

counseling (HIBC) to prevent STIs, intensive behavioral therapy for cardiovascular disease, and behavioral counseling for obesity furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) *Emergency department or initial inpatient telehealth consultations.* The Medicare payment amount for emergency department or initial inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to initial hospital care provided by a physician or practitioner.

(ii) *Follow-up inpatient telehealth consultations.* The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

(2) The CF for an anesthesia service furnished by a CRNA not directed by a physician may not exceed the CF for a service personally performed by a physician.

(b) *To whom payment may be made.* Payment for an anesthesia service furnished by a CRNA may be made to the CRNA or to any individual or entity (such as a hospital, critical access hospital, physician, group practice, or ambulatory surgical center) with which the CRNA has an employment or contract relationship that provides for payment to be made to the individual or entity.

(c) *Condition for payment.* Payment for the services of a CRNA may be made only on an assignment related basis, and any assignment accepted by a CRNA is binding on any other person presenting a claim or request for payment for the service.

[60 FR 63178, Dec. 8, 1995, as amended at 62 FR 46037, Aug. 29, 1997; 64 FR 59441, Nov. 2, 1999; 77 FR 69363, Nov. 16, 2012]

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) *Basis for payment.* Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be

paid under one of the following conditions:

(1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.

(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) *Level of payment.* The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in § 414.46(c) of this subpart.

[74 FR 62006, Nov. 25, 2009]

§ 414.62 Fee schedule for clinical psychologist services.

The fee schedule for clinical psychologist services is set at 100 percent of the amount determined for corresponding services under the physician fee schedule.

[62 FR 59102, Oct. 31, 1997]

§ 414.63 Payment for outpatient diabetes self-management training.

(a) Payment under the physician fee schedule. Except as provided in paragraph (d) of this section, payment for outpatient diabetes self-management training is made under the physician fee schedule in accordance with §§ 414.1 through 414.48.

(b) To whom payment may be made. Payment may be made to an entity approved by CMS to furnish outpatient diabetes self-management training in accordance with part 410, subpart H of this chapter.

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(c) Limitation on payment. Payment may be made for training sessions actually attended by the beneficiary and documented on attendance sheets.

(d) Payments made to those not paid under the physician fee schedule. Payments may be made to other entities not routinely paid under the physician fee schedule, such as hospital outpatient departments, ESRD facilities, and DME suppliers. The payment equals the amounts paid under the physician fee schedule.

(e) Other conditions for fee-for-service payment. The beneficiary must meet the following conditions:

(1) Has not previously received initial training for which Medicare payment was made under this benefit.

(2) Is not receiving services as an inpatient in a hospital, SNF, hospice, or nursing home.

(3) Is not receiving services as an outpatient in an RHC or FQHC.

[65 FR 83153, Dec. 29, 2000]

§ 414.64 Payment for medical nutrition therapy.

(a) *Payment under the physician fee schedule.* Medicare payment for medical nutrition therapy is made under the physician fee schedule in accordance with subpart B of this part. Payment to non-physician professionals, as specified in paragraph (b) of this section, is the lesser of the actual charges or 80 percent of 85 percent of the physician fee schedule amount.

(b) *To whom payment may be made.* Payment may be made to a registered dietician or nutrition professional qualified to furnish medical nutrition therapy in accordance with part 410, subpart G of this chapter.

(c) *Effective date of payment.* Medicare pays suppliers of medical nutrition therapy on or after the effective date of enrollment of the supplier at the carrier.

(d) *Limitation on payment.* Payment is made only for documented nutritional therapy sessions actually attended by the beneficiary.

(e) *Other conditions for fee-for-service payment.* Payment is made only if the beneficiary:

(1) Is not an inpatient of a hospital, SNF, nursing home, or hospice.

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(2) Is not receiving services in an RHC, FQHC or ESRD dialysis facility.

[66 FR 55332, Nov. 1, 2001]

§ 414.65 Payment for telehealth services.

(a) *Professional service.* Medicare payment for the professional service via an interactive telecommunications system is made according to the following limitations:

(1) The Medicare payment amount for office or other outpatient visits, subsequent hospital care services (with the limitation of one telehealth visit every 3 days by the patient's admitting physician or practitioner), subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days by the patient's admitting physician or nonphysician practitioner), professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one "hands on" visit per month to examine the access site), individual and group medical nutrition therapy services, individual and group kidney disease education services, individual and group diabetes self-management training services (except for one hour of "hands on" services to be furnished in the initial year training period to ensure effective injection training), individual and group health and behavior assessment and intervention, smoking cessation services, alcohol and/or substance abuse and brief intervention services, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression in adults, screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs, intensive behavioral therapy for cardiovascular disease, and behavioral counseling for obesity furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) *Emergency department or initial inpatient telehealth consultations.* The