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42 CFR Part 400, 405, et al.

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1996; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 405, 410, 411, 412, 413, 414, 415, 417, and 489

[BPD–827–P]

RIN 0938–AG96

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1996

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule discusses several policy changes affecting payment for physician services including:

- Medicare payment for physician services in teaching settings.
- Changes in calculating the default Medicare volume performance standard beginning in fiscal year 1996.
- Our efforts to implement the statutory requirement in the Social Security Act Amendments of 1994 to develop a resource-based system for practice expenses.

The rule would redesignate current regulations on teaching hospitals, on the services of physicians to providers, on the services of physicians in providers, and on the services of interns and residents. This redesignation would consolidate related rules affecting a specific audience in a separate part and, thereby, make them easier to use.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 25, 1995.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–827–P, P.O. Box 7519, Baltimore, MD 21207–0519.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Before August 4, 1995

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, MD 21207.

After August 6, 1995

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–827–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT: Elizabeth Holland, (410) 966–1309 (after September 1, 1995, (410) 786–1309) (for all issues except those related to physician services in teaching settings). William Morse, (410) 966–4520 (after September 1, 1995, (410) 786–4520) (for issues related to physician services in teaching settings).

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this preamble, we are providing the following table of contents. Some of the issues discussed in this preamble affect the payment policies but do not require changes to the regulations in the Code of Federal Regulations (CFR).

Table of Contents

In addition, because of the many organizations and terms to which we refer by acronym in this final rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

AMA American Medical Association
ASC Ambulatory surgical center
CF Conversion factor
CFR Code of Federal Regulations
COBRA Consolidated Omnibus Budget Reconciliation Act
CPEP Clinical Practice Expert Panel
CPT [Physicians'] Current Procedural Terminology [4th Edition, 1994,

copyrighted by the American Medical Association]
CRNA Certified Registered Nurse Anesthetist
CY Calendar year
DEFRA Deficit Reduction Act
EKG Electrocardiogram
ESRD End-stage renal disease
FQHC Federally Qualified Health Centers
FTE Full-Time Equivalent
FY Fiscal year
GAF Geographic adjustment factor
GPCI Geographic practice cost index
GPVS Group-Specific Volume Performance Standards
HCFA Health Care Financing Administration
HCPAC Health Care Professional Advisory Council
HCPCS HCFA Common Procedure Coding System
HHA Home health agency
HHS [Department of] Health and Human Services
I.L. Intermediary Letter
IPL Independent Physiological Laboratory
MAC Maryland Access to Care
ME Malpractice Expense
MVPS Medicare volume performance standards
NCI National Cancer Institute
OBRA Omnibus Budget Reconciliation Act
OMB Office of Management and Budget
ORA Omnibus Reconciliation Act
OTIP Occupational Therapists in Independent Practice
PE Practice Expense
PMP Primary Medical Provider
PPS Prospective Payment System
PTIP Physical Therapists in Independent Practice
RCE Reasonable compensation equivalency
RFA Regulatory Flexibility Act
RFP Request for Proposal
RHC Rural Health Clinics
RUC [AMA Specialty Society] Relative [Value] Update Committee
RVU Relative Value Unit
SNF Skilled Nursing Facility
TEFRA Tax Equity and Fiscal Responsibility Act
TEG Technical Expert Group
VI Volume and Intensity

I. Background

A. Legislative History

The Medicare program was established in 1965 by the addition of title XVIII to the Social Security Act (the Act). Since January 1, 1992, Medicare pays for physician services under section 1848 of the Act, ''Payment for Physicians' Services.'' This section contains three major elements: (1) A fee schedule for the payment of physician services; (2) a Medicare volume performance standard (MVPS) for the rates of increase in Medicare expenditures for physician services; and (3) limits on the amounts that nonparticipating physicians can charge beneficiaries. The Act requires that payments under the fee schedule be based on national uniform relative value units (RVUs) based on the resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense (ME).

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs because of changes resulting from a review of those RVUs may not cause total physician fee schedule payments to differ by more than $20 million from what they would have been had the adjustments not been made. If this tolerance is exceeded, we must make adjustments to preserve budget neutrality.

B. Published Changes to the Fee Schedule

We published a final rule on November 25, 1991, (56 FR 59502) to implement section 1848 of the Act by establishing a fee schedule for physician services furnished on or after January 1, 1992. In the November 1991 final rule (56 FR 59511), we stated our intention to update RVUs for new and revised codes in the American Medical Association's (AMA's) Physicians' Current Procedural Terminology (CPT) through an ''interim RVU'' process every year. The updates to the RVUs and fee schedule policies follow:

- November 25, 1992, as a final notice with comment period on new and revised RVUs only (57 FR 55914).
- December 2, 1993, as a final rule with comment period (58 FR 63626) to revise the refinement process used to establish physician work RVUs and to revise payment policies for specific physician services and supplies. (We solicited comments on new and revised RVUs only.)
- December 8, 1994, as a final rule with comment period (59 FR 63410) to revise the geographic adjustment factor (GAF) values, fee schedule payment areas, and payment policies for specific physician services. The final rule also discussed the process for periodic review and adjustment of RVUs not less frequently than every 5 years as required by section 1848(c)(2)(B)(i) of the Act.

This proposed rule would affect the regulations set forth at 42 CFR part 400, which consists of an introduction to, and definitions for, the Medicare and Medicaid programs; part 405, which encompasses regulations on Federal health insurance for the aged and disabled; part 410, which consists of regulations on supplementary medical insurance benefits; part 414, which covers regulations on payment for Part B medical and other health services; and new part 415, which contains regulations on services of physicians in providers, supervising physicians in teaching settings, and residents in certain settings. We are making technical and conforming amendments to parts 411, 412, 413, 417, and 489.

II. Specific Proposals for Calendar Year (CY) 1996

A. Budget-Neutrality Adjustments for Relative Value Units (RVUs)

We make annual adjustments to RVUs for the physician fee schedule to reflect changes in CPT codes and changes in estimated physician work. As stated earlier, the statute requires that these revisions may not change physician expenditures by more than $20 million compared to estimated expenditures that would have occurred if the RVU adjustments had not been made. To maintain this statutorily-mandated budget neutrality, we make an adjustment across all RVUs in the physician fee schedule.

We have received a number of suggestions (including those from the American Medical Association (AMA), private payers, and State Medicaid programs that base payments on the Medicare RVUs) that we apply these adjustments to the conversion factors (CFs) rather than across all RVUs. This would reduce the number of billing system changes required by the annual revisions to the physician fee schedule.

We agree with the commenters that it would be administratively simpler to apply the adjustments to the CFs rather than the RVUs. We propose that these budget-neutrality adjustments be applied to the physician fee schedule CFs. The impact on payment amounts would be minimal (slight differences could be caused by rounding). This alternative approach would be administratively simpler for Medicare and other payers that base payments on the Medicare RVUs, including many State Medicaid programs. In addition, this change would provide for consistent RVUs from year to year, thus making it easier to analyze payment and policy changes. For example, CPT code 99215 had 1.53 work RVUs in 1994. Because of the 1.1 percent budget-neutrality adjustment in 1995, this code has 1.51 work RVUs this year. If the proposed policy had been in effect in 1995, the work RVUs for CPT code 99215 would have remained at 1.53, but all 1995 CFs would have been reduced 1.1 percent.

Therefore, in § 414.28 (''Conversion factors''), we propose to revise paragraph (b) (''Subsequent CFs'') to state that beginning January 1, 1996, the

CF for each CY may be further adjusted to maintain budget neutrality.

B. Bundled Services

1. Hydration Therapy and Chemotherapy

Hydration therapy intravenous (IV) infusion is billed under CPT codes 90780 (up to 1 hour) and 90781 (each additional hour, up to 8 hours). The saline solution used in hydration therapy IV infusion is billed and paid separately under the appropriate HCFA Common Procedure Coding System (HCPCS) ''J'' code. Chemotherapy IV infusion is billed under CPT codes 96410 (up to 1 hour), 96412 (each additional hour, up to 8 hours), and 96414 (more than 8 hours). The chemotherapy drug is billed and paid separately under the appropriate HCPCS ''J'' code.

Hydration therapy IV infusion may be administered at the same time as chemotherapy. In some cases, the saline solution is mixed with the chemotherapy drug. We believe that paying for hydration therapy IV infusion and chemotherapy IV infusion administered at the same time represents duplicate payment. Therefore, we propose not paying separately for CPT codes 90780 and 90781 when billed on the same day as CPT codes 96410, 96412, and 96414. We would continue to pay separately for the saline solution and the chemotherapy drug. This proposal reflects a policy change that is not explicitly addressed in our regulations.

2. Evaluation of Psychiatric Records and Reports and Family Counseling Services

At present, we allow separate payment for the following codes:

- CPT code 90825 (Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes).
- CPT code 90887 (Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient).

We believe that these activities are generally performed as part of the prework and postwork of other physician services. For example, the work involved in a psychiatric evaluation of records and tests as described by CPT code 90825 is a fundamental element of the prework and postwork of other psychiatric services, such as individual psychotherapy (CPT codes 90842 through 90844). The interpretation or explanation of the results of medical examinations or procedures as described by CPT code 90887 is also an integral part of the prework and postwork of other physician services. Counseling of the family is part of the postwork of evaluation and management services.

When these types of activities are performed in conjunction with evaluation and management services or with surgical services, payment for them is included in the prework and postwork components of the visit or procedure. The psychiatric evaluation of hospital records and the interpretation or explanation of psychiatric examinations are not significantly different from other types of medical evaluations of records or interpretation of other examinations. With the exception of family counseling services, the RVUs for psychiatric services (CPT codes 90801 and 90835 through 90857) already include the prework and postwork activities described by CPT codes 90825 and 90887. Thus, continuing to allow separate payment for these procedures, in addition to payment for other psychiatric services, results in duplicate payments and is inconsistent with our policy for other services. (We also note that the times associated with the individual medical psychotherapy CPT codes 90842 through 90844 are face-to-face times. While payment for the review and preparation of records is included in the fee schedule payment for these codes, the time spent in those activities should not be counted for purposes of determining and reporting the level of the individual psychotherapy code.)

With respect to family counseling services, Medicare has a longstanding policy of covering these services if they are needed to assess the capability of the family in, and to assist family members in, managing the patient. The service must relate primarily to the management of the beneficiary's problems and not to the treatment of problems of the family member. Counseling principally concerned with the effects of the beneficiary's condition on the family member is not considered part of the physician's personal service to the beneficiary; thus, it is not covered under Medicare. While we have always considered counseling activities to be included in the evaluation and management services, such as office and hospital visits that are described by CPT codes 99201 through 99353, we have not had the same policy for the psychotherapy codes. We believe it is appropriate to bundle covered family counseling procedures into the other psychiatric codes so that our policy is consistent with our policy on services furnished by other physician specialties.

Therefore, we propose to change the status indicator for CPT codes 90825 and 90887 to ''B'' to show that payment for these codes is bundled into the payment for another service, and separate payment would not be allowed. We would implement this change in a budget-neutral manner by redistributing the RVUs for CPT codes 90825 and 90887 across the following psychiatric codes: 90801, 90820, 90835, 90842 through 90847, and 90853 through 90857. This proposal reflects a policy change that is not explicitly addressed in our regulations.

3. Fitting of Spectacles

The fitting, repair, and adjustment of prosthetic devices (including spectacles) are covered under section 1861(s)(8) of the Act. Services under section 1861(s)(8) are not included in the definition of physician services as defined in section 1848(j)(3) of the Act and should not be payable under the physician fee schedule. Nevertheless, we inadvertently established payment amounts for the fitting of spectacles and low vision systems under the physician fee schedule. Payment for the fitting of spectacles is included in the payment for the spectacles in the same way that payment for other prosthetic fitting services is included in the payment for the prosthetic device.

Therefore, we propose to cease paying separately for the fitting of spectacles and low vision systems to end this duplicate payment for the fitting service. We propose to assign a ''B'' status indicator for the following CPT codes to indicate that the services are covered under Medicare, but payment for them is bundled into the payment for the spectacles:

CPT code	Description
92352	Fitting of spectacle prosthesis for aphakia; monofocal.
92353	Fitting of spectacle prosthesis for aphakia; multifocal.
92354	Fitting of spectacle mounted low vision aid; single element system.
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system.
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials).
92371	Repair and refitting spectacles; spectacle prostheses for aphakia.

This proposed change clarifies both the coverage and payment policies. The

coverage policy is clarified in that the fitting service is clearly covered as part of the prosthesis. The payment policy is clarified in that the payment for the spectacles includes the fitting services. This proposal reflects a policy change that is not explicitly addressed in our regulations.

C. X-Rays and Electrocardiograms (EKGs) Taken in the Emergency Room

This issue concerns our policy regarding the interpretation of x-rays or electrocardiograms (EKGs) by a hospital emergency room physician and a second interpretation by a hospital's radiologist or cardiologist. The emergency room physician may be an emergency medicine specialist, a physician covering the emergency room, or the patient's personal physician.

Our current national policy, issued in 1981 in section 2020G of the Medicare Carriers Manual, states that when a hospital radiologist interprets an x-ray that has already been interpreted by another physician, the service of the radiologist almost always constitutes a physician service and should be paid by the Medicare carrier. The instruction also states that any interpretation performed by the physician in the emergency room is paid through his or her emergency room visit fee. (This manual section also applies this policy to the interpretation of EKGs by cardiologists.)

Some Medicare carriers are paying separately for the interpretations of both the emergency room physician and the radiologist or cardiologist.

In our deliberations about the nature of the appropriate Medicare policy on payments for these interpretations, we have taken into account the following factors:

- The statement in the existing manual instruction about the inclusion of the x-ray interpretation in the emergency room visit is inconsistent with the AMA's CPT coding system that we use to describe and process claims for physician services. In discussing the guidelines for the evaluation and management service codes, the CPT states on page 2 of the 1995 Edition:

> The actual performance of diagnostic tests/studies for which specific CPT codes are available is not included in the levels of E/M [evaluation and management] services. Physician performance of diagnostic tests/studies for which specific CPT codes are available should be reported separately, in addition to the appropriate E/M code.

We note that the AMA has not distinguished between the evaluation and management codes applicable to the emergency room and other evaluation and management codes in this regard.

- Somewhat differently, the questionnaire used by the Harvard School of Public Health (in a cooperative agreement with us) to develop work RVUs for the physician fee schedule specifically indicates that the interpretation of x-rays is included in the emergency room codes (but not in the other evaluation and management codes). However, we do not believe that the use of the term ''interpretation'' in this context indicates that the emergency room physician has furnished an in-depth interpretation with a report analogous to an interpretation and a report performed by a radiologist. We believe it is common practice for an emergency room physician to ''review'' x-rays and use the information gained in diagnosing and treating the patient, but that this review, without a report for inclusion in the patient's medical record maintained by the hospital, does not meet the requirement for payment of a professional component radiologic service.
- Section 13514 of the Omnibus Reconciliation Act of 1993, Public Law 103–66, enacted on August 10, 1993, requires us to make separate payment for EKG interpretations and to exclude the RVUs for EKG interpretations from the RVUs for visits and consultations.
- In a July 1993 report entitled, ''Medicare's Reimbursement for Interpretations of Hospital Emergency Room X-rays,'' the Office of Inspector General (OIG) recommended that we pay for a reinterpretation of x-rays only if the attending physician specifically requests a second physician's interpretation to furnish appropriate medical care before the patient is discharged. The report stated that any other reinterpretation of the attending physician's original interpretation should be treated and paid as part of the hospital's quality assurance program. (We note that the costs of quality control activities as discussed above are taken into account in determining payments made to the hospital by the hospital's Medicare fiscal intermediary.) The net effect of the OIG's proposal would be that, in many cases, Medicare carriers would not pay separately for the interpretation of x-rays by either the radiologist or the emergency room physician since the OIG operated on the assumption (as set forth in the Medicare Carriers Manual) that the emergency room physician is paid for the interpretation through the emergency room visit charge.
- The CPT coding system differs in its treatment of EKGs and x-rays. For EKGs, there is a separate code for the taking of an EKG tracing (CPT code 93005) and for the interpreting *and* reporting of the procedure (CPT code 93010). For x-rays, the code represents all aspects of the procedure, and a CPT modifier −26 is used when only the professional component is billed. On page 230 of the 1995 Edition, the CPT states: ''A written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation.''
- Under § 405.550(b)(2) (proposed to be redesignated as § 415.100(b)(2)), the Medicare carrier pays for services of physicians to patients of hospitals only if the services contribute directly to the diagnosis and treatment of an individual patient.
- There is no legal basis for a Medicare carrier to deny payment to any physician for the interpretation of a reasonable and necessary diagnostic test if payment for the interpretation is not made in some other way.

