting period and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician volunteer services did not exceed the rate of $30,000 per year per physician.

**STATISTICAL AND FINANCIAL DATA:**

Total salaries paid to the full-time salaried physicians by the hospital (excluding interns and residents) .................................. $800,000

Total physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks × 40 hours per week) hours per year .......... 20

Average hourly rate equivalent: $800,000 ÷ 41,600 (2,080 × 20) ......... $19.23

Computation of total imputed value of physician volunteer services applicable to all patients:

Total donated hours × average hourly rate equivalent): 5,000 × $19.23 ......................... $96,150

Total inpatient days (as defined in paragraph (h)(2) of this section) and outpatient visit days (as defined in paragraph (h)(3) of this section) ........ 75,000

Average per diem for physician direct medical and surgical services to all patients: $96,150 ÷ 75,000 = $1.28 per diem

Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $1.28 per diem × 20,000 ................ $25,600

Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $1.28 per diem × 5,000 ................... $6,400

Imputed value of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $1.28 per diem × 5,000 ................... $6,400

Total ........................................... $33,280

(j) Allocation of compensation paid to physicians in a teaching hospital. (1) In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. (However, see paragraph (d) of this section for the computation of the "salary equivalent" payments for volunteer services furnished to patients.)

(2) This allocation must be made and must be capable of substantiation on the basis of the proportion of each physician’s time spent in furnishing each type of service to the hospital or medical school.

§ 415.164 Payment to a fund.

(a) General rules. Payment for certain voluntary services by physicians in teaching hospitals (as these services are described in §415.160) is made on a salary equivalent basis (as described in §415.162(d)) subject to the conditions and limitations contained in parts 405 and 413 of this chapter and this part 415, to a single fund (as defined in paragraph (b) of this section) designated by the organized medical staff of the hospital (or, if the services are furnished in the hospital by the faculty of a medical school, to a fund as may be designated by the faculty), if the following conditions are met:

(1) The hospital (or medical school furnishing the services under arrangement with the hospital) incurs no actual cost in furnishing the services.

(2) The hospital has an agreement with CMS under part 489 of this chapter.

(3) The intermediary, or CMS as appropriate, has received written assurances that—

(i) The payment is used solely for the improvement of care of hospital patients or for educational or charitable purposes; and

(ii) Neither the individuals who are furnished the services nor any other persons are charged for the services (and if charged, provision is made for the return of any moneys incorrectly collected).

(b) Definition of a fund. For purposes of paragraph (a) of this section, a fund is an organization that meets either of the following requirements:

(1) The organization has and retains exemption, as a governmental entity or
§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

Services meeting the conditions for payment in §415.102(a) furnished in teaching settings are payable under the physician fee schedule if—

(a) The services are personally furnished by a physician who is not a resident; or

(b) The services are furnished by a resident in the presence of a teaching physician except as provided in §415.172 (concerning physician fee schedule payment for services of teaching physicians), §415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), §415.176 (concerning renal dialysis services), and §415.184 (concerning psychiatric services), as applicable.

§ 415.172 Physician fee schedule payment for services of teaching physicians.

(a) General rule. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

(i) In the case of surgery, the teaching physician’s presence is not required during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

(2) In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of §415.174 apply.)

(b) Documentation. Except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.

(c) Payment level. In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

(a) In the case of certain evaluation and management codes of lower and mid-level complexity (as specified by CMS in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply,
all of the following conditions must be met:

(1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§413.75 through 413.83.

(2) Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.

(3) The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—

(i) Have no other responsibilities at the time;

(ii) Assume management responsibility for those beneficiaries seen by the residents;

(iii) Ensure that the services furnished are appropriate;

(iv) Review with each resident during or immediately after each visit, the beneficiary’s medical history, physical examination, diagnosis, and record of tests and therapies; and

(v) Document the extent of the teaching physician’s participation in the review and direction of the services furnished to each beneficiary.

(4) The range of services furnished by residents in the center includes all of the following:

(i) Acute care for undifferentiated problems or chronic care for ongoing conditions.

