than 115 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB minus 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(c) *Adjustment of 1992 payments for radiology services.* For radiology services furnished during CY 1992 the following rules apply:

(1) If the AHPB determined under paragraph (a) of this section is from 85 percent to 109 percent of the fee schedule amount for the area for services furnished in 1992, payment is at the fee schedule amount.

(2) If the AHPB determined under paragraph (a) of this section is less than 85 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB plus 15 percent of the fee schedule amount is substituted for the fee schedule amount.

(3) If the AHPB determined under paragraph (a) of this section is greater than 109 percent of the fee schedule amount for the area for services furnished in 1992, an amount equal to the AHPB minus 9 percent of the fee schedule amount is substituted for the fee schedule amount.

(d) *Computation of payments for CY 1993.* For physician services subject to the transition rules in CY 1992 and furnished during CY 1993, the fee schedule is equal to 75 percent of the amount that would have been paid in the fee schedule area under the 1992 transition rules, adjusted by the amount of the 1993 update, plus 25 percent of the 1993 fee schedule amount.

(e) *Computation of payments for CY 1994.* For physician services subject to the transition rules in CY 1993, and furnished during CY 1994, the fee schedule is equal to 67 percent of the amount that would have been paid in the fee schedule area under the 1993 transition rules, adjusted by the amount of the 1994 update, plus 33 percent of the 1994 fee schedule amount.

(f) *Computation of payments for CY 1995.* For physician services subject to the transition rules in CY 1994 and furnished during CY 1995, the fee schedule is equal to 50 percent of the amount that would have been paid in the fee schedule area under the 1994 transition rules, adjusted by the amount of the 1995 update, plus 50 percent of the 1995 fee schedule amount.

§ 414.46 Additional rules for payment of anesthesia services.

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

(1) *Base unit* means the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual preoperative and postoperative visits, the administration of fluids and blood incident to anesthesia care, and monitoring services.

(2) *Anesthesia practitioner*, for the purpose of anesthesia time, means a physician who performs the anesthesia service alone, a CRNA who is not medically directed who performs the anesthesia service alone, or a medically directed CRNA.

(3) *Anesthesia time* means the time during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

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

(1) The carrier bases the fee schedule amount for an anesthesia service on the product of the sum of allowable base and time units and an anesthesia-specific CF. The carrier calculates the time units from the anesthesia time reported by the anesthesia practitioner

for the anesthesia procedure. The physician who fulfills the conditions for medical direction in § 415.110 (Conditions for payment: Anesthesiology services) reports the same anesthesia time as the medically-directed CRNA.

(2) CMS furnishes the carrier with the base units for each anesthesia procedure code. The base units are derived from the 1988 American Society of Anesthesiologists' Relative Value Guide except that the number of base units recognized for anesthesia services furnished during cataract or iridectomy surgery is four units.

(3) Modifier units are not allowed. Modifier units include additional units charged by a physician or a CRNA for patient health status, risk, age, or unusual circumstances.

(c) *Physician personally performs the anesthesia procedure.* (1) CMS considers an anesthesia service to be personally performed under any of the following circumstances:

(i) The physician performs the entire anesthesia service alone.

(ii) The physician establishes an attending physician relationship in one or two concurrent cases involving an intern or resident and the service was furnished before January 1, 1994.

(iii) The physician establishes an attending physician relationship in one case involving an intern or resident and the service was furnished on or after January 1, 1994 but prior to January 1, 1996. For services on or after January 1, 1996, the physician must be the teaching physician as defined in §§ 415.170 through 415.184 of this chapter.

(iv) The physician and the CRNA or AA are involved in a single case and the services of each are found to be medically necessary.

(v) The physician is continuously involved in a single case involving a student nurse anesthetist.

(vi) The physician is continuously involved in a single case involving a CRNA or AA and the service was furnished prior to January 1, 1998.

(2) CMS determines the fee schedule amount for an anesthesia service personally performed by a physician on the basis of an anesthesia-specific fee schedule CF and unreduced base units and anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit.

(d) *Anesthesia services medically directed by a physician.* (1) CMS considers an anesthesia service to be medically directed by a physician if:

(i) The physician performs the activities described in § 415.110 of this chapter.