We believe that, in any situation in which the interpretation of the radiologist or cardiologist is furnished contemporaneously with the diagnosis and treatment of the patient, the Medicare carrier should pay for the interpretation made by the radiologist or cardiologist and deny any claim submitted by an emergency room physician for the x-ray interpretation. However, in the case of emergency room services, the specialist often does not perform the interpretation and prepare the report until a significant period of time (days in some situations) after the patient has been diagnosed, treated, and discharged. We believe that there are situations in which an emergency room physician performs the interpretation and report required by the patient and that a later interpretation furnished by the cardiologist or radiologist is essentially a quality control activity, the costs of which may be taken into account by Medicare fiscal intermediaries in their payments to hospitals. Nevertheless, if the hospital elects to have the cardiologist or radiologist perform and receive payment for the interpretation in every emergency room case, the hospital should ensure that other physicians who practice on its premises do not also bill for the same interpretation.

We believe that when a physician bills for the interpretation of an EKG or the professional component of an x-ray furnished to a beneficiary in an emergency room, the physician is indicating that he or she has prepared a written report of the findings for inclusion in the patient's medical record maintained by the hospital. We note that this also means the physician is

assuming legal responsibility for the interpretation and report.

We believe that, in most situations, the Medicare carrier should receive only one claim for an interpretation of each procedure. However, when multiple claims are received for the interpretation and report or professional component of an x-ray or an EKG, the carrier should pay for the service that directly contributed to the diagnosis and treatment of the beneficiary.

We will provide further guidance to the Medicare carriers through operating instructions. However, in practice, the carrier would almost always pay the first claim received (since the carrier would not know if a second bill will arrive). If a second bill is received, the Medicare carrier would suspend the claim to determine whether to pay the claim.

Listed below are the elements of our proposed policy. If the policy is adopted, we will incorporate the policy in a new Medicare Carriers Manual instruction.

- The carrier should generally pay separately for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. However, there should be provision for an additional interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.
- The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. We propose to place this requirement in the radiology section of the regulations on services of physicians in providers at § 405.554(a). (Under the recodification proposed in this regulation, this section would become 415.120(a).)
- We would distinguish between an ''interpretation and report'' of an x-ray or an EKG procedure and a ''review'' of the procedure. An interpretation and report of the procedure is separately payable by the carrier. A review of the findings of these procedures, without a written report, does not meet the conditions for separate payment of the service since the review is already included in the emergency room visit payment.
- In the case of multiple bills for the same interpretation and report, we would instruct the carriers to adopt the following procedures:

+ End the policy of considering physician specialty to be the prime consideration in deciding which interpretation and report to pay regardless of when the service is performed.

+ Pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.

+ Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed contemporaneously with the diagnosis and treatment of the beneficiary. (This interpretation may be a verbal report conveyed to the treating physician that will be written in a report at a later time.)

- We propose to minimize the carrier's need to make decisions about which claim to pay when multiple claims for the interpretation and report of the same procedure are received by—

+ Encouraging hospitals to exercise their authority over the medical staff to ensure that only one claim per interpretation is submitted;

+ Advising hospitals that if they allow a physician to perform and bill for a medically necessary service (the interpretation and report) in an emergency room and permit another physician to perform and bill for the same service, the Medicare carrier will not pay two claims;

+ Advising hospitals that the Medicare carrier may determine that the hospital's ''official interpretation'' is for quality control and liability purposes only and is a service to the hospital rather than to an individual beneficiary; and

+ Advising hospitals that Medicare fiscal intermediaries consider costs incurred for quality control activities in determining payments to hospitals.

- When the Medicare carrier receives only one claim for an interpretation and the procedure is reasonable and necessary, the carrier will pay the claim. When the claim is from a cardiologist or radiologist, we will not require the Medicare carrier to make a determination of whether the service is a quality control service. We will presume that the one service billed was a service to the individual beneficiary.

D. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers (ASCs)

Services that are performed more than 50 percent of the time in office settings are subject to a site-of-service payment differential if they are performed in hospital outpatient departments and inpatient settings. For these procedures, the PE RVUs are reduced by 50 percent. We base the PE RVUs on charge data from the office setting. We assume that office charge data accurately reflect physician PEs in the office setting. Therefore, for office-based services, the PE RVUs reflect office practice costs. The payment differential reflects the fact that PEs are lower for services performed in hospital settings using hospital equipment, personnel, and space. We developed the site-of-service payment differential under the authority of section 1848(c)(4) of the Act, which permits the Secretary to establish ancillary policies necessary to implement the physician fee schedule. Services furnished in ASCs were originally exempt from the site-of-service payment differential because ASC-approved procedures were performed less than 50 percent of the time in a physician's office, that is, the ASC list and site-of-service payment differential were mutually exclusive.

However, now a procedure furnished more than 50 percent of the time in a physician's office may be an ASC-approved procedure, for example, when the ASC setting is more appropriate in cases when a patient needs anesthesia. Therefore, we propose extending the site-of-service payment differential to office-based services if those services are performed in an ASC.

We see no reason for exempting these procedures from the site-of-service payment differential because payments for overhead and other expenses included in the PE RVUs duplicate the expenses paid in the ASC facility payment rate, that is, the physician does not bear these expenses himself as he would in his own office. Therefore, in § 414.32 (''Determining payments for certain physician services furnished in facility settings''), we propose to remove from paragraph (d) (''Services excluded from the reduction'') the subordinate paragraph (d)(2), which would have the effect of applying the site-of-service payment differential to ASC services.

The following procedure codes currently on the ASC list are furnished more than 50 percent of the time in a physician's office. Therefore, we propose adding them to the list of services subject to the site-of-service payment differential.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST

HCPCS	Description
11042	Cleansing of skin/tissue.
11404	Removal of skin lesion.
11424	Removal of skin lesion.
11444	Removal of skin lesion.
11446	Removal of skin lesion.
11604	Removal of skin lesion.
11624	Removal of skin lesion.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
11644	Removal of skin lesion.
12021	Closure of split wound.
13100	Repair of wound or lesion.
13101	Repair of wound or lesion.
13120	Repair of wound or lesion.
13121	Repair of wound or lesion.
13131	Repair of wound or lesion.
13132	Repair of wound or lesion.
13150	Repair of wound or lesion.
13151	Repair of wound or lesion.
13152	Repair of wound or lesion.
14000	Skin tissue rearrangement.
14020	Skin tissue rearrangement.
14040	Skin tissue rearrangement.
14041	Skin tissue rearrangement.
14060	Skin tissue rearrangement.
14061	Skin tissue rearrangement.
15740	Island pedicle flap graft.
19100	Biopsy of breast.
20670	Removal of support implant.
21025	Excision of bone, lower jaw.
21026	Excision of facial bone(s).
21040	Removal of jaw bone lesion.
21041	Removal of jaw bone lesion.
21208	Augmentation of facial bones.
21210	Face bone graft.
21215	Lower jaw bone graft.
21248	Reconstruction of jaw.
21249	Reconstruction of jaw.
21440	Repair dental ridge fracture.
21485	Reset dislocated jaw.
21550	Biopsy of neck/chest.
21920	Biopsy soft tissue of back.
23066	Biopsy shoulder tissues.
23330	Remove shoulder foreign body.
23620	Treat humerus fracture.
23931	Drainage of arm bursa.
24065	Biopsy arm/elbow soft tissue.
24362	Reconstruct elbow joint.
25065	Biopsy forearm soft tissues.
25624	Treat wrist bone fracture.
25635	Treat wrist bone fracture.
26070	Explore/treat hand joint.
26432	Repair finger tendon.
26605	Treat metacarpal fracture.
26645	Treat thumb fracture.
27086	Remove hip foreign body.
27323	Biopsy thigh soft tissues.
27520	Treat kneecap fracture.
27604	Drain lower leg bursa.
27613	Biopsy lower leg soft tissue.
27760	Treatment of ankle fracture.
27780	Treatment of fibula fracture.
27786	Treatment of ankle fracture.
27788	Treatment of ankle fracture.
28003	Treatment of foot infection.
28030	Removal of foot nerve.
28043	Excision of foot lesion.
28092	Removal of toe lesions.
28222	Release of foot tendons.
28261	Revision of foot tendon.
28313	Repair deformity of toe.
28400	Treatment of heel fracture.
28635	Treat toe dislocation.
28665	Treat toe dislocation.
29850	Knee arthroscopy/surgery.
30124	Removal of nose lesion.
30560	Release of nasal adhesions.
30580	Repair upper jaw fistula.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
30801	Cauterization inner nose.
31233	Nasal/sinus endoscopy, dx.
31235	Nasal/sinus endoscopy, dx.
31237	Nasal/sinus endoscopy, surg.
31238	Nasal/sinus endoscopy, surg.
31525	Diagnostic laryngoscopy.
31570	Laryngoscopy with injection.
33011	Repeat drainage of heart sac.
38300	Drainage lymph node lesion.
38505	Needle biopsy, lymph node(s).
40510	Partial excision of lip.
40801	Drainage of mouth lesion.
40814	Excise/repair mouth lesion.
40816	Excision of mouth lesion.
40819	Excise lip or cheek fold.
40820	Treatment of mouth lesion.
41000	Drainage of mouth lesion.
41008	Drainage of mouth lesion.
41105	Biopsy of tongue.
41110	Excision of tongue lesion.
41112	Excision of tongue lesion.
41113	Excision of tongue lesion.
41800	Drainage of gum lesion.
41805	Removal foreign body, gum.
41806	Removal foreign body, jaw-bone.
41827	Excision of gum lesion.
42000	Drainage mouth roof lesion.
42104	Excision lesion, mouth roof.
42106	Excision lesion, mouth roof.
42107	Excision lesion, mouth roof.
42160	Treatment mouth roof lesion.
42300	Drainage of salivary gland.
42310	Drainage of salivary gland.
42335	Removal of salivary stone.
42340	Removal of salivary stone.
42405	Biopsy of salivary gland.
42408	Excision of salivary cyst.
42700	Drainage of tonsil abscess.
45305	Proctosigmoidoscopy; biopsy.
45308	Proctosigmoidoscopy.
45309	Proctosigmoidoscopy.
46050	Incision of anal abscess.
46220	Removal of anal tab.
46610	Anoscopy; remove lesion.
46611	Anoscopy.
51710	Change of bladder tube.
51725	Simple cystometrogram.
51726	Complex cystometrogram.
51772	Urethra pressure profile.
51785	Anal/urinary muscle study.
52000	Cystoscopy.
52010	Cystoscopy & duct catheter.
52281	Cystoscopy and treatment.
52285	Cystoscopy and treatment.
53420	Reconstruct urethra, stage 1.
54065	Destruction, penis lesion(s).
55700	Biopsy of prostate.
56405	I & D of vulva/perineum.
56605	Biopsy of vulva/perineum.
57180	Treat vaginal bleeding.
57800	Dilation of cervical canal.
60000	Drain thyroid/tongue cyst.
61070	Brain canal shunt procedure.
63600	Remove spinal cord lesion.
64420	Injection for nerve block.
65270	Repair of eye wound.
65805	Drainage of eye.
66030	Injection treatment of eye.
66762	Revision of iris.

PROCEDURE CODES TO BE ADDED TO THE SITE-OF-SERVICE DIFFERENTIAL LIST—Continued

HCPCS	Description
67031	Laser surgery, eye strands.
67101	Repair, detached retina.
67105	Repair, detached retina.
67141	Treatment of retina.
67208	Treatment of retinal lesion.
67921	Repair eyelid defect.
69424	Remove ventilating tube.

E. Services of Teaching Physicians

1. General Background

The focus of this proposal is Medicare payment for those services furnished under graduate medical education (GME) programs that are not payable through the mechanisms established for direct GME costs by section 1886(h) of the Act. Section 1886(h) addresses Medicare payments to hospitals and hospital-based providers for the costs of approved GME programs in medicine, osteopathy, dentistry, and podiatry. These costs include residents' salaries and fringe benefits, physician compensation costs for GME program activities that are not payable on a fee schedule basis, and other GME program costs.

Medicare intermediary expenditures under section 1886(h) of the Act for fiscal year (FY) 1996 are estimated to be approximately $1.9 billion. In addition, under section 1886(d)(5)(B) of the Act, Medicare makes additional payments to teaching hospitals under the prospective payment system (PPS) for the higher indirect operating costs hospitals incur by having GME programs. (These are costs other than direct GME costs.) Medicare indirect GME payments for FY 1996 are estimated to be approximately $4.9 billion. Medicare also supports GME programs in teaching hospitals through billings for the services of attending physicians who involve residents in the care of their patients. The amount of Medicare expenditures for these services is not known since attending physicians are not required to distinguish between services they personally furnish and those they furnish as attending physicians in claims submitted to the part B carriers.

This proposal addresses services of teaching physicians that are payable on a fee schedule basis, services of residents in settings that are not payable under section 1886(h), and services of moonlighting residents. In addition, the proposed rule addresses, but does not substantially change, existing rules on related issues on Medicare payments for the services of residents in approved

GME programs furnished in certain freestanding skilled nursing facilities (SNFs) and home health agencies (HHAs), and services of residents who are not in approved GME programs. We refer to the section 1886(h) mechanisms to distinguish between that payment methodology and other payment mechanisms.

Title XVIII of the Act provides separate coverage and payment bases for provider services and physician services. Under Medicare, provider services, such as inpatient hospital services and SNF services, are covered under Hospital Insurance (Part A) and are paid from the Part A Trust Fund. Outpatient hospital services are covered under Supplementary Medical Insurance (Part B) and are paid from the Part B Trust Fund. Provider services are paid on a prospective payment, reasonable cost, or other payment mechanism through Medicare contractors called ''fiscal intermediaries.'' Physician services and other ''medical and other health services,'' as defined in section 1861(s) of the Act are generally paid under Part B through Medicare contractors called ''carriers.'' To administer the Medicare program, we must distinguish clearly between provider services and physician services to determine the appropriate payment methodology and the appropriate Trust Fund that is liable for payment.

In part 405 (''Federal Health Insurance for the Aged and Disabled''), subpart D (''Principles of Reimbursement for Services by Hospital-Based Physicians''), regulations beginning with § 405.480 set forth the basic principles regarding payment for services of physicians who practice in providers. Additional principles applicable to payment for physician services in teaching hospitals appear in subpart E (''Criteria for Determination of Reasonable Charges; Payment for Services of Hospital Interns, Residents, and Supervising Physicians'') in §§ 405.520 and 405.521. Principles applicable to services of interns and residents appear in §§ 405.522 through 405.525. Sections 405.465 and 405.466 address the payment methodology for teaching hospitals that elect reasonable cost payments for physician services. (See sections 1832(a)(2)(B)(i)(II) and 1861(b)(7) of the Act.) Since the publication of these regulations, the Congress has enacted a series of legislative changes that affect payments for these services, and we propose to revise the regulations to conform to these statutory changes and to clarify current policy.

Section 948 of the Omnibus Reconciliation Act of 1980 (ORA '80) (Pub. L. 96–499), enacted on December 5, 1980, as amended by section 2307 of the Deficit Reduction Act of 1984 (DEFRA '84) (Pub. L. 98–369), enacted on July 18, 1984, addressed payments for physician services in teaching settings. (See section 1842(b)(7) of the Act.) Another pertinent legislative change, section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) (Pub. L. 97–248), enacted on September 3, 1982, added a new section 1887 to the Act. That legislation dealt explicitly with distinguishing between the professional services physicians furnish to individual patients in a provider and services physicians furnish to the provider itself. While section 1887 of the Act does not specifically address teaching physicians or GME issues, it is consistent with Medicare policy on classifying the activities in which physicians in teaching hospitals are engaged.

We published a final rule with comment period in the **Federal Register** on March 2, 1983 (48 FR 8902), which implemented the provisions of section 1887 of the Act. That final rule revised the regulations that govern Medicare payment for services of physicians who practice in providers such as hospitals, SNFs, and comprehensive outpatient rehabilitation facilities. As a part of that final rule, we revised §§ 405.480 through 405.482, removed §§ 405.483 through 405.488, and added new §§ 405.550 through 405.557. Those regulations—

- Set forth basic criteria for distinguishing those physician services furnished in providers that are payable by Part B carriers as physician services to individual patients from those services that are payable by fiscal intermediaries as physician services to the provider itself;
- Set limits on the amounts payable on a reasonable cost basis to providers for physician services to the provider; and
- Established more specific criteria for determining the basis and amount of payment for physician services in the specialties of anesthesiology, radiology, and pathology.