(ii) Coordination of care furnished by other physicians and providers.

(iii) Comprehensive care not limited by organ system, or diagnosis.

(5) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.

(b) Nothing in paragraph (a) of this section may be construed as providing a basis for the coverage of services not determined to be covered under Medicare, such as routine physical check-ups.


§ 415.176 Renal dialysis services.

In the case of renal dialysis services, physicians who are not paid under the physician monthly capitation payment method (as described in §414.314 of this chapter) must meet the requirements of §§415.170 and 415.172 (concerning physician fee schedule payment for services of teaching physicians).

§ 415.178 Anesthesia services.

(a) General rule. (1) For services furnished prior to January 1, 2010, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in §414.46(c)(1)(iii) of this chapter.

(2) For services furnished on or after January 1, 2010, payment made under §414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) Documentation. Documentation must indicate the teaching physician’s presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

[74 FR 62014, Nov. 25, 2009]
§ 415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.

(a) General rule. Physician fee schedule payment is made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident.

(b) Documentation. Documentation must indicate that the physician personally performed the interpretation or reviewed the resident’s interpretation with the resident.

§ 415.184 Psychiatric services.

To qualify for physician fee schedule payment for psychiatric services furnished under an approved GME program, the physician must meet the requirements of §§ 415.170 and 415.172, including documentation, except that the requirement for the presence of the teaching physician during the service in which a resident is involved may be met by observation of the service by use of a one-way mirror, video equipment, or similar device.

§ 415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

(a) Basis, purpose, and scope. This section describes the conditions under which Medicare pays on a fee schedule basis for the services of an assistant at surgery in a teaching hospital. This section is based on section 1842(b)(7)(D)(I) of the Act and applies only to hospitals with an approved GME residency program. Except as specified in paragraph (c) of this section, fee schedule payment is not available for assistants at surgery in hospitals with—

(1) A training program relating to the medical specialty required for the surgical procedure; and

(2) A resident in a training program relating to the specialty required for the surgery available to serve as an assistant at surgery.

(b) Definition. Assistant at surgery means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(c) Conditions for payment for assistants at surgery. Payment on a fee schedule basis is made for the services of an assistant at surgery in a teaching hospital only if the services meet one of the following conditions:

(1) Are required as a result of exceptional medical circumstances.

(2) Are complex medical procedures performed by a team of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician.

(3) Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.

(4) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon does not use interns and residents in the surgical procedures that the surgeon performs (including preoperative and postoperative care).

(5) Are not related to a surgical procedure for which CMS determines that assistants are used less than 5 percent of the time.

Subpart E—Services of Residents

§ 415.200 Services of residents in approved GME programs.

(a) General rules. Services furnished in hospitals by residents in approved GME programs are specifically excluded from being paid as “physician services” defined in § 414.2 of this chapter and are payable as hospital services. This exclusion applies whether or not the resident is licensed to practice under the laws of the State in which he or she performs the service. The payment methodology for services of residents in hospitals and hospital-based providers is set forth in §§ 413.75 through 413.83 of this chapter.

(b) Exception. For low and mid-level evaluation and management services furnished under certain conditions in centers located in hospital outpatient departments and other ambulatory settings, see § 415.174.

(c) Definitions. See § 415.152 for definitions of terms used in this subpart E.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]
§ 415.202 Services of residents not in approved GME programs.

(a) General rules. For services of a physician employed by a hospital who is authorized to practice only in a hospital setting and for the services of a resident who is not in any approved GME program, payment is made to the hospital on a Part B reasonable cost basis regardless of whether the services are furnished to hospital inpatients or outpatients.

(b) Payment. For services described in paragraph (a) of this section, payment is made under Part B by reducing the reasonable costs of furnishing the services by the beneficiary deductible and paying 80 percent of the remaining amount. No payment is made for other costs of unapproved programs, such as administrative costs related to teaching activities of physicians.