(ii) The physician directs qualified individuals involved in two, three, or four concurrent cases.

(iii) Medical direction can occur for a single case furnished on or after January 1, 1998 if the physician performs the activities described in § 415.110 of this chapter and medically directs a single CRNA or AA.

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(3) Payment for medical direction is based on a specific percentage of the payment allowance recognized for the anesthesia service personally performed by a physician alone. The following percentages apply for the years specified:

(i) CY 1994—60 percent of the payment allowance for personally performed procedures.

(ii) CY 1995—57.5 percent of the payment allowance for personally performed services.

(iii) CY 1996—55 percent of the payment allowance for personally performed services.

(iv) CY 1997—52.5 percent of the payment allowance for personally performed services.

(v) CY 1998 and thereafter—50 percent of the payment allowance for personally performed services.

(e) *Physicians involved with two concurrent cases with residents.* The physician can bill base units and time units based on the amount of time the physician is actually present with the resident during each of two concurrent cases furnished on or after January 1, 2004.

(1) To bill the base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units.

(2) If the physician is not present with the resident during pre- and post-anesthesia care, then the physician may bill the case as a medically directed case in accordance with paragraph (d) of this section.

(f) *Physician medically supervises anesthesia services.* If the physician medically supervises more than four concurrent anesthesia services, CMS bases the fee schedule amount on an anesthesia-specific CF and three base units. This represents payment for the physician's involvement in the pre-surgical anesthesia services.

(g) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1) CMS allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. CMS makes payment for these services in accordance with the general physician fee schedule rules in § 414.20. These services are described in program operating instructions.

(2) CMS makes no separate payment for other medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

(h) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. The carrier makes payment for add-on anesthesia codes according to program operating instructions.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 60 FR 63177, Dec. 8, 1995; 64 FR 59441, Nov. 2, 1999; 67 FR 80041, Dec. 31, 2002; 68 FR 63261, Nov. 7, 2003]

§ 414.48 Limits on actual charges of nonparticipating suppliers.

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

(b) *Specific limits.* For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the fee schedule amount for nonparticipating suppliers. For items or services CMS excludes from payment under the physician fee schedule (in accordance with section 1848 (j)(3) of the Act), the limiting charge is 115 percent of 95 percent of the payment basis applicable to participating suppliers as calculated in § 414.20(b).

[58 FR 63687, Dec. 2, 1993, as amended at 62 FR 59102, Oct. 31, 1997]

§ 414.50 Physician or other supplier billing for diagnostic tests performed or interpreted by an outside supplier or at a site other than the office of the billing physician or other supplier.

(a) *General rules.* (1) For services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act), if a physician or other supplier bills for the technical component or professional component of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control as described in § 413.17 of this chapter) and the diagnostic test is either purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier, the payment to the billing physician or other supplier (less

§ 415.110 Conditions for payment: Medically directed anesthesia services.

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

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

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

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

(b) *Medical documentation.* The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

[63 FR 58912, Nov. 2, 1998]

§ 415.120 Conditions for payment: Radiology services.

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

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

§ 415.130 Conditions for payment: Physician pathology services.

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

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

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

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

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

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

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

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

(1) Surgical pathology services.

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

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

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

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

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

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

(3) Result in a written narrative report included in the beneficiary's medical record.

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

(d) *Physician pathology services furnished by an independent laboratory.* The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient before January 1, 2001 may be paid to the laboratory on a fee schedule basis. After December 31, 2000 but before January 1, 2003, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service Medicare beneficiary who is an inpatient or outpatient of a covered hospital, the carrier will treat the technical component as a service for which payment will be made to the laboratory under the physician fee schedule. For these two years the service will not be treated as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of the Act or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of the Act. After December 31, 2002, the technical component for physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient is paid only to the hospital.

[60 FR 63178, Dec. 8, 1995, as amended at 64 FR 59442, Nov. 2, 1999; 66 FR 55332, Nov. 1, 2001]

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 one of the following:

(1) 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 Commission on Dental Accreditation of the American Dental Association, or by