In the preamble to the March 1983 final rule (48 FR 8906), we stated that because of problems related to applying portions of the revised regulations to teaching hospitals and to implement sections 1842(b)(6) and 1861(b)(7) of the Act for physician payment (as amended by section 948 of ORA '80), we planned to publish, in a separate document, proposed regulations that would establish special rules governing payment for services of physicians in teaching hospitals. These rules would have superseded §§ 405.520 and 405.521 if they became effective. Subsequently, however, the Congress passed DEFRA '84, which further amended section 1842(b)(6) of the Act and redesignated it as section 1842(b)(7).

Another statutory change that affected payments to teaching hospitals was section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85) (Pub. L. 99–272), enacted on April 7, 1986, as amended by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) (Pub. L. 99–509), enacted on October 21, 1986, which added a new section 1886(h) to the Act. Section 1886(h) of the Act revised the method of calculating Medicare payment for the direct costs of approved GME activities such as residents' salaries and fringe benefits, from reasonable cost payment to payments based on hospital-specific per-resident amounts multiplied by the number of full-time equivalent (FTE) residents working in the hospital during a hospital's cost reporting period.

A major change in the Medicare payment rules for physician services in general was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) (Pub. L. 101–239), enacted on December 19, 1989, which added section 1848 to the Act. Section 1848 replaced the reasonable charge payment mechanism with a fee schedule for physician services. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Pub. L. 101–508), enacted on November 5, 1990, contained several modifications and clarifications to the OBRA '89 provisions that established the physician fee schedule.

2. Payment for Physician Services Furnished in Teaching Settings

a. Current Practices. Of the nearly 7,000 hospitals that participate in Medicare, approximately 1,200 have GME programs that are approved for residency training by the appropriate accrediting organization. (We are using the term ''residents'' in this preamble to include residents, interns, and fellows who are in formally organized and approved GME programs.)

For hospital cost reporting periods beginning on or after July 1, 1985, the costs of residents' compensation (representing payment for the residents' services), certain physician compensation costs related to GME programs, and other GME program costs are payable based on hospital-specific per-resident amounts as described in

§ 413.86, in accordance with section 1886(h) of the Act. Physician compensation costs for administrative and supervisory services unrelated to the GME program or other approved educational activities are payable as operating costs through diagnosis-related group payments under PPS for inpatient services and on a reasonable cost basis for inpatient services in hospitals excluded from PPS and for outpatient services.

In the case of those few teaching hospitals that elect reasonable cost payments for physician direct medical and surgical services under section 1861(b)(7) of the Act instead of billing for services to Medicare beneficiaries on a fee-for-service basis, the election and payment mechanisms described in current §§ 405.465 and 405.466 would be set forth in this proposed rule in new § 415.160 and in redesignated §§ 415.162 and 415.164.

Practices vary widely among and within teaching hospitals with respect to the degree of physician involvement in the care of patients. In some cases, teaching physicians personally direct residents in furnishing patient care services. In others, residents assume a greater degree of responsibility for the care patients receive, and the teaching physicians exercise only general control over the residents' activities.

b. Statutory and Other Developments Pertaining to Teaching Physician Services. (1) Original Medicare Law and Regulations. As originally enacted, title XVIII of the Act excluded the services of physicians, interns, and residents from the definition of ''inpatient hospital services,'' except for the services of interns and residents in approved training programs. The services of residents in an approved program of a hospital with which an SNF has a transfer agreement are included in the definition of ''extended care services'' and in the definition of ''home health services'' in the case of an HHA that is affiliated with or under common control of a hospital having the program. These provisions established the costs of approved GME programs for provider services payable by intermediaries on a reasonable cost basis. The Act did not include special rules for payment of physician services in teaching hospitals.

Under §§ 405.520 and 405.521 for teaching physician services, and §§ 405.522 through 405.525 for residents' services, a physician in a teaching setting is considered the attending physician for a Medicare patient, and thereby qualifies for Part B payment, only if he or she furnishes ''personal and identifiable direction'' to the interns and residents who provide the actual services to the patient. Before January 1, 1992, Part B physician services were paid under the reasonable charge payment system. As of January 1, 1992, these physician services are paid under the physician fee schedule set forth in part 414 (56 FR 59502).

Although § 405.521(b) lists examples that illustrate the types of responsibilities attending physicians typically carry out, the list is not exhaustive. In individual cases, it may be difficult to determine, by referring to § 405.521, whether a physician in a teaching setting is the ''attending physician'' for a Medicare patient. It may be necessary for the carrier to review hospital charts to see if the attending physician requirements were met; however, the involvement of the teaching physician in individual services is often unclear from a review of the charts.

It became apparent, shortly after §§ 405.520 and 405.521 were issued, that some Medicare carriers were paying charges for physician services in some teaching hospitals, even though interns and residents were primarily responsible for the care of the patients. The physicians who were billing for these services were often assuming only limited responsibility for the medical management of the patients' treatment. It also became clear that some physicians were submitting charges for services furnished to Medicare patients even though non-Medicare patients were not billed for similar services, and patients generally were not obligated to pay for these physician services.

In April 1969, these problems led to the issuance of Intermediary Letter (I.L.) 372, which sets forth specific conditions that physicians in teaching settings must meet to be considered attending physicians and, thus, qualify to charge the carrier for services in which they involve residents. It also specifies how carriers must determine the reasonable charges for these services. Although I.L. 372, which is still in effect, has provided guidance to Medicare carriers and intermediaries on payment for these services, it has not been applied uniformly by all Medicare carriers.

(2) 1972 Amendments. On October 30, 1972, the Congress amended the Act to provide rules on payment for physician services (as distinguished from the services of interns and residents) furnished in teaching hospitals. Section 227 of the Social Security Amendments of 1972 (Pub. L. 92–603) amended section 1861(b) of the Act to require that Medicare treat these services as hospital services and pay for them on a reasonable cost basis, except under certain specific circumstances. Section 227 also made certain incentives available to hospitals that elected to be paid for physician services on a reasonable cost basis.

In subsequent legislation (section 15 of Pub. L. 93–233, enacted on December 31, 1973, and section 7 of the End-Stage Renal Disease Program Amendments of 1978 (Pub. L. 95–292), enacted on June 13, 1978), the Congress deferred implementation of all provisions of section 227 of the 1972 amendments except for the incentives to elect reasonable cost payment for physician direct medical and surgical services. The cost reimbursement provisions were implemented through § 405.465, as published in a final rule on August 8, 1975 (40 FR 33440). The statutory provisions for which the Congress deferred implementation were eventually replaced by new provisions passed by the Congress in ORA '80. ORA '80 reaffirmed, but did not otherwise affect, the provisions of section 227 of the 1972 amendments authorizing cost reimbursement incentives.

(3) ORA '80. Section 948 of ORA '80 made several important changes in the sections of the Medicare statute that address payment for physician services in teaching hospitals. Specifically, section 948—

- Repealed the provisions of the 1972 Amendments that required Medicare to pay for these services (with certain exceptions) on a reasonable cost basis;
- Amended section 1861(b) of the Act to allow hospitals with approved teaching programs to elect to be paid on a reasonable cost basis for physician direct medical and surgical services furnished to their Medicare patients and for the supervision of interns and residents in the care of individual patients if all physicians in the hospital agree not to bill charges for their services furnished to Medicare patients; and
- Added section 1842(b)(6) of the Act (now section 1842(b)(7)) to specify the conditions that must be met to permit payment under Part B for physician services in teaching hospitals that do not elect cost reimbursement, and to provide special payment rules for determining the customary charges applicable in this situation.

In the Conference Report accompanying ORA '80 (H.R. Rep. No. 1479, 96th Cong., 2d Sess. 145 (1980)), the Conference Committee stated that its intention was to permit payment for physician services in a teaching hospital on a reasonable charge basis only if the physician is the patient's ''attending physician.'' The conferees also endorsed

the attending physician criteria in I.L. 372.

The Conference Report further states that ''[t]he conferees intend (without precluding reasonable changes in the future) that in determining the amount payable on a charge basis under Medicare Part B for services of physicians in teaching hospitals, the policies contained in I.L. 372 should be generally followed where these are not inconsistent with the provisions of the conference agreement.'' *Ibid. p. 146.*

(4) DEFRA '84. Subsequently, section 2307(a) of DEFRA '84 further amended section 1842(b)(7) of the Act concerning conditions for payment for physician services furnished in teaching hospitals that do not elect cost reimbursement. Section 2307(a) was later amended by sections 3(b) (5) and (6) of the DEFRA Technical Amendments (Pub. L. 98–617), enacted on November 8, 1984. As revised, section 1842(b)(7) of the Act (which was redesignated from section 1842(b)(6) of the Act by section 2306 of DEFRA '84) provides that—

- The customary charge of a physician qualifying as a teaching physician is set no lower than 85 percent of the prevailing charge paid for similar services in the same locality; and
- If all the teaching physicians in a teaching hospital agree to accept assignment for all the services they furnish to Medicare patients in that hospital, the customary charge is set at 90 percent of the prevailing charge paid for similar services in the same locality.

(5) 1989 Proposed Rule. On February 7, 1989, we published a proposed rule that would have implemented the teaching physician payment provisions of both ORA '80 and DEFRA '84 (54 FR 5946). In that document, we proposed the following changes relating to teaching physicians:

- Revise the regulations governing the conditions under which Medicare payment is made for the services of physicians in teaching settings and implement a special methodology for determining customary charges for the services of teaching physicians.
- Revise the regulations governing Medicare payment to providers for compensation paid to physicians who furnish services that are of general benefit to patients in the provider.

That proposed rule was never published in final because legislation enacted in 1989 and 1990 that mandated the implementation of the Medicare physician fee schedule had the effect of replacing the payment methodology of the proposed rule.

3. Payments for Supervising Physicians in Teaching Settings and for Residents in Certain Settings

We propose to revise the regulations because of the substantial changes that have taken place in the way Medicare payments for physician services are determined (that is, the replacement of the reasonable charge system with the physician fee schedule); the length of time since the publication of the February 1989 proposed rule; and our decision to propose to replace the attending physician criteria of that proposed rule.

We propose to change the attending physician criteria from those of I.L. 372 to make the criteria more flexible in terms of the individual teaching physician who may serve as the responsible physician for a particular service while ensuring that a physician is present during at least some portion of each service payable by the carrier. We also propose rules based on other Medicare policies that have been in effect for years but have never been explicitly addressed in the regulations.

a. Distinction Between Teaching Hospital and Teaching Setting. We propose to distinguish between ''teaching hospital'' and ''teaching setting,'' because the former is more directly related to intermediary payments, and the latter (although defined in terms of intermediary payments) is more directly related to carrier payments. We propose to define ''teaching hospital'' as a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry. We propose to define ''teaching setting'' as a provider or freestanding setting in which Medicare payment for the services of residents is made under the direct GME payment provisions of § 413.86 (hospitals, hospital-based providers, and settings, including nonprovider settings, meeting the requirements for residents in § 413.86(f)(1)(iii)), or on a reasonable cost basis under the provisions of § 409.26 or § 409.40(f) for residents' services furnished in freestanding SNFs or HHAs, respectively.

b. Statutory Requirements for Payment in Teaching Hospitals Not Electing Reasonable Costs for Physician Services to Individual Patients. Section 1842(b)(7) of the Act is generally premised on the use of customary charges, that is, the reasonable charge system, as the basis for Medicare payments for the services of physicians in teaching hospitals. Section 1848 of the Act, however, established the physician fee schedule as the payment methodology for physician services furnished beginning January 1, 1992 without any exception for physician services furnished in teaching settings. Therefore, we based the policies in this proposed rule on principles established in legislation on payment for physician services generally under the physician fee schedule, on payment for physician services furnished in providers, and on payment to hospitals for GME programs. With regard to payment to hospitals for GME programs, this proposal addresses activities associated with GME programs that are not payable through fiscal intermediary payment mechanisms.

c. Intermediary Letter (I.L.) 372 Attending Physician Criteria. The I.L. 372 attending physician criteria and related policy were developed by Medicare in 1969 as a means of documenting the involvement of teaching physicians in patient care services furnished in teaching hospitals and have been controversial ever since. It was recognized then and now that residents must furnish patient care services to develop their skills as physicians or other types of practitioners. The ''attending physician'' policy was developed as a mechanism to make Part B fee schedule payments for services in which residents were involved. The main requirement of the policy was that there would be a single attending physician who personally examined the beneficiary within a reasonable time after admission, confirmed the diagnosis and course of treatment, and was continuously involved in the care of the beneficiary throughout the stay. The attending physician policy as set forth in I.L. 372 and related issuances specifically stated that the attending physician had to be present when a major surgical procedure or a complex or dangerous medical procedure was performed, but was vague, perhaps necessarily, on the matter of the presence of the physician during other occasions of inpatient service. There was less ambiguity with regard to hospital outpatients. Part A I.L. No. 70–7/Part B I.L. No. 70–2 (issued in January 1970), a question-and-answer I.L. on I.L. 372, indicated that the supervising physician must either personally perform the service or function as the attending physician and be present while a service is being furnished (question 14).

Medicare carriers were directed to periodically review the hospital charts for verification of the establishment of attending physician relationships and their involvement in individual services. If the chart did not substantiate a sufficient level of involvement in the care furnished, the teaching physician role was seen as supervisory in nature,

rather than as an attending physician, even though the teaching physician may have had legal responsibility for the care furnished to the patient. Consequently, the fiscal intermediary for the hospital would pay Medicare's share of the salary costs of the teaching physician attributable to the supervision of residents, but the Medicare carrier would not make payment for the physician services on the basis of reasonable charges.

We believe, after years of working experience with the I.L. 372 attending physician policy, that we should replace it. The amount of postpayment review necessary to verify the establishment and continuity of the attending physician relationship from patient charts has become impractical given reductions in contractor budgets and is inconsistent with more recent congressional action. While the Congress endorsed the attending physician policy in the Conference Report accompanying ORA '80, the I.L. 372 policy may be viewed as not entirely consistent with the payment mechanism enacted in OBRA '86 under section 1886(h) of the Act for payment of direct GME costs in teaching hospitals. For example, I.L. 372 indicates that, if a physician is not an attending physician but supervises a resident who furnishes a service, the costs of the physician services are payable by the intermediary. Under section 1886(h) of the Act, if a service is determined not to be an attending physician service billable under Part B, the service cannot become a provider service for purposes of additional payments made under Part A since the GME payments are prospectively determined amounts that cannot be adjusted based on the individual circumstances of the delivery of individual services. Further, allocation agreements between physicians and hospitals identifying the various activities in which the physicians are involved for purposes of determining the appropriate payment amounts have no effect on GME payments in an individual hospital cost reporting period. The costs that were allocated during the GME base period are carried forward regardless of changes in the physician activities.

Moreover, the I.L. 372 policy left it to individual carriers to determine coverage of the services based on customary practices in the area or on the competence of individual residents. For example, a sentence in I.L. 372.A. reads as follows:

> If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

While this policy might have been appropriate 30 years ago in the early days of Medicare, we now believe it is inappropriate to base the determination of whether a carrier will pay several thousand dollars or zero dollars for a surgical procedure on this standard, which could result in a wide disparity of policy from area to area regarding when payment is made.

Another problem with the I.L. 372 policy is reliance on a single physician to be the attending physician for the beneficiary throughout the inpatient stay. The only exception permitting an attending physician relationship for only a portion of a stay was if the portion was a distinct segment of the patient's course of treatment, such as the postoperative period. Another example from I.L. 372 reads as follows:

> A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patients' attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

We now believe that this emphasis on a single teaching physician serving as the attending physician through the stay is no longer necessary, and that we should provide teaching hospitals and GME programs with flexibility in the determination of the responsible teaching physician in an individual case. We no longer believe the I.L. 372 requirement that a single physician be recognized by the beneficiary as his or her personal physician through a period of hospitalization reflects current realities. Further, the existing attending physician regulation may operate at cross-purposes with managed care arrangements that often employ treatment teams.