§ 415.204 Services of residents in skilled nursing facilities and home health agencies.

(a) Medicare Part A payment. Payment is made under Medicare Part A for interns’ and residents’ services furnished in the following settings that meet the specified requirements:

(1) Skilled nursing facility. Payment to a participating skilled nursing facility may include the cost of services of an intern or resident who is in an approved GME program in a hospital with which the skilled nursing facility has a transfer agreement that provides, in part, for the transfer of patients and the interchange of medical records.

(2) Home health agency. A participating home health agency may receive payment for the cost of the services of an intern or resident who is under an approved GME program of a hospital with which the home health agency is affiliated or under common control if these services are furnished as part of the home health visits for a Medicare beneficiary. (Nevertheless, see §§ 413.75 through 413.83 of this chapter for the costs of approved GME programs in hospital-based providers.)

(b) Medicare Part B payment. Medical services of a resident of a hospital that are furnished by a skilled nursing facility or home health agency are paid under Medicare Part B if payment is not provided under Medicare Part A. Payment is made under Part B for a resident’s services by reducing the reasonable costs of furnishing the services by the beneficiary deductible and paying 80 percent of the remaining amount.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 415.206 Services of residents in nonprovider settings.

Patient care activities of residents in approved GME programs that are furnished in nonprovider settings are payable in one of the following two ways:

(a) Direct GME payments. If the conditions in § 413.78 regarding patient care activities and training of residents are met, the time residents spend in nonprovider settings such as clinics, nursing facilities, and physician offices in connection with approved GME programs is included in determining the number of full-time equivalency residents in the calculation of a teaching hospital’s resident count. The teaching physician rules on carrier payments in §§ 415.170 through 415.184 apply in these teaching settings.

(b) Physician fee schedule. (1) Services furnished by a resident in a nonprovider setting are covered as physician services and payable under the physician fee schedule if the following requirements are met:

(i) The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the service is performed.

(ii) The time spent in patient care activities in the nonprovider setting is not included in a teaching hospital’s full-time equivalency resident count for the purpose of direct GME payments.

(2) Payment may be made regardless of whether a resident is functioning within the scope of his or her GME program in the nonprovider setting.

(3) If fee schedule payment is made for the resident’s services in a nonprovider setting, payment must not be made for the services of a teaching physician.

(4) The carrier must apply the physician fee schedule payment rules set forth in subpart A of part 414 of this
§ 415.208 Services of moonlighting residents.

(a) Definition. For purposes of this section, the term services of moonlighting residents refers to services that licensed residents perform that are outside the scope of an approved GME program.

(b) Services in GME program hospitals.

(1) The services of residents to inpatients of hospitals in which the residents have their approved GME program are not covered as physician services and are payable under §§ 413.75 through 413.83 regarding direct GME payments.

(2) Services of residents that are not related to their approved GME programs and are performed in an outpatient department or emergency department of a hospital in which they have their training program are covered as physician services and payable under the physician fee schedule if all of the following criteria are met:

(i) The services are identifiable physician services and meet the conditions for payment of physician services to beneficiaries in providers in § 415.102(a).

(ii) The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

(iii) The services performed can be separately identified from those services that are required as part of the approved GME program.

(3) If the criteria specified in paragraph (b)(2) of this section are met, the services of the moonlighting resident are considered to have been furnished by the individual in his or her capacity as a physician, rather than in the capacity of a resident. The carrier must review the contracts and agreements for these services to ensure compliance with the criteria specified in paragraph (b)(2) of this section.

(4) No payment is made for services of a "teaching physician" associated with moonlighting services, and the time spent furnishing these services is not included in the teaching hospital's full-time equivalency count for the indirect GME payment (§ 412.105 of this chapter) and for the direct GME payment (§§ 413.75 through 413.83 of this chapter).

(c) Other settings. Moonlighting services of a licensed resident in an approved GME program furnished outside the scope of that program in a hospital or other setting that does not participate in the approved GME program are payable under the physician fee schedule as set forth in § 415.206(b)(1).