(3) Comprehensive outpatient rehabilitation facilities.

(4) Comprehensive inpatient rehabilitation facilities.

(5) Inpatient psychiatric facilities.

(6) Skilled nursing facilities.

(b) *General rule.* If physicians' services of the type routinely furnished in physicians' offices are furnished in facility settings before January 1, 1999, the physician fee schedule amount for those services is determined by reducing the practice expense RVUs for the services by 50 percent. For services furnished on or after January 1, 1999, the practice expense RVUs are determined in accordance with § 414.22(b)(5).

(c) *Services covered by the reduction.* CMS establishes a list of services routinely furnished in physicians' offices nationally. Services furnished at least 50 percent of the time in physicians' offices are subject to this reduction.

(d) *Services excluded from the reduction.* The reduction established under this section does not apply to the following:

(1) Rural health clinic services.

(2) Surgical services not on the ambulatory surgical center covered list of procedures published under § 416.65(c) of this chapter when furnished in an ambulatory surgical center.

(3) Anesthesiology services and diagnostic and therapeutic radiology services.

[58 FR 63687, Dec. 2, 1993, as amended at 60 FR 63177, Dec. 8, 1995; 62 FR 59102, Oct. 31, 1997; 63 FR 58911, Nov. 2, 1998; 64 FR 25457, May 12, 1999]

§ 414.34 Payment for services and supplies incident to a physician's service.

(a) *Medical supplies.* (1) Except as otherwise specified in this paragraph, office medical supplies are considered to be part of a physician's practice expense, and payment for them is included in the practice expense portion of the payment to the physician for the medical or surgical service to which they are incidental.

(2) If physician services of the type routinely furnished in provider settings are furnished in a physician's office, separate payment may be made for certain supplies furnished incident to that physician service if the following requirements are met:

(i) It is a procedure that can safely be furnished in the office setting in appropriate circumstances.

(ii) It requires specialized supplies that are not routinely available in physicians' offices and that are generally disposable.

(iii) It is furnished before January 1, 1999.

(3) For the purpose of paragraph (a)(2) of this section, provider settings include only the following settings:

(i) Hospital inpatient and outpatient departments.

(ii) Ambulatory surgical centers.

(4) For the purpose of paragraph (a)(2) of this section, ''routinely furnished in provider settings'' means furnished in inpatient or outpatient hospital settings or ambulatory surgical centers more than 50 percent of the time.

(5) CMS establishes a list of services for which a separate supply payment may be made under this section.

(6) The fee schedule amount for supplies billed separately is not subject to a GPCI adjustment.

(b) *Services of nonphysicians that are incident to a physician's service.* Services of nonphysicians that are covered as incident to a physician's service are paid as if the physician had personally furnished the service.

[56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, as amended at 63 FR 58911, Nov. 2, 1998]

§ 414.36 Payment for drugs incident to a physician's service.

Payment for drugs incident to a physician's service is made in accordance with § 405.517 of this chapter.

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

(b) *Exception.* Separate payment is made under the following conditions

for physician care plan oversight services furnished to beneficiaries who receive HHA and hospice services that are covered by Medicare:

(1) The care plan oversight services require recurrent physician supervision of therapy involving 30 or more minutes of the physician's time per month.

(2) Payment is made to only one physician per patient for services furnished during a calendar month period. The physician must have furnished a service requiring a face-to-face encounter with the patient at least once during the 6-month period before the month for which care plan oversight payment is first billed. The physician may not have a significant ownership interest in, or financial or contractual relationship with, the HHA in accordance with §424.22(d) of this chapter. The physician may not be the medical director or employee of the hospice and may not furnish services under an arrangement with the hospice.

(3) If a physician furnishes care plan oversight services during a postoperative period, payment for care plan oversight services is made if the services are documented in the patient's medical record as unrelated to the surgery.

(c) *Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare.* (1) An NPP can furnish physician care plan oversight (but may not certify a patient as needing home health services) only if the physician who signs the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for care plan oversight and either—

(i) The physician and NPP are part of the same group practice; or

(ii) If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or

(iii) If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

(2) Payment may be made for care plan oversight services furnished by an NPP when:

(i) The NPP providing the care plan oversight has seen and examined the patient;

(ii) The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care; and

(iii) The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

[59 FR 63463, Dec. 8, 1994; 60 FR 49, Jan. 3, 1995; 60 FR 36733, July 18, 1995 as amended at 69 FR 66423, Nov. 15, 2004; 70 FR 16722, Apr. 1, 2005]

§ 414.40 Coding and ancillary policies.

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

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

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

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

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

§ 414.42 Adjustment for first 4 years of practice.

(a) *General rule.* For services furnished during