The I.L. 372 requirements for continuity of care may be difficult for carriers to verify from reviews of medical records, may be interpreted in different ways by different carriers, and may be counterproductive and burdensome in the delivery of services to the patient. We believe the proposed policy would address potential sources of misunderstanding and abuse that have been longstanding Medicare program concerns. For example, I.L. 372 requires the attending physician to personally examine the patient, review the history and record of test results, etc. From discussions with carrier medical directors, it is our understanding that some carriers consider the requirements to be met if the responsible physician first sees the patient 1 or 2 days after admission. In these situations, the carrier might pay for an admission history and physical performed by a resident on Saturday while the responsible physician does not actually see and examine the patient until Monday. Other carriers would maintain that, to pay for the admission history and physical as an attending physician, the teaching physician would have to see the patient on the day the service was performed.

We now believe that the most important consideration should be the presence of the teaching physician during the key portion of the service or procedure being furnished by the resident, and that requiring both an attending physician relationship *and* the presence of that same physician during every billable service is not warranted. Thus, under our proposal, carriers would no longer pay for services such as admission evaluation and management services unless a teaching physician was present during the key portion of the service.

d. Carrier Payment for Services of Teaching Physicians—General. We propose to eliminate the I.L. 372 attending physician criteria from the determination of whether payment should be made for the services of physicians in teaching settings. We recognize that the term ''attending physician'' is used in academic medicine to denote the responsible physician, and we believe that hospitals and GME programs should be free to designate any physician to be the attending physician of the patients in the teaching setting. We propose to require the following conditions for services of teaching physicians (physicians who involve residents in the care of their patients) in both inpatient and outpatient settings to be payable under the physician fee schedule:

- A teaching physician (a physician other than a resident or fellow in an approved program) must be present for a key portion of the time during the performance of the service for which payment is sought.
- In the case of surgery or a dangerous or complex procedure, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure. We would specify that the teaching physician presence requirement is not met when

the presence of a teaching physician is required in two places for concurrent major surgeries. The operative notes must indicate when the teaching physician presence in individual procedures began and ended. In the case of minor procedures, such as an endoscopy in which a body area, rather than a representation, is viewed, we would not make payment if the teaching physician was not present during the viewing. A discussion of the findings with a resident would not be sufficient. The situation is contrasted with a diagnostic procedure, such as an x-ray, in which the physician would not be expected to be present during the performance of a test and could bill for an interpretation by reviewing the film with the resident (or by performing an independent interpretation).

- In the case of services such as evaluation and management services (for example, visits and consultations), for which there are several levels of service available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service if the service had been fully furnished by the teaching physician. In other words, if the medical decisionmaking in an individual service is highly complex to an inexperienced resident, but straightforward to the teaching physician, payment is made at the lower payment level reflecting the involvement of the teaching physician in the service. We intend to promote flexibility and leave the decision to the teaching physician as to whether the teaching physician should perform hands-on care, in addition to the care furnished by the resident in the presence of the teaching physician. However, in the case of both hospital inpatient and outpatient evaluation and management services, the teaching physician must be present during the key portion of the visit.
- The presence of the physician during the service or procedure must be documented in the medical records.

The proposal eliminates the I.L. 372 requirement that the attending physician personally examine the patient and leaves the decision to the teaching physician as to whether he or she should perform an examination in addition to the resident's examination based on medical and risk management considerations rather than Medicare payment rules. For example, a beneficiary may be admitted to the hospital on a Saturday and be examined by a resident in the presence of a teaching physician on duty at the time. On Monday, another teaching physician might be designated to be the attending physician in the case. Under the proposal to eliminate the I.L. 372 attending physician criteria, the services of both teaching physicians in this example would be payable (as long as distinct services are furnished).

Under our proposal, we are clarifying that services of teaching physicians that involve the supervision of residents in the care of individual patients are payable under the physician fee schedule only if the teaching physician is present during the key portion of the service. If a teaching physician is engaged in such activities as discussions of the patient's treatment with a resident but is not present during any portion of the session with the patient, we believe that the supervisory service furnished is a teaching service as distinguished from a physician service to an individual patient.

We believe that this clarification is consistent with existing policy. Part A I.L. No. 70–7/Part B I.L. No. 70–2, issued in January 1970 and still in effect, contains a series of questions and answers about the attending physician policy set forth in I.L. No. 372. Question 14 of that issuance addresses services furnished in emergency rooms and outpatient departments and states the following:

> Q. Intermediary letter No. 372 states, ''An emergency room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff, etc.'' Is this also true in the hospital's outpatient department?
>
> A. Yes, because an attending physician relationship is not normally established with anyone other than the treating physician in an outpatient department. If the Part B bills are submitted for services performed by a physician in either the emergency room or in any part of the outpatient department, the hospital records should clearly indicate either that: The supervising physician *personally* performed the service; or he functioned as the patient's attending physician and was present at the furnishing of the service for which payment is claimed.

At the same time we are concerned about the integrity of the Medicare payment process, we recognize that application of this policy to the reimbursement of teaching physicians in family practice residency programs raises special concerns about the viability of these programs. Family practice residency programs are different from other programs because training occurs primarily in an outpatient setting, known as a family practice center. In these centers, residents are assigned a panel of patients for whom they will provide care throughout their 3 years of training. While teaching physicians supervise this care and, indeed, are present during the actual furnishing of services in some circumstances (most notably with first year residents and for more complex patient cases) a general requirement that teaching physicians be physically present during all visits to the family practice center would undermine the development of this physician/patient relationship. This requirement also would be incompatible with the way family practice centers are organized and staffed and could require the hiring of additional teaching physicians when the faculty are already in short supply.

We are willing to develop a special rule for paying teaching family physicians that takes into account the unique nature of these training programs while clarifying the appropriate level of involvement of the teaching physician in patient care in family practice centers. We invite comments on the structure and content of such a rule, or a legislative proposal, along with any supportive data. We also invite comments on whether and how such a rule might be applied to other primary care training programs.

e. Special Treatment—Psychiatric Services. During the period in which we were developing the February 1989 proposed rule, we met with representatives of psychiatric GME programs who indicated that it was inappropriate for a physician other than the treating resident to be viewed by psychiatric patients as their physician. In psychiatric programs, the teaching physician may observe a resident's treatment of patients only through one-way mirrors or video equipment. We have accepted this position and propose that, with respect to psychiatric services (including evaluation and management services) furnished under an approved psychiatric GME program, the teaching physician would be considered to be ''present'' during each visit for which payment is sought as long as the teaching physician observes the visit through visual devices and meets with the patient after the visit.

f. Physician Services Furnished to Renal Dialysis Patients in Teaching Hospitals. Effective for services furnished on or after August 1, 1983, Medicare pays for physician services to end-stage renal disease (ESRD) patients on the basis of the physician monthly capitation payment method described in § 414.314. This payment method generally applies to renal-related physician services furnished to outpatient maintenance dialysis patients, regardless of where the services are furnished (that is, in an independent ESRD facility, a hospital-based ESRD facility, or in the patient's home). Physician services furnished to ESRD patients on or after August 7,

1990 may also be paid on the basis of the initial method as described in § 414.313. We would continue application of these physician payment methods to teaching hospitals with ESRD facilities. We would not impose any special medical record documentation requirements solely because the ESRD facility is based in a teaching hospital.

Physician fee schedule payments for covered physician services furnished to inpatients in a hospital by a physician who elects not to continue to receive payment on a monthly capitation basis through the period of the inpatient stay, or who is paid based on the initial method, would be determined according to the rules described in proposed § 415.170. Physicians would have to either personally furnish the services, or furnish the services as a teaching physician as described in proposed § 415.172.

g. Special Criteria for Anesthesia Services and Interpretation of Diagnostic Tests. Special criteria for anesthesia services involving residents appear in § 414.46(c)(2)(iii). In the case of diagnostic radiology and other diagnostic tests, we make payment for the interpretation if the physician either personally performs the interpretation or reviews the resident's interpretation.

h. Services of Residents. We propose to incorporate into the regulations longstanding Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services. These policies are currently in operating instructions and other issuances.

Generally, the services of residents in approved GME programs furnished in hospitals and hospital-based providers are payable through the direct GME payment methodology in § 413.86. For hospital cost reporting periods beginning on or after July 1, 1985, a teaching hospital is entitled to include residents working in the hospital and hospital-based providers in the FTE count used to compute direct GME payments. These payments are based on per-resident amounts reflecting GME costs incurred during a base period and updated by the Consumer Price Index. Further, effective July 1, 1987, under the conditions set forth in § 413.86(f)(1)(iii), a teaching hospital may elect to enter into a written agreement with another entity for the purpose of including the time spent by residents in furnishing patient care services in a setting outside the hospital in the hospital's FTE count of residents for GME purposes. The agreement must specify that the hospital compensate the resident for the services in the nonhospital setting. When an agreement is in effect, the teaching setting guidelines of proposed §§ 415.170 through 415.184 would apply to services in which physicians involve residents in the nonhospital setting. The services of residents in these settings are payable as hospital services rather than physician services. Proposed § 415.200 would replace the current § 405.522.

The current § 405.523 addresses payment for the services of residents who are not in approved programs. The section is applicable to the services of a physician employed by a hospital who is authorized to practice only in a hospital setting and to residents in an unapproved program. We propose to replace this rule with proposed § 415.202. The proposed rule incorporates the policy currently in section 404.1.B of the Provider Reimbursement Manual (HCFA Pub. 15–1) which provides that only the costs of the residents' services are allowable as Part B costs, and that other costs, such as teaching costs, of an unapproved program are not allowable.

The current § 405.524 (''Interns' and residents' services outside the hospital'') provides for reasonable cost payments for the services of residents in freestanding SNFs and HHAs. We propose to rename this section to clarify that its scope is limited to these types of providers and to include it with only minor changes into a new § 415.204.

We propose to establish a new § 415.206 to address payment issues relating to the services of residents in nonprovider settings, such as freestanding clinics that are not part of a hospital. Paragraph (a) addresses situations when a teaching hospital and another entity have entered into a written agreement under which the time the residents spend in patient care activities in these nonhospital settings is included in the hospital's FTE count used to compute direct GME payments. If an agreement is in force, the carrier would make payments for teaching physician and other physician services under the rules in §§ 415.170 through 415.190.

If a nonprovider entity, such as a freestanding family practice or multispecialty clinic, does not enter into this type of agreement for residency training with a teaching hospital, the payment mechanism in proposed § 415.206(b) would apply in the case of services furnished by certain residents. We modified the policy on Part B billings for services furnished by licensed residents in the late 1970's in an action designed to enhance the ability of primary care residency programs to finance their training activities outside the teaching hospital setting. We revised the Medicare Carriers Manual (HCFA Pub. 14–3) to cover residents' services furnished in a setting that is not part of a hospital as physician services if the resident was fully licensed to practice by the State in which the service was performed. This policy applies whether or not the residents are functioning within the scope of their approved GME program. Under these circumstances, the resident is functioning in the capacity of a physician, and the teaching physician guidelines do not apply.

Additionally, the services of residents practicing in freestanding Federally qualified health centers (FQHCs) and rural health clinics (RHCs) who meet the requirements of proposed § 415.206(b) would be eligible for payment under the FQHC payment methodology. (We would make payments for residents' services in a hospital-based entity under the provisions of § 413.86 for direct GME payments.) We propose to allow freestanding FQHCs and RHCs to include the costs of a service performed by a resident meeting those requirements as an allowable cost on the entity's cost report. We propose to amend § 405.2468(b)(1), which sets forth allowable costs for FQHC and RHC services, to recognize these costs. Further, a resident is considered to be a physician as defined in revised § 405.2401(b) for the purpose of determining payments to the FQHC or RHC. Consistent with the FQHC and RHC payment method, payments for FQHC and RHC services furnished by residents in FQHCs and RHCs would be paid under § 405.2462 rather than under the physician fee schedule. In other words, services of the resident would be treated in exactly the same manner as services of other physicians who are not residents in the FQHC or RHC. We believe that recognizing the costs of these residents in FQHC and RHC settings would create more uniformity in the way these costs are treated by the Medicare program.

We propose to establish a new § 415.208 to address carrier payments for the services of ''moonlighting'' residents. Paragraph (a) defines these services as referring to services that licensed residents perform that are outside the scope of an approved GME program. Paragraph (b) reflects the policy set forth in section 2020.8.C. of the Medicare Carriers Manual under which carriers may pay under the physician fee schedule for the services of moonlighting residents in the outpatient department or emergency

department of a hospital in which they have their training program if there is a contract between the resident and the hospital indicating that the following criteria are met:

- The services are identifiable physician services and meet the criteria in § 415.100(b) (currently § 405.550(b)).
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the services are performed.
- The services can be separately identified from those services that are required as part of the approved GME program.

Paragraph (c) indicates that the moonlighting services of a resident furnished outside the scope of an approved GME program in a hospital or other setting that does not participate in the GME program are payable as physician services under the physician fee schedule.

i. Redesignation of Regulations on Teaching Hospitals, Teaching Physicians, and Physicians Who Practice in Providers. As a part of this rulemaking process, we would redesignate the regulations currently set forth in §§ 405.465 and 405.466, 405.480 through 405.482, 405.522 through 405.524, 405.550, 405.551, 405.554, 405.556, and 405.580 into a new part 415, along with the new regulations proposed in this rule. This redesignation is part of our continuing effort to improve the overall organization of title 42 of the CFR and, in this case, specifically, the organization of the regulations on teaching hospitals, teaching physicians, and physicians who practice in providers.

Except as indicated below, we are making only technical changes to conform cross-references, and no substantive changes are included. We would remove §§ 405.520 and 405.521 because the applicable rules for payment of services are obsolete. We would also remove the chart for payment to interns and residents in § 405.525 as obsolete. In addition, we would remove § 405.552 because the applicable payment rules for anesthesia services are set forth in § 414.46.

We intend this redesignation to make these regulations easier to use. Following is a distribution table that indicates where each section of the original material would be moved or why it would no longer be needed, and the new section numbers that would result from the redesignation:

DISTRIBUTION TABLE

Old section	New section
405.465	415.162.
405.466	415.164.
405.480	415.55.
405.481	415.60.
405.482	415.70.
405.520	Removed.
405.521	Removed.
405.522	415.200.
405.523	415.202.
405.524	415.204.
405.525	Removed.
405.550	415.100.
405.551	415.105.
405.552	Removed.
405.554	415.120.
405.556	415.130.
405.580	415.190.

Following is a derivation table that shows the origin of each section of the new material:

DERIVATION TABLE

New section	Old section
415.1	
415.50	
415.55	405.480
415.60	405.481
415.70	405.482
415.100	405.550
415.105	405.551
415.120	405.554
415.130	405.556
415.150	
415.152	
415.160	
415.162	405.465
415.164	405.466
415.170	
415.172	
415.176	
415.178	
415.180	
415.184	
415.190	405.580
415.200	405.522
415.202	405.523
415.204	405.524
415.206	
415.208	

F. Unspecified Physical and Occupational Therapy Services (HCPCS Codes M0005 Through M0008 and H5300)

We propose to eliminate HCPCS codes M0005 through M0008 and H5300 and redistribute the RVUs to the codes in the physical medicine section of the CPT (CPT codes 97010 through 97799). This proposal represents a single way of reporting and paying for a service for which there are now two ways to report and would be a payment policy change. We propose no change to what services may be covered, only to how covered services would be billed and paid.

We propose this change because HCPCS codes M0005 through M0008 and H5300 fail to accurately describe the services furnished. Therefore, we are unable to establish resource-based work RVUs for them as the statute requires. Moreover, because the codes do not accurately describe the services being furnished, they preclude effective review to determine that the services being paid are covered by Medicare.

We believe that the CPT codes and the remaining HCPCS codes provide a sufficient means for physicians, physical therapists in independent practice (PTIPs), and occupational therapists in independent practice (OTIPs) to bill and be paid for the covered services they furnish. In 1995, the AMA revised the codes in the Physical Medicine and Rehabilitation section of the CPT to better reflect the provision of physical and occupational therapy services. The American Physical Therapy Association and the American Occupational Therapy Association are members of the Health Care Professional Advisory Committee (HCPAC) of the AMA's Relative Value Update Committee (RUC) and participated in the creation of new codes for 1995 and in the RUC's recommendations to us for the assignment of work RVUs for these codes.

As a result of these coding changes, we established interim resource-based work RVUs for the services described by the new CPT codes. We will consider public comments received on the interim RVUs and establish final RVUs for these new codes for 1996. The CPT and RUC processes of the AMA provide for the opportunity to include all codes necessary to bill physical and occupational therapy services listed in the CPT, should further changes to the CPT be necessary.

In addition to the new CPT codes for physical medicine services, HCPCS codes Q0103, Q0104, Q0109, and Q0110 describe the evaluation and management work of PTIPs and OTIPs when they establish a plan of care and periodically review that plan. While physicians may bill the CPT evaluation and management codes, PTIPs and OTIPs may not bill these codes because, unlike physicians, the evaluation and management services PTIPs and OTIPs furnish do not include consideration of chemotherapeutic or surgical alternatives to physical or occupational therapy. We understand that the HCPAC will be considering creation of codes to describe the evaluation and management services furnished by

PTIPs and OTIPs for 1997, at which time we expect to eliminate the Q codes that currently serve this purpose.

We believe that each unit of service currently billed under the codes we propose to delete will be billed under a CPT or HCPCS code and that the total amount of Medicare payment for physical medicine services will not change significantly as a result of the elimination of these codes. This proposal reflects a policy change that is not explicitly addressed in our regulations.

G. Transportation in Connection With Furnishing Diagnostic Tests

We have received a number of inquiries about the conditions under which carriers should pay for the transportation of diagnostic equipment used to furnish procedures payable under the physician fee schedule. Medicare carriers have been told for years that, in the absence of specific instructions from us, it was within their discretion to determine when payment for the transportation of diagnostic equipment should be made. We are proposing to enunciate a national policy now. Under our proposal, Medicare carriers would apply the general physician fee schedule policy on additional payments for travel expenses to transportation services except as indicated below.

Section 1861(s)(3) of the Act establishes the coverage of diagnostic x-rays furnished in a place of residence used as the patient's home if the performance of the tests meets health and safety conditions established by the Secretary. This provision is the basis for payment of x-ray services furnished by approved portable suppliers to beneficiaries in their homes and in nursing facilities.

Although the Congress did not explicitly so state, we determined that, because there were increased costs in transporting the x-ray equipment to the beneficiary, the Congress intended that we pay an additional amount for the transportation expenses. Therefore, we established HCPCS codes R0070 and R0075 (for single-patient and multiple-patient trips, respectively) to pay approved portable x-ray suppliers a transportation ''component'' when they furnish the services listed in section 2070.4.C of the Medicare Carriers Manual.

We later added the taking of an EKG tracing to the list of services approved suppliers of portable x-ray services may furnish (section 2070.4.F. of the Medicare Carriers Manual) and established HCPCS code R0076 to pay for the transportation of EKG equipment. Many Medicare carriers have limited the use of HCPCS code R0076 to approved portable x-ray suppliers, but some Medicare carriers permit other types of entities, such as independent physiological laboratories (IPLs), to use the code.

Further, section 2070.1.G of the Medicare Carriers Manual provides for the coverage of an EKG tracing by an independent laboratory—

- In a home if the beneficiary is a ''homebound patient''; or
- In an institution used as a place of residence if the patient is confined to the facility and the facility does not have on-duty personnel qualified to perform the service.
- The Act does not make specific provision for furnishing diagnostic procedures payable under the physician fee schedule, other than portable x-rays, to beneficiaries in their residences. We have received inquiries from our regional offices regarding payment for the transportation of diagnostic equipment that have generally involved the equipment used to furnish ultrasound and cardiography procedures. We have also received complaints from suppliers of these types of services about variations in individual Medicare carrier policies on transportation payments. We have little information about the amounts of payments; however, in the case of portable x-ray services (which would not be affected by this proposal), the transportation payment is often several times higher than the payment for the procedure furnished.

As discussed in the preamble to our November 1991 final rule (56 FR 59605), the physician fee schedule policy includes travel in the PE of a medical practice; therefore, travel is compensated through the PE component of the RVUs for a service. The preamble of the November 1991 final rule further states that CPT code 99081 may be used to bill for unusual travel in unusual cases and that carriers would handle these billings on a ''by report'' basis. Section 15026 of the Medicare Carriers Manual adds the stipulation that CPT code 99082 is payable only when the travel is ''very unusual.''

The scope of this proposal is limited to transportation expenses associated with diagnostic tests that are payable under the physician fee schedule. It would apply both to payments made in connection with the transportation of diagnostic equipment to the beneficiary and to the transportation of equipment to a site, such as a physician's office, for use in furnishing tests to beneficiaries. We are not proposing to place this policy in regulations, but we would change the applicable sections of the Medicare Carriers Manual.

Under our proposal, Medicare carriers would continue to pay for the transportation of x-ray and EKG equipment in some cases. The following exceptions to the general rule on payment for travel are based on our interpretation of statutory requirements in the case of x-rays and specific longstanding policy in the case of EKGs.

- Medicare carriers would continue to make transportation payments under HCPCS codes R0070 and R0075 in connection with portable x-ray procedures if approved suppliers furnish the services described in section 2070.4.C. of the Medicare Carriers Manual:
  + Skeletal films involving arms and legs, pelvis, vertebral column, and skull.
  + Chest films that do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations).
  + Abdominal films that do not involve the use of contrast media.
- Medicare carriers would make transportation payments under HCPCS code R0076 in connection with standard EKG procedures if the approved portable x-ray supplier furnishes the service described by CPT code 93005 (or CPT 93000, if the interpretation is billed with the tracing).
- Medicare carriers would make transportation payments under HCPCS R0076 in connection with standard EKG procedures (CPT code 93005) furnished by an IPL when—
  + The IPL meets applicable State and local licensure laws;
  + The EKG is ordered by a referring physician; and
  + The carrier determines the service to be reasonable and necessary. (See section 2070.5. of the Medicare Carriers Manual.)
- We would delete the reference to EKGs in the existing section 2070.1.G. of the Medicare Carriers Manual and place the policy in a revised section 2070.5 of the Medicare Carriers Manual. However, we would remove the requirement that the beneficiary be confined to his or her home or to an institution for the EKG tracing to be covered since this requirement does not apply to EKG tracings taken by portable x-ray suppliers.
- For all other types of diagnostic tests payable under the physician fee schedule, Medicare carriers would pay for the transportation of equipment only on a ''by report'' basis under CPT code 99082 if a physician submits documentation to justify the ''very unusual'' travel as set forth in section

15026 of the Medicare Carriers Manual. An example of such a circumstance could be when a beneficiary in a nursing facility is in immediate need of a diagnostic test and there is a problem, such as extreme obesity, with transporting the individual to a facility.

H. Maxillofacial Prosthetic Services

At present, payment amounts for the maxillofacial prosthetic services (CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021) are determined by individual Medicare carriers. We propose to eliminate the carrier-priced status and establish RVUs for these codes effective for services performed on or after January 1, 1996. We propose to determine fee schedule payment amounts based on the RVUs shown in the table below.

PROPOSED RELATIVE VALUE UNITS FOR MAXILLOFACIAL PROSTHESIS SERVICES

CPT code	Description	Proposed work RVUs	Proposed PE RVUs	Proposed ME RVUs
21079	Impression and custom preparation; interim obturator prosthesis	20.88	27.93	2.25
21080	Impression and custom preparation; definitive obturator prosthesis	23.46	31.38	2.52
21081	Impression and custom preparation; mandibular resection prosthesis	21.38	28.59	2.30
21082	Impression and custom preparation; palatal augmentation prosthesis	19.50	26.08	2.10
21083	Impression and custom preparation; palatal lift prosthesis	18.04	24.13	1.94
21084	Impression and custom preparation; speech aid prosthesis	21.04	28.14	2.28
21085	Impression and custom preparation; oral surgical splint	8.41	11.25	0.90
21086	Impression and custom preparation; auricular prosthesis	23.29	31.15	2.51
21087	Impression and custom preparation; nasal prosthesis	23.29	31.15	2.51
G0020	Impression and custom preparation; surgical obturator prosthesis	12.54	16.77	1.35
G0021	Impression and custom preparation; orbital prosthesis	31.54	42.18	3.39

The work RVUs that we propose were developed by the American Academy of Maxillofacial Prosthetics. We believe they appropriately represent the work involved in these procedures. Because the CPT codes were new in 1991 and the Level 2 HCPCS codes are new in 1995, we have little or no charge data on which to base PE and ME RVUs in accordance with section 1848(c)(2)(C) of the Act. Therefore, we have imputed the PE and ME RVUs from the work RVUs based on the practice cost shares provided by the American Association of Oral and Maxillofacial Surgeons. Those shares are 54.7 percent for PE and 4.4 percent for ME.

We would establish a 90-day global period for these services with the exception of CPT code 21085 and HCPCS code G0020, which we believe require only a 10-day global period. (Under a global period, a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during, and after the procedure within the time period assigned to the service.)

CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021 should be used only if the physician actually designs and prepares the prosthesis. If the physician has designed and prepared the prosthesis and bills a CPT code in the range of 21079 through 21087 and HCPCS codes G0020 and G0021, we will not pay the physician separately for the prosthesis. We consider the cost of the materials used in preparing the prosthesis to be included in the PE portion of the codes.

HCPCS codes L8610 through L8618 identify prostheses that are prepared by an outside laboratory. Payment for HCPCS codes L8610 through L8618 is not made under the physician fee schedule. Payment is made on an individual consideration basis.

CPT codes 21079 through 21087 and HCPCS codes G0020 and G0021 are on the list of codes subject to the site-of-service payment differential since they are predominantly office-based services.

While we welcome any written public comments, we have found from past experience that the most useful comments have followed a particular pattern. They include the CPT code, a clinical description of the service, and a discussion of the work of that service.

Physician work has two components: time and intensity. The clinical analogy for many services can be strengthened by dividing the service into the following three time segments:

- Preservice work—Work performed before the actual procedure such as review of records, solicitation of informed consent, and preparation of equipment. Time spent by the physician dressing, scrubbing, and waiting for the patient should be identified. Preservice work also includes the time spent scrubbing, positioning, or otherwise preparing the patient. For surgical procedures with global periods, commenters should include estimates of the number, time, and type of visits from the day before surgery until the time the patient enters the operating room. The visit when the physician decides to operate and the visits preceding it should not be included in the estimate of preservice work since these services are not included in the Medicare definition of global period.
- Intraservice work—The actual performance of the procedure. For evaluation and management services, this would be described as ''face-to-face'' time in the office setting and ''unit/floor'' time in the inpatient setting. For surgical procedures, the customary term would be ''skin-to-skin'' time or its equivalent for those procedures not beginning with incisions.
- Postservice work—Analysis of data collected from the encounter, preparation of a report, and communication of the results. For procedures with global periods, commenters should identify the time spent by the physician with the patient after the procedure on the same day and whether the patient typically goes home, to an ordinary hospital bed, or goes to the intensive care unit. Commenters should describe the number, time, and type of physician visits from the day after the procedure until the end of the global period.

They should also distinguish inpatient from outpatient visits.

We encourage commenters, in making these estimations, to provide detailed clinical information such as data derived from operating logs, operative reports, and medical charts concerning the length of service, the amount of work performed before and after the service, and the length of stay in the hospital. The usefulness of these data is greatly increased if the data are presented with comparable data for reference services and evidence that justifies that the data presented are nationally representative of the average work involved in furnishing the service. We often receive data that are not helpful to us because the data are not representative of national practices. In

addition, some commenters have presented a lengthy and elaborate description of the work in the service, but omitted, or provided an incomplete description of, the comparability of the work in the service to the work in a reference procedure or procedures identified.

Intensity of the work in the service is best compared by breaking the intensity into the following elements:

- Mental effort and judgment—Commenters should compare the service in question with a reference service as to the amount of clinical data that needs to be considered, the depth of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- Technical skill and physical effort—One useful measure of skill is the point in training when a resident is expected to be able to perform the procedure. Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physician effort are not reflected accurately by differences in the time involved; if they are, considerations of physician effort amount to double counting of physician work in the service.
- Psychological stress—Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and a mistake has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

Intensity often varies significantly in the course of furnishing a service. Sometimes commenters ''anchor'' the value of the service to a point of maximum intensity during the service as the basis for comparing services. It is unlikely that the maximum intensity is an accurate reflection of the average intensity of a service; a lengthy procedure that is simple except for a few moments of extreme intensity is probably less work than one of equal length during which a fairly high level of intensity is maintained throughout.

This proposal reflects a policy change that is not explicitly addressed in our regulations.

I. Coverage of Mammography Services

In the December 31, 1990 interim final rule (55 FR 53510) and the September 30, 1994 final rule (59 FR 49808), we based our present definitions of ''diagnostic'' and ''screening'' mammography and related provisions on advice from the Food and Drug Administration (FDA), the National Cancer Institute (NCI), our own medical consultants, and other components of HHS.

These definitions are important because of the impact they can have on how frequently mammograms are covered under the Medicare program. The Medicare law and current regulations limit the frequency of coverage for ''screening'' mammography services according to the patient's age and for women over age 39 but under age 50 based on whether she is considered at high risk of developing breast cancer. On the other hand, coverage of ''diagnostic'' mammography is not restricted by specific statutory frequency limitations but depends on whether the examination has been (1) ordered by the patient's physician, and (2) is determined by the local Medicare contractor to be medically necessary for the patient.

In response to inquiries from beneficiaries, practicing physicians, and others in the medical community, we have reexamined our definitions of ''diagnostic'' and ''screening'' mammography in § 410.34 (Mammography services: Conditions for and limitations on coverage''). In addition, we have consulted further with FDA, NCI, and a Medicare Carrier Medical Director workgroup regarding the appropriateness of the definitions. We have also reexamined the current definitions in view of our previous Medicare policy on diagnostic mammograms as described in section 50–21 of the Coverage Issues Manual (HCFA Pub. 6) that permits coverage for diagnostic mammograms for patients with a personal history of breast cancer and certain other patients, even though they are not symptomatic (that is, they do not have any signs or symptoms of a medical problem with their breasts).

Based on our reexamination of this issue, we propose to revise the definitions of ''diagnostic'' and ''screening'' mammography in § 410.34 to make them consistent with previous Medicare coverage policy regarding ''diagnostic'' mammography, and with the way these terms are used in general clinical practice in the United States.

Some clinicians and mammography experts consider patients with a personal history of breast disease, such as breast cancer and chronic fibrocystic disease, to be candidates for diagnostic mammography for a period following treatment of the disease and then candidates for screening mammography thereafter. However, most clinicians and mammography experts in the United States consider patients with a personal history of breast disease to be candidates for diagnostic mammography for the rest of their lives, following the onset of their disease and its treatment.

In view of the above information, we propose to expand the definition of ''diagnostic'' mammography to include patients with a personal history of breast disease; however, we propose to leave the definition of ''screening'' mammography unchanged so that patients with a personal history of breast cancer can be considered candidates for the ''screening'' examination, if the patients and their physicians decide that this is appropriate.

We propose that the present definition of ''diagnostic'' mammography in paragraph (a)(1) of § 410.34 be expanded to include also, as a candidate for this service, a patient who does not have signs or symptoms of breast disease but who has a personal history of biopsy-proven breast disease.

The present regulations include as candidates for ''screening'' mammography all asymptomatic women regardless of whether they have had a personal history of biopsy-proven breast disease. We propose to leave unchanged the substance of the present definition of ''screening'' mammography in paragraph (a)(2) of § 410.34 but clarify it to read as follows: ''Screening mammography means a radiological procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.'' This might include an asymptomatic woman (that is, a woman without signs or symptoms of breast disease) with a history of biopsy-proven breast disease who might otherwise qualify for a diagnostic mammography as defined in the current § 410.34(a)(1). The woman and her physician would determine which examination to request (that is, either a diagnostic or a screening mammography). Although a history of biopsy-proven breast disease would ordinarily require recurrent diagnostic examinations, in some cases, when the

breast disease is no longer present, screening mammography might be appropriate.

We also propose that certain minor and technical changes be made in the limitations on coverage of screening mammography services to make them consistent with the proposed revisions to the definitions in ''diagnostic'' and ''screening'' mammography in § 410.34(a)(1) and (a)(2), respectively, and to simplify the language in § 410.34(d)(1) regarding the postmastectomy patient.

J. Use of Category-Specific Volume and Intensity (VI) Growth Allowances in Calculating the Default Medicare Volume Performance Standard (MVPS)

Currently, the default formula uses an estimate of the average annual percentage growth in the VI of physician services that is the same for all categories of physician services. Although historically the data available to us allowed an accurate estimate of the overall growth in the VI of physician services, they did not allow us to estimate the VI growth for each individual category of service with the degree of accuracy required for the MVPS calculation. More recent data now allow us to do this. We propose to calculate the MVPS for FY 1996 and all future years based on estimates of the average VI growth specific to each category. This would be consistent with our use of category-specific estimates of the MVPS factors for the weighted-average increase in physician fees and the percentage change in expenditures resulting from changes in law or regulations. The effect this proposal would have on a future MVPS for a category depends on the difference between the VI growth for that category and for physician services overall. To illustrate, the following table compares the estimated FY 1996 VI allowance for each category based on the overall average and the category-specific average:

	Overall average VI (percent)	Category-specific VI (percent)
Surgical Services	4.4	2.3
Primary Care Services	4.4	5.3
Nonsurgical Services	4.4	5.1
All Physician Services	4.4	4.4

As can be seen from the table, the FY 1996 MVPS VI allowance for primary care is higher using the category-specific VI factor than using the single VI factor. This is because the average VI growth for primary care services has been higher than the average VI growth for all physician services. Although for FY 1996 this change in methodology would result in a higher primary care MVPS, this does not necessarily mean it would have a similar result in future years. The impact on any individual category is dependent on the future relationship between the average VI growth for that category and for physician services overall. If future growth in the VI of primary care services is lower than overall physician growth, this change would result in a lower MVPS for primary care services. Similar reasoning applies to the surgical and other nonsurgical categories. This proposal reflects a policy change that is not explicitly addressed in our regulations.

Although we are proposing this regulatory change now to address immediate problems in the fee schedule, it is our intention to move toward the development of a legislative proposal to implement a single MVPS and CF for all Medicare physician fee schedule services. Because of past differential updates, the surgical CF is currently 8 percent and 14 percent higher than the CFs for primary care and other nonsurgical services, respectively. We are concerned that this situation clearly undermines the original intent of the Medicare physician fee schedule.

III. Issue for Change in Calendar Year (CY) 1998—Two Anesthesia Providers Involved in One Procedure

The certified registered nurse anesthetist (CRNA) fee schedule regulations provide that if an anesthesiologist and a CRNA are both involved in a single procedure, we deem the service to be personally performed by the anesthesiologist and allow payment only for the physician service.

Approximately equal percentages of CRNAs are employed by physicians and hospitals. When the physician employs the CRNA, payment for both the CRNA's and the physician's service go into the same practice revenue pool that is used to pay both providers. Our policy described above does not create any problems for this type of arrangement, since the practice views itself as being paid for the service. However, if the hospital employs the CRNA and the physician is involved with this CRNA in a single procedure, then only the physician is paid. The hospital is not paid under the Medicare program for the CRNA service.

Although we have not received many complaints from hospitals about this policy, the CRNAs have stated that our policy causes hospitals to lower CRNA salaries. While the CRNAs have not been able to produce information on the extent of this practice, they believe that this type of arrangement is not unusual.

The CRNAs also have expressed concern that the CRNA is the person furnishing the service to the patient. The anesthesiologist is present in the room usually because the hospital has an operating policy that the CRNA service always be supervised or directed.

Currently our medical direction rules apply only to concurrent procedures (that is, two, three or four) directed by a physician. We have not applied these rules to a single procedure. The application of the medical direction payment policy to a single procedure would have resulted in increased program payment, approximately 30 percent greater than the current policy. Thus, part of our concern for not extending the medical direction payment policy to a single procedure has been the additional cost to the Medicare program.

Section 13516 of OBRA '93 established a new payment methodology for both the physician's medical direction service and the medically directed CRNA service. For 1994, the allowance for each of these services is equal to 60 percent of the allowance that would be recognized for the procedure personally performed by the physician alone. These percentages are reduced each year so that in 1998, the allowance for each service is equal to 50 percent of the allowance that would be recognized for the procedure personally performed by the physician alone. The objective is that in 1998, the allowance for anesthesia care in a given area will be the same whether the care is furnished by the physician alone, a nonmedically directed CRNA, or the anesthesia care team.

As a result of the revised payment methodology for the anesthesia care team, we propose to apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. Thus, in § 414.46 we propose to revise paragraphs (c) and (d) to state that in this situation the allowance for the medical direction 50 service of the physician and the medically directed service of the CRNA or the anesthesiologist assistant is based on the specified percentage of the allowance in § 416.40(d)(2). In addition, we propose that in 1998 and later years, this allowance is equal to 50 percent of the allowance for personally performed procedures.

We propose to implement this policy on January 1, 1998. At that time, the change in policy will be done in a budget-neutral manner. If we were to

implement this policy earlier, the policy would cause program payments to increase relative to the current policy.

IV. Issues for Discussion

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

With the exception of anesthesia services, physician services and other diagnostic services paid under the physician fee schedule have PE and ME RVUs. Payments for PE RVUs account for approximately 42 percent of physician fee schedule payments.

The PE RVUs are derived from historical allowed charge data. The common criticism is that the PE RVUs are not truly resource-based because they are not based on resource costs.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, requires the Secretary to develop a methodology for a resource-based system for determining PE RVUs for each physician service. In developing the methodology, the Secretary must consider the staff, equipment, and supplies used in the provision of medical and surgical services in various settings. The Secretary must report to the Congress on the methodology by June 30, 1996. The new payment methodology is effective for services furnished in 1998. There is no transition provision for these services.

To implement this statutory provision, we published a Request for Proposal (RFP) in the Commerce Daily in November 1994. Offerors were required to respond by January 17, 1995.

The objective of the RFP is to develop a uniform database that can be used to support a number of analytical methods (for example, microcosting or economic cost functions) to estimate PE per service. The contractor will provide us with both direct and indirect PE estimates for all services paid under the physician fee schedule. Further, we expect that these estimates will vary based on the site where the service is furnished. For example, the PE for a physician service furnished in the hospital outpatient department will differ from the PE for the same service furnished in the physician's office. The physician does not ordinarily incur the costs of clinical labor, medical supplies, or equipment associated with services in the hospital outpatient department.

The contractor will be responsible for identifying candidates for a technical expert group (TEG) who will assist with the development of data collection instruments to obtain PEs (both direct and indirect) and resource profiles. Resource profiles will be used to measure the quantities of inputs, such as clinical labor, equipment, and supplies used in producing specific services. The group of experts can be researchers and others who have published articles in this area or are members of the medical community, including clinical personnel, nonclinical personnel, and practice managers.

The TEG can have as many as 20 participants. We will make the final selection of participants in the TEG. The TEG will assume an active role in the process. It will be responsible for monitoring the entire project up to the point of delivery of data for analysis.

The contractor, with our assistance, will select clinical practice expert panels (CPEPs). The contractor will address the following issues in selecting the CPEPs:

- The choice and grouping of participating specialties.
- The mix of physicians, other clinicians, and practice managers.
- The number of panels.
- The grouping of codes and specialties in panels.
- The overlap of panels.
- Techniques for resolving disagreements across panels.

The actual number of panels and the size of the panels will be determined by the contractor and us. We expect that there will be fewer than 15 panels and the size of a panel will vary but will not exceed 12 persons.

The primary tasks of the CPEPs will be twofold. The first task will be to classify services and procedures into clinical and practice cost coherent groups. The common groups will be based on the direct cost of the procedure. The second task will be to select a reference procedure for each common grouping of codes. The CPEPs will complete a detailed resource profile for each reference procedure for the different practice sites. These profiles will consider only items that are direct-costed.

After the resource profiles are completed, the contractor will assign input prices to the resource inputs. This will produce a direct cost estimate for each reference procedure. In addition, the contractor will extrapolate the direct cost estimates for the reference procedure to other codes included in the same group, based on the relationship that the CPEP has established between the reference code and the other codes in the same group.

In addition to the procedure-specific profiles, the following kinds of data will be collected:

- Cost information from physician practices categorized by direct and indirect costs.
- Profiles of services from physician practices by place of service.
- Input price (including wage) information.

The first two kinds of information will be collected primarily by mail or by telephone survey from approximately 3,000 respondents. The contractor will gather the input price information from standard representative national data sources. Also, the contractor will be responsible for designing, organizing, and assembling the results into a documented database for access and use by multiple researchers.

The contractor will be responsible for generating PE estimates (both direct and indirect) for all CPT codes including radiology and anesthesia codes as well as the technical component and diagnostic testing codes that are paid under the physician fee schedule.

There are a number of methods by which the contractor could derive indirect cost estimates per code. Approaches include economic cost functions or accounting-based methods, whereby indirect costs are allocated based on factors, such as direct expense, physician work, or time. Regardless of which option is proposed, direct and indirect PE cost estimates will be presented for each code.

We awarded the contract to Abt Associates on March 31, 1995. The principal investigator is Monica Noether, Ph.D. In addition to Abt, the project team consists of the following:

- Consulting services furnished by Mark Pauly, Ph.D., and Gerald Wedig, Ph.D., economists at the University of Pennsylvania; and William Katz, D.B.A., a health care management consultant.
- The subcontractors are EnterMedica Resources, a management consulting firm that has conducted microcosting studies of physician practices in a variety of settings; and the Center for Research in Ambulatory Health Care Administration, the research arm of the Medical Group Management Association.
- The clinical consultants are Drs. Sankey Williams and Jose Escarce, practicing primary care physicians and health service researchers at the University of Pennsylvania.

The RFP includes the schedule for the completion of certain key activities. For example, the data collection and delivery must be completed by March 1996, and the report on analysis must be finished by September 1996. We expect to publish the proposed rule in the **Federal Register** in March 1997 and the final rule in November 1997. We will

implement the resource-based PE RVUs beginning January 1, 1998.

This discussion of our efforts to implement the requirement in the statute to develop a resource-based relative value scale for PEs is not a formal proposal. We are notifying the physician community and others about our progress to date and are providing other helpful information about the effort.

B. Primary Care Case Management and Other Managed Care Approaches

We are considering approaches to increasing managed care options under Medicare. One approach could be to apply primary care case management methods currently used by private payers and Medicaid programs to the Medicare fee-for-service system. There are many interpretations of primary care case management. The CPT defines case management as ''a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.'' The State of Maryland operates a primary care case management system known as Maryland Access to Care (MAC). Under the MAC program, Medicaid recipients are linked to a primary medical provider (PMP). Each PMP acts as a ''gatekeeper'' to the health care system, furnishing primary care and preventive services and making referrals to specialty care when necessary. Permutations of the gatekeeper approach are being used in many managed care arrangements. Under the physician fee schedule, we could construct fee arrangements with primary care physicians that would promote greater use of case management. We also are considering whether to undertake demonstrations of primary care case management that involve beneficiary enrollment or election and different approaches for a primary care option. We welcome comments on a possible framework for a Medicare primary care case management option either under current regulations or through a demonstration project.

We are already exploring case management options through several Medicare demonstration and developmental efforts that are underway. One demonstration is a voluntary program of Medicare case management for targeted high-cost illnesses such as congestive heart failure and cancer. The case management services consist of regular telephone calls to provide education and monitor treatment, assistance in arranging support services, caregiver support, and occasional in-person visits. These services are furnished by teams of nurses and social workers who coordinate their efforts with the beneficiary's physician. This demonstration tests whether the case management service will reduce the cost and aggravation incurred when patients with specific conditions are unnecessarily rehospitalized or must revisit a physician.

Other projects involve a new method for paying physicians that provides incentives for effective management of care to beneficiaries. Physician groups will be paid either on a capitated basis or incentive through payment for specified bundles of services associated with the treatment of chronic conditions and acute episodes of care.

The intent of these new payment arrangements is to transfer financial risk to the physician groups, thereby finding efficient ways to provide care and increasing incentives to the physician groups to contain costs. Five payment models will be evaluated that range from a model of full capitation that transfers the financial risk to the physician group furnishing all Medicare-covered services to models that reduce the amount of risk transferred to the group and limit the requirement for an enrolled population.

These approaches represent a sample of available options. We are not prepared to make a specific proposal now. Rather, our intent at this time is to solicit information, recommendations, and suggestions from the public on how we might apply primary care case management to the Medicare fee-for-service system. We are particularly interested in the following:

- Which physicians, providers, or other health care professionals should be designated as case managers?
- Which types of patients would benefit from case management?
- What evidence is there that case management is valuable to patients other than those with chronic illness or acute episodes?
- Should Medicare pay for case management services and how should they be paid?

V. Collection of Information Requirements

Sections 415.60(f)(1) (concerning determination and payment of allowable physician compensation costs), 415.60(g) (concerning recordkeeping requirements for allocation of physician compensation costs), and 415.70(e) (concerning limits on compensation for services of physicians in providers) of this document contain information collection requirements. The information collection requirements in § 415.60(f)(1) concern the amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not paid under either Part A or Part B of Medicare; and assurance that the compensation is reasonable in terms of the time devoted to these services. The information collection requirements in § 415.60(g) concern time records used to allocate physician compensation, information on which the physician compensation allocation is based, and retention of this information for a 4-year period after the end of each cost reporting period to which the allocation applies. The information collection requirements in § 415.70(e) concern an exception to the limits on compensation for services of physicians in providers if the provider can demonstrate to the intermediary that it is unable to recruit or maintain an adequate number of physicians at a compensation level within these limits. Respondents who will provide the information include providers, intermediaries, and physicians.

Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct them to the OMB official whose name appears in the **ADDRESSES** section of this preamble.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians are considered to be small entities.

This proposed rule would not have a significant economic impact on a substantial number of small entities. Nevertheless, we are preparing a regulatory flexibility analysis because the provisions of this rule are expected

to have varying effects on the distribution of Medicare physician payments and services. We anticipate that virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries would be affected by one or more provisions of this rule. In addition, physicians who are paid by private insurers for non-Medicare services would be affected to the extent that they are paid by private insurers that choose to use the proposed RVUs. However, with few exceptions, we expect that the impact would be limited.

If these proposals result in increases in Medicare payment amounts, beneficiary liability would also increase because the coinsurance amounts would increase. In addition, if nonparticipating physicians do not accept assignment, the amount that they may bill above the fee schedule amount would also increase because the limiting charge for the service would increase. If a proposal results in a decrease in Medicare payment amounts or the bundling of payment for one service into payment for another, beneficiary liability would decrease.

Section 1848(c)(2)(B) of the Act requires that adjustments in a year may not cause the amount of expenditures for the year to differ by more than $20 million from the amount of expenditures that would have been made if these adjustments had not been made. If this threshold is exceeded, we usually make adjustments to the RVUs in order to preserve budget neutrality. The proposals discussed in sections B through K below would have no impact on total Medicare expenditures because the effects of these changes would be neutralized in the establishment of RVUs for 1996.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

B. Budget-Neutrality Adjustments for Relative Value Units

Under this proposal, budget neutrality adjustments would be applied to the fee schedule CFs instead of procedure RVUs. This alternative approach would be administratively simpler for Medicare and other payers that base their payments on the Medicare RVUs, including many Medicaid programs and would facilitate policy and data analyses of RVUs. Any changes to procedure payment amounts or total payment would be due to rounding and would be minimal.

We do not expect any objection to this proposal because we are responding to requests by the AMA, private payers, and Medicaid programs that base payment on Medicare RVUs.

C. Bundled Services

1. Hydration Therapy and Chemotherapy

Presently, we allow separate payment for hydration therapy IV infusion (CPT codes 90780 and 90781) when it is performed on the same day as chemotherapy IV infusion (CPT codes 96410, 96412, and 96414). The Medicare charge data show that in 1994, CPT codes 90780 and 90781 (hydration therapy IV infusion) were billed in addition to chemotherapy IV infusion only 9.3 percent and 4 percent of the time, respectively, and accounted for $8.5 million in Medicare expenditures.

We believe that paying for hydration therapy IV infusion and chemotherapy IV infusion administered on the same day represents duplicate payment. Therefore we propose not paying separately for CPT codes 90780 and 90781 when billed on the same day as CPT codes 96410, 96412, and 96414. We propose implementing this proposal in a budget neutral manner by redistributing the payment for hydration therapy IV infusion performed on the same day as chemotherapy IV infusion across all RVUs.

2. Evaluation of Psychiatric Records and Reports and Family Counseling Services

We propose to bundle payment for CPT codes 90825 and 90887 into the payment for other psychiatric codes. Thus, separate payment would no longer be made for either CPT code 90825 or CPT code 90887. The annual expenditures for CPT code 90825 under our current policy are approximately $2.3 million. The current policy allowing separate payment for CPT code 90887 results in annual expenditures of approximately $2.5 million. We would implement this change in policy by redistributing the payment for CPT codes 90825 and 90887 equally into the following psychiatric procedure codes: 90801, 90820, 90835, 90842 through 90847, and 90853 through 90857. We estimate that this change would increase the RVUs for the latter codes by approximately 0.7 percent.

3. Fitting of Spectacles

We propose to cease making separate payment under the physician fee schedule for fitting of spectacles and low vision systems, CPT codes 92352 through 92358 and 92371, beginning January 1, 1996. We would redistribute the payment currently made for these codes across all physician services, which is what would have occurred had we not included these fees when the fee schedule was created. Payment for these services is already included in the payment for the prosthetic device.

Because the total payment for spectacle fitting services is relatively low (approximately $3 million in CY 1993) compared to the total payment for all physician services, we believe the impact on RVUs for all physician services would be negligible.

Virtually all of the providers who have been billing for the fitting as a professional service have been optometrists. Under this proposal, they would no longer be able to bill separately for this service. The effect on individual optometrists would depend upon the amount of their income derived from billing for fitting services.

D. X-Rays and Electrocardiograms (EKGs) Taken in the Emergency Room

Under current policy, issued in 1981, the interpretation of an x-ray or EKG furnished to an emergency room patient by a radiologist or cardiologist, respectively, ''almost always'' constitutes a covered Part B service payable by the carrier, regardless of whether the test results have been previously used in the diagnosis and treatment of the patient by a physician in the emergency room and regardless of when the specialist furnishes the interpretation. A study completed by the OIG of DHHS, dated July 1993, recommended that we change this policy to indicate that the second interpretation is generally a quality control service to be taken into account by intermediaries in determining hospital reasonable costs. Further, we understand that some carriers are currently paying both the emergency room physician and the radiologist or cardiologist for the interpretation of the same x-ray or EKG.

We propose to pay for only one interpretation of an x-ray or EKG furnished to an ER patient except under unusual circumstances. In situations in which both the ER physician and the radiologist or cardiologist bill for the interpretation, the carriers would be instructed to pay for the interpretation used in the diagnosis and treatment of the patient. The second interpretation would be considered a quality control service. Under this proposal, the incidence of carriers' paying twice for an interpretation would be reduced, but we have no estimate of the number of duplicate payments that would be eliminated. We believe the specialists would be affected primarily. If hospitals want to ensure that their specialists are paid for these interpretations, they could make arrangements to preclude

the ER physician from billing for the same service.

E. Extension of Site-of-Service Payment Differential to Services in Ambulatory Surgical Centers (ASCs)

We propose to extend the site-of-service payment differential to office-based services if those services are furnished in an ASC, effective for services furnished beginning January 1, 1996. We propose adding 152 codes to the list. Were it not for budget-neutrality adjustments, we estimate that these additions would result in a $25.7 million reduction in Medicare payments.

F. Services of Teaching Physicians

This proposed change would remove the single attending physician criteria for hospital patients and allow and promote supervision of the care by physician group practices. We believe allowing for more than one teaching physician per beneficiary inpatient stay would result in negligible additional cost, but the lack of any data prevents us from quantifying the effects of this change. In addition, this proposed rule would incorporate long-standing Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services.

We propose to require the physical presence of a teaching physician during the key portion of the service. Details regarding the physical presence of a teaching physician during different types of services and procedures are discussed in section II. F. of this preamble. Although we lack specific data, we believe that the provisions of this part of the proposed rule would have little budgetary effect.

G. Unspecified Physical and Occupational Therapy Services (HCPCS Codes M0005 through M0008 and H5300)

We propose to eliminate HCPCS codes M0005 through M0008 and H5300 and redistribute the RVUs to codes in the physical medicine and rehabilitation section of the CPT (codes 97010 through 97039). The codes we propose to delete are general codes that do not describe adequately the service being provided. Their use precludes effective review necessary to ensure that the services being paid are covered by Medicare. In 1995, the AMA revised the CPT codes in the Physical Medicine and Rehabilitation section of the CPT to better reflect the provision of physical and occupational therapy services.

We believe that each unit of service currently billed under the codes we propose to delete would be billed under a CPT or HCPCS code and that the total amount of Medicare payment for physical medicine services would not change significantly as a result of the elimination of these codes. Therefore, we are assuming that there would not be any additional costs or savings as a result of this proposed change in billing. Since the original codes were not descriptive, we would have no way of comparing payments. However, we believe we would eliminate any manipulation of payment and improve the data we collect by requiring these practitioners to use the more specific codes when billing for services.

H. Transportation in Connection With Furnishing Diagnostic Tests

Except for portable x-ray and EKG equipment, this proposed rule would no longer authorize payments for the transportation of diagnostic equipment to the patient or to a site, such as a physician office, for use in furnishing tests to Medicare beneficiaries. The transportation expense is ''bundled'' into the payment for the procedure. Individual carrier policies on making transportation payments vary. This proposed rule would establish a national Medicare policy on payments for the transportation of diagnostic test equipment. The little data we have indicate that the transportation payment is often several times higher than the payment we make for the specific procedure furnished.

I. Maxillofacial Prosthetic Services

We propose to establish national RVUs for these services and to discontinue pricing by individual carriers. We estimate that total estimated expenditures for CPT codes 21079 through 21087 and codes G0020 and G0021 based on the proposed RVUs will be approximately $2.4 million in CY 1996. The 1994 Medicare expenditures for the codes under the carrier pricing methodology were approximately $1.5 million which, if updated for 1995 would be approximately $1.6 million. Thus, we estimate an increase of approximately $800,000 for these codes. However, total expenditures for physician services would not increase as a result of this proposal because we would implement this change in a budget neutral manner in accordance with section 1848(c)(2)(B)(II) of the Act.

These services are furnished most frequently by oral surgeons (dentists only) and by maxillofacial surgeons. Because the total expenditures for these services are estimated to increase slightly, we expect that in general the physicians who perform and bill for these procedures will realize an increase in payment. However, in some areas, the payment amounts based on national RVUs may be lower than those calculated by the local carrier.

J. Coverage of Mammography Services

We propose to expand the definition of ''diagnostic'' mammography to include as candidates for this service asymptomatic men or women who have had a personal history of biopsy-proven breast disease. At present, the definition includes as candidates for mammography services only persons showing signs or symptoms of breast disease. We do not believe this change will result in a significant increase in the total number of mammography services because information from carriers indicates that most asymptomatic patients with a personal history of breast disease are already receiving diagnostic mammography services.

K. Use of Category-Specific Volume and Intensity (VI) Growth Allowances in Calculating the Default Medicare Volume Performance Standard (MVPS)

The use of category-specific VI in the MVPS default formula would be budget neutral overall, although it would have redistributional effects on the surgical, primary care, and nonsurgical categories.

L. Two Anesthesia Providers Involved in One Procedure

We propose to apply the medical direction payment policy to the single procedure involving both the physician and the CRNA. We do not propose to implement this policy until January 1, 1998 at which time the proposal will be budget neutral. In 1998, the allowance for the medically-directed CRNA service and the medical-direction service of the anesthesiologist will be equivalent to 50 percent of the allowance recognized for the service personally performed by the anesthesiologist alone. Thus, payment for both services will be no different than what would be allowed for the anesthesia service personally performed by the anesthesiologist.

Although this proposal is budget neutral, total payments to anesthesiologists will decrease slightly and payments to the CRNAs' employers will increase slightly. We cannot quantify the amount of the losses to the anesthesiologists or the gains to the CRNAs' employers. However, anesthesiologists can lessen their losses by actually personally performing as many of these cases as possible and receiving the same allowance they

would have in the absence of this proposal.

M. Rural Hospital Impact Statement

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This proposed rule would have little direct effect on payments to rural hospitals since this rule would change only payments made to physicians and certain other practitioners under Part B of the Medicare program and would make no change in payments to hospitals under Part A. We do not believe the changes would have a major, indirect effect on rural hospitals.

Therefore, we are not preparing an analysis for section 1102(b) of the Act since we have determined, and the Secretary certifies, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, Health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR chapter IV would be amended as set forth below:

A. Part 400 is amended as set forth below:

PART 400—INTRODUCTION; DEFINITIONS

1. The authority citation for part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

2. In § 400.202, the introductory text is republished and the definition of GME is added in alphabetical order to read as follows:

§ 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

* * * * *

GME stands for graduate medical education.

* * * * *

B. Part 405 is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart D—[Removed and Reserved]

1. Subpart D, consisting of §§ 405.465 through 405.482, is removed and reserved.

2. Subpart E is amended as set forth below:

a. The authority citation for subpart E is revised to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1834(a) (b), and (c), 1842(b), (h), and (i), 1848, 1861(b), (s), (v), (aa), and (jj), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395m(a), (b), and (c), 1395u(b), (h), and (i), 1395w–4, 1395x(b), (s), (v), (aa), and (jj), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

b. The heading for subpart E is revised to read as follows:

Subpart E—Criteria for Determining Reasonable Charges

c. Subpart E is amended by removing §§ 405.520 through 405.525.

Subpart F—[Removed and Reserved]

3. Subpart F, consisting of §§ 405.550 through 405.580, is removed and reserved.

4. Subpart X is amended as set forth below:

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

a. The authority citation for subpart X continues to read as follows:

Authority: Secs. 1102, 1833, 1861(aa), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l, 1395x(aa), and 1395hh).

b. In § 405.2401, paragraph (b), the introductory text is republished, and the definition for *physician* is revised to read as follows:

§ 405.2401 Scope and definitions.

* * * * *

(b) *Definitions.* As used in this subpart, unless the context indicates otherwise:

* * * * *

Physician means the following:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed.

(2) Within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, a doctor of podiatry or surgical chiropody or a chiropractor. (See section 1861(r) of the Act for specific limitations.)

(3) A resident (including residents as defined in § 415.152 of this chapter who meet the requirements in § 415.206(b) of this chapter for payment under the physician fee schedule).

* * * * *

C. Part 410 is amended as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

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

2. Section 410.34 is amended by republishing the introductory text to paragraph (a) and revising paragraphs (a)(1), (a)(2), and (d) to read as follows:

§ 410.34 Mammography services: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

(1) *Diagnostic mammography* means a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, or a personal history of biopsy-proven breast disease, and includes a physician's interpretation of the results of the procedure.

(2) *Screening mammography* means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

* * * * *

(d) *Limitations on coverage of screening mammography services.* The following limitations apply to coverage of screening mammography services as described in paragraph (a)(2) of this section:

(1) The service must be, at a minimum a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.

(2) Payment may not be made for screening mammography performed on a woman under age 35.

(3) Payment may be made for only 1 screening mammography performed on a woman over age 34, but under age 40.

(4) For a woman over age 39, but under age 50, the following limitations apply:

(i) Payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed if the woman has—

(A) A personal history of breast cancer;

(B) A personal history of biopsy-proven benign breast disease;

(C) A mother, sister, or daughter who has had breast cancer; or

(D) Not given birth before age 30.

(ii) If the woman does not meet the conditions described in paragraph (d)(4)(i) of this section, payment may be made for a screening mammography performed after at least 23 months have passed following the month in which the last screening mammography was performed.

(5) For a woman over age 49, but under age 65, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

(6) For a woman over age 64, payment may be made for a screening mammography performed after at least 23 months have passed following the month in which the last screening mammography was performed.

D. Part 414 is amended as set forth below:

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

1. The authority citation for part 414 continues to read as follows:

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

2. In § 414.28, the introductory text is republished, and paragraph (b) is revised to read as follows:

§ 414.28 Conversion factors.

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

* * * * *

(b) *Subsequent CFs.* Beginning January 1, 1993, 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 CY 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.

§ 414.32 [Amended]

3. In § 414.32, paragraph (d)(2) is removed, and paragraph (d)(3) is redesignated as paragraph (d)(2).

§ 414.46 [Amended]

4. In § 414.46, the following changes are made:

a. The word ''procedure'' in paragraphs (c)(2) introductory text, (c)(2)(i), (d)(1) introductory text, and (g) is removed, and the word ''service'' is added in its place. The word ''procedures'' in paragraphs (a)(1), (c)(1), (d)(1)(i), (d)(1)(ii), (d)(1)(iii), (d)(1)(iv), (d)(2)(i), (d)(2)(ii), (d)(2)(iii), (d)(2)(iv), (d)(2)(v), the heading of paragraph (e), and paragraphs (e) and (g) is removed, and the word ''services'' is added in its place.

b. Paragraphs (c)(2)(ii) and (c)(2)(iii) are redesignated as paragraphs (c)(2)(iii) and (c)(2)(ii), respectively.

c. Newly redesignated paragraph (c)(2)(ii) and paragraph (c)(3) are revised, a new paragraph (c)(4) is added, and the introductory text to paragraph (d) and paragraph (d)(2) are revised to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(c) *Physician personally performs the anesthesia service.*

* * * * *

(2) * * *

(ii) For services furnished before January 1, 1998, the physician is continuously involved in a single case involving a certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA), or student nurse anesthetist.

* * * * *

(3) For services furnished before January 1, 1998, no payment is made under the CRNA fee schedule for the services of a CRNA or AA involved in a service described in paragraph (c)(2) of this section unless HCFA determines that it was medically necessary for both the physician and the CRNA or AA to be involved in the same case.

(4) For services furnished on or after January 1, 1998, if a physician is continuously involved in a single service involving a CRNA or AA, the payment allowance for the service of the CRNA or the AA is determined on the basis of the payment methodology in paragraph (d)(2) of this section.

(d) *Physician medically directs concurrent anesthesia services.* HCFA uses one of the following payment methodologies to determine the fee schedule amount for concurrent medically directed anesthesia services furnished by a physician during a specified CY.

* * * * *

(2) *Beginning CY 1994.* Payment is based on a specified percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. For services furnished on or after January 1, 1998, if a physician is continuously involved in a single service involving a CRNA, AA, or a student nurse anesthetist, the payment rules for medical direction in this paragraph apply. The following percentages apply for the years specified:

* * * * *

5. In § 414.60, paragraph (b) is revised, and paragraph (c) is added to read as follows:

§ 414.60 Payment for the services of certified registered nurse anesthetists.

* * * * *

(b) *Beginning CY 1994.* The allowance for an anesthesia service furnished by a

medically directed CRNA beginning CY 1994 is based on a fixed percentage, as specified in § 414.46(d)(2), of the allowance recognized for the anesthesia service personally performed by the physician alone. The CF for an anesthesia service furnished by a nonmedically directed CRNA beginning CY 1994 cannot exceed the CF for a service personally performed by an anesthesiologist.

(c) *Individuals or entities that can receive payment.* The allowance for an anesthesia service furnished by a CRNA or an AA can be made to the CRNA furnishing the service, or to a hospital, rural primary care hospital, physician, group practice, or ambulatory surgical center with which the CRNA furnishing the service has an employment or contractual relationship that provides for payment to be made for the service to the entity. Payment for the service of a CRNA may be made only on an assignment-related basis, and any assignment agreed to by a CRNA is binding on any other person presenting a claim or request for payment for the service.

§§ 414.450–414.453 [Removed]

6. Subpart H, consisting of §§ 414.450 through 414.453, is removed.

E. A new part 415 is added to read as follows:

PART 415—SERVICES OF PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

Subpart A—General Provisions

Sec.
415.1 Basis and scope.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

Sec.
415.50 Scope.
415.55 General payment rules.
415.60 Allocation of physician compensation costs.
415.70 Limits on compensation for physician services in providers.

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

Sec.
415.100 Conditions for fee schedule payment for physician services to beneficiaries in providers: General provisions.
415.105 Payment for physician services to beneficiaries in providers.
415.120 Conditions for payment: Radiology services.
415.130 Conditions for payment: Physician pathology services.

Subpart D—Physician Services in Teaching Settings

Sec.
415.150 Scope.
415.152 Definitions.
415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.
415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.
415.164 Payment to a fund.
415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.
415.172 Physician fee schedule payment for services of teaching physicians.
415.176 Renal dialysis services.
415.178 Anesthesia services.
415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.
415.184 Psychiatric services.
415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

Subpart E—Services of Residents

Sec.
415.200 Services of residents in approved GME programs.
415.202 Services of residents not in approved GME programs.
415.204 Services of residents in SNFs and HHAs.
415.206 Services of residents in nonprovider settings.
415.208 Services of moonlighting residents.

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

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.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

§ 415.50 Scope.

This subpart sets forth rules for payment by fiscal intermediaries to providers for services furnished by physicians. Payment for covered services is made either under the prospective payment system (PPS) to PPS-participating providers in accordance with part 412 of this chapter or under the reasonable cost method to non-PPS participating providers in accordance with part 413 of this chapter.

§ 415.55 General payment rules.

(a) *Allowable costs.* Except as specified otherwise in §§ 413.102 of this chapter (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 § 415.100(b) 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 § 413.86 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) *Limits on allowable costs.* The intermediary must apply the limits on compensation set forth in § 415.70 to determine its payments to a provider for the costs of services.

§ 415.60 Allocation of physician compensation costs.

(a) *Definition.* For purposes of this subpart, *physician compensation costs* means monetary payments, fringe benefits, deferred compensation, and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician services. Other organizations are entities related to the provider within the meaning of § 413.17 of this chapter or entities that furnish services for the provider under arrangements within the meaning of the Act.

(b) *General rule.* Except as provided in paragraph (d) of this section, each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services, among—

(1) Physician services to the provider (as described in § 415.50);

(2) Physician services to beneficiaries (as described in § 415.100); and

(3) Activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.

(c) *Allowable physician compensation costs.* Only costs allocated to paid physician services to the provider (as described in § 415.50) are allowable costs to the provider under this subpart.

(d) *Allocation of all compensation to services to the provider.* The total physician compensation received by a physician is allocated among all services furnished by the physician to the provider, 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 those patients and personally receives the payment from the billings. 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 § 415.100(b), HCFA does not require a written allocation agreement between the physician and the provider.

(f) *Determination and payment of allowable physician compensation costs.* (1) 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 beneficiaries, and services that are not paid 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 the intermediary or the carrier on an annual basis and promptly notify the intermediary or carrier of any revisions to the compensation allocation.

(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, HCFA establishes reasonable compensation equivalency (RCE) 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 § 415.50(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 § 413.86 of this chapter.

(3) Compensation that a physician receives for activities that may not be paid for under either Part A or Part B of Medicare is not considered in applying these limits.

(b) *Methodology for establishing limits.* HCFA establishes a methodology for determining annual RCE limits and considers average physician incomes by specialty and type of location to the extent possible 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 RCE limit by the cost of the malpractice insurance expense related to the physician service furnished to beneficiaries in providers.

(e) *Exception to limits.* An intermediary may grant a provider an exception to the limits established under paragraph (b) of this section only if the provider can demonstrate to the intermediary that it is unable to recruit or maintain an adequate number of physicians at a compensation level within these limits.

(f) *Notification of changes in methodologies and payment limits.* (1) Before the start of a cost reporting period to which limits established under this section will be applied, HCFA publishes a notice in the **Federal Register** that sets forth the amount of the limits and explains how it calculated the limits.

(2) If HCFA proposes to revise the methodology for establishing payment limits under this section, HCFA publishes a notice, with opportunity for public comment, in the **Federal Register**. The notice explains the

proposed basis and methodology for setting limits, specifies the limits that would result, and states the date of implementation of the limits.

(3) If HCFA updates limits by applying the most recent economic index data without revising the limit methodology, HCFA publishes the revised limits in a notice in the **Federal Register** without prior publication of a proposal or public comment period.

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

§ 415.100 Conditions for fee schedule payment for physician services to beneficiaries in providers: General provisions.

(a) *Scope.* This section implements section 1887(a)(1) 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 415.105 sets forth general requirements for determining the amounts of payment for services that meet the conditions of this section. Sections 415.120 through 415.130 set forth additional conditions for payment for physician services in the specialties of radiology and pathology (laboratory services).

(b) *Conditions for payment for physician services to beneficiaries in providers.* The carrier pays for services of physicians furnished to beneficiaries in providers on a fee schedule basis if 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.

(c) *Services of physicians to providers.* If a physician furnishes services in a provider that do not meet the requirements in paragraph (b) of this section, but are related to beneficiary care by the provider, the intermediary pays for those services, if otherwise covered, under the rules for payment of physician services to providers in §§ 415.50 and 415.60 on the basis of reasonable cost or PPS, as appropriate.

(d) *Effect of billing charges for physician services to a provider.* (1) For services furnished by a physician that may be paid under the reasonable cost rules in § 415.50 or § 415.60, 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 § 413.86 of this chapter, neither the provider nor the physician may seek payment from the carrier, beneficiary, or another insurer.

(2) The carrier does not pay on a fee schedule basis for services furnished by a physician 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).

(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 § 415.50(a), HCFA considers the provider to whom the services are furnished to have violated its provider participation agreement, and may terminate that agreement. See part 489 of this chapter for rules governing provider agreements.

(e) *Effect of physician assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, and the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services, the following rules apply:

(1) If the conditions set forth in paragraph (b) of this section are met, the carrier pays for the physician services under the physician fee schedule in part 414 of this chapter.

(2) To the extent the provider incurs a cost payable on a reasonable cost basis under part 413 of this chapter, the intermediary pays the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supplies, equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) is treated as being related to the provider within the meaning of § 413.17 of this chapter (concerning cost to related organizations).

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

§ 415.105 Payment for physician services to beneficiaries in providers.

(a) *General rule.* The carrier determines amounts of payment for physician services to beneficiaries in providers in accordance with the general rules governing the physician fee schedule payment in part 414 of this chapter, except as provided in paragraph (b) of this section.

(b) *Application in certain settings*—(1) *Teaching hospitals.* In determining whether fee schedule payment should be made for physician services to individual beneficiaries in a teaching hospital, the carrier applies the rules in subpart D of this part (concerning physician services in teaching settings), in addition to those in this section.

(2) *Hospital-based ESRD facilities.* The carrier applies §§ 414.310 through 414.314 of this chapter, which set forth determination of reasonable charges under the ESRD program, to determine the amount of payment for physician services furnished to individual beneficiaries in a hospital-based ESRD facility approved under part 405 subpart U.

§ 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 § 415.100(b) 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 § 415.50 for provider costs; § 415.100(e)(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) *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 § 415.100(b) 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 (b) of this section.

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

(b) *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.

(4) Require the exercise of medical judgment by the consultant physician.

(c) *Physician pathology services furnished by an independent laboratory.* Laboratory services, including the technical component of a service, furnished to a hospital inpatient or outpatient by an independent laboratory are paid on a fee schedule basis under this subpart only if they are physician pathology services as described in paragraph (a) of this section.

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 § 413.86 of this chapter.

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

§ 415.152 Definitions.

As used in this subpart—

Approved graduate medical education (GME) program means a residency program approved by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatric Medicine Education of the American Podiatric Medical Association.

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, SNF, HHA, or CORF 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 involves 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 § 413.86, or on a reasonable-cost basis under the provisions of § 409.26 or § 409.40(f) for resident services furnished in SNFs or HHAs, respectively.

§ 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 in the care of 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 § 413.86 of this chapter.)

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

(1) For physician 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 § 413.86.

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

(a) *General.* Payments for direct medical and surgical services of physicians furnished to beneficiaries and supervision of interns and residents in the care of 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 in the care of 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 furnished to beneficiaries and supervision of interns and residents in*

the care of beneficiaries in a teaching hospital. Physician services furnished to beneficiaries and supervision of interns and residents in the care of beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis. For purposes of this paragraph, *reasonable cost* is defined as the direct salary paid to these physicians, plus applicable fringe benefits. 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. 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.

(c) *Reasonable costs incurred by a teaching hospital for the services furnished by a medical school or related organization in a hospital.* An amount is payable to the hospital by HCFA 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 furnished to beneficiaries and supervision of interns and residents in the care of beneficiaries in a teaching hospital by physicians on the faculty of a medical school or organization related to the medical school.* (i) 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, the cost of these services are allowable costs to the hospital under the provisions of § 413.17 of this chapter and 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) 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. 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. 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. 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. 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 physician services furnished to beneficiaries and supervision of interns and residents in the care of beneficiaries in a teaching hospital by medical school faculty (or organization related to the medical school).* 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 physician services furnished to beneficiaries and supervision of interns and residents in the care of 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 medical school costs incurred by the medical school for the services furnished to all patients of the hospital.

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

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. 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. 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. 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. 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 his or her 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 his or her 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 ($10,000) 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 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). 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. 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 for physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries furnished in a teaching hospital*—(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 HCFA.

(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 furnished in a teaching hospital.* If the requirements for payment for physician direct medical and surgical services furnished to beneficiaries in a teaching hospital described in paragraph (e) of this section 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 for physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries furnished in a teaching hospital*—(1) *Aggregate per diem method of apportionment for the costs of physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries.* 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) *Aggregate per diem method of apportionment for the imputed value of physician volunteer direct medical and surgical services.* The imputed value of physician direct medical and surgical services furnished 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 the outpatient department.

(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 inpatient 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
Total inpatient Part A days.....20,000
Total inpatient Part B days if Part A coverage is not available 1,000
Total outpatient Part B visit days.....5,000

Computation of imputed value of physician volunteer direct medical and surgical services furnished to Medicare beneficiaries:

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 × 1,000 1,280
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.* 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.) 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 HCFA under part 489 of this chapter.

(3) The intermediary, or HCFA 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 monies 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 under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation.

(2) The organization is an organization of physicians who, under the terms of their employment by an entity that meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income that the physician organization derives from the physician services.

(c) *Status of a fund.* A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under Medicare except that it does not enter into an agreement with HCFA under part 489 of this chapter.

§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

Services meeting the conditions for payment in § 415.100(b) 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), § 415.176 (concerning renal dialysis services), or § 415.184 (concerning psychiatric services), as applicable.

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

(a) *General rule.* When residents participate in a service furnished in a teaching setting, physician fee schedule payment is made only when a teaching physician is present during the key portion of any service or procedure for which payment is sought. In the case of surgery or a dangerous or complex procedure, 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. In the case of evaluation and management services (that is, visits and consultations), the teaching physician must be present during the portion of the service that determines the level of service billed, that is, type of decisionmaking, type of history, and examination, etc.

(b) *Documentation.* In the case of every service billed, the hospital chart must document the presence of the teaching physician at the time of the service. The presence of the teaching physician may be demonstrated by the notes made by a physician, resident, or nurse.

(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.

§ 415.176 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.* An unreduced physician fee schedule payment may be made if an anesthesiologist is not involved in directing concurrent services with more than one resident or with a resident and a nonphysician anesthetist (see § 414.46(c)(1)(iii) for additional rules for payment of anesthesia services).

(b) *Documentation.* Documentation must indicate the physician's presence or participation in the administration of the anesthesia and a preoperative and postoperative visit by the physician.

§ 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 through a one-way mirror, video tape, 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 HCFA 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 of residents in approved GME programs furnished in hospitals 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 services. The payment methodology for services of residents in hospitals and hospital-based providers is set forth in § 413.86 of this chapter.

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

§ 415.202 Services of residents not in approved GME programs.

(a) *General rules.* Payment is made to a hospital for the services of a resident who is not in an approved GME program on a Part B reasonable cost basis regardless of whether the services are furnished to hospital inpatients or outpatients. For purposes of this section, these services are deemed to include services of a physician employed by a hospital who is authorized to practice only in a hospital setting.

(b) *Payment.* 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. 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 SNFs and HHAs.

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

(2) *HHA.* A participating HHA 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 HHA is affiliated or under common control if these services are furnished as part of the posthospital home health visits for a Medicare beneficiary. (Nevertheless, see § 413.86 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 SNF or HHA 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.

§ 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 § 413.86(f)(1)(iii) 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 chapter to payments for services furnished by a resident in a nonprovider setting.

§ 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 § 413.86 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 § 415.100(b).

(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 (§ 413.86 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).

F. Technical Amendments

§ 400.310 [Amended]

1. In § 400.310, the following changes are made:

a. The entries for §§ 405.481 and 405.552 are removed.

b. In § 400.310, the table is amended by adding the following entries:

§ 400.310 Display of currently valid OMB control numbers.

Sections in 42 CFR that contain collections of information	Current OMB control numbers
* * * * *	
415.60	0938–0301
415.70	0938–0301
* * * * *	

§ 405.501 [Amended]

2. In § 405.501, the following changes are made:

a. Paragraphs (c) and (d) are removed, and paragraphs (e) and (f) are redesignated as paragraphs (c) and (d), respectively.

b. In newly redesignated paragraph (c), the phrase ''§§ 405.480 through 405.482 and §§ 405.550 through 405.557'' is removed, and the phrase ''§§ 415.55 through 415.70 and §§ 415.100 through 415.130 of this chapter'' is added in its place.

§ 405.502 [Amended]

3. In § 405.502(a)(10), the phrase ''§ 405.580(c) (2) or (3)'' is removed, and the phrase ''§ 415.190 (c)(2) or (c)(3) of this chapter'' is added in its place.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

4. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1834, 1842(l), 1861, 1862, 1866, 1871, 1877, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395u(l), 1385x, 1395y, 1395cc, 1395hh, 1395nn, and 1395pp).

§ 411.15 [Amended]

5. In § 411.15(m)(2)(i), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase ''§ 415.100(b) of this chapter'' is added in its place.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

6. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102, 1815(e), 1820, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395i–4, 1395hh, and 1395ww).

§ 412.50 [Amended]

7. In § 412.50, the following changes are made:

a. In paragraph (a), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase ''§ 415.100(b) of this chapter'' is added in its place.

b. In paragraph (b), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase ''§ 415.100(b) of this chapter'' is added in its place.

§ 412.71 [Amended]

8. In § 412.71(c)(1)(i), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase ''§ 415.100(b) of this chapter'' is added in its place.

§ 412.105 [Amended]

9. In § 412.105(g)(1)(i)(A), the phrase ''§ 405.522(a) of this chapter'' is removed, and the phrase ''§ 415.200(a) of this chapter'' is added in its place.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

10. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

§ 413.5 [Amended]

11. In § 413.5(c)(9), the phrase ''(as described in § 405.465 of this chapter) where elected as provided for in § 405.521 of this chapter'' is removed, and the phrase ''(as described in § 415.162 of this chapter if elected as provided for in § 415.160 of this chapter)'' is added in its place.

§ 413.13 [Amended]

12. In § 413.13(g)(1)(i), the phrase ''§§ 405.480 through 405.482 of this chapter'' is removed, and the phrase ''§§ 415.55 through 415.70 of this chapter'' is added in its place.

§ 413.80 [Amended]

13. In § 413.80(h), the phrase '', as described in § 414.450 of this chapter,'' is removed.

§ 413.86 [Amended]

14. In § 413.86, the following changes are made:

a. In paragraph (b), in the definition of ''Approved medical residency program'' in paragraph (1), the phrase ''§ 405.522(a) of this chapter'' is removed, and the phrase ''§ 415.200(a) of this chapter'' is added in its place.

b. In paragraph (g)(1)(ii), the phrase ''§ 405.522(a) of this chapter'' is removed, and the phrase ''§ 415.200(a) of this chapter'' is added in its place.

§ 413.174 [Amended]

15. In § 413.174(b)(4)(iv), the phrase ''§ 405.465 through 405.482 of this chapter'' is removed, and the phrase ''§§ 415.55 through 415.70, § 415.162, and § 415.164 of this chapter'' is added in its place.

§ 414.2 [Amended]

16. In § 414.2, in the definition for ''Physicians' services,'' in paragraph (2), the phrase ''physicians' services'' is removed, and the phrase ''physician services'' is added in its place.

§ 414.58 [Amended]

17. In § 414.58, the following changes are made:

a. In paragraph (a), the phrase ''§§ 405.550 through 405.580 of this chapter'' is removed, and the phrase ''§§ 415.100 through 415.130, and § 415.190 of this chapter'' is added in its place.

b. In paragraph (b), the phrase ''§ 405.465 of this chapter if the hospital exercises the election described in § 405.521(c)(2) of this chapter'' is removed, and the phrase ''§ 415.162 of this chapter if the hospital exercises the election described in § 415.160 of this chapter'' is added in its place.

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

18. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

§ 417.554 [Amended]

19. In § 417.554, the phrase ''§ 405.480, part 412 of this chapter, and §§ 413.55 and 413.24 of this chapter'' is removed, and the phrase ''part 412, §§ 413.24 and 413.55, and § 415.55 of this chapter'' is added in its place.

PART 489—PROVIDER AND SUPPLIER AGREEMENTS

20. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, and 1395hh).

§ 489.20 [Amended]

21. In § 489.20(d)(1), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase § 415.100(b) of this chapter'' is added in its place.

§ 489.21 [Amended]

22. In § 489.21(f), the phrase ''§ 405.550(b) of this chapter'' is removed, and the phrase ''§ 415.100(b) of this chapter'' is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 5, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: July 6, 1995.

Donna E. Shalala,

Secretary.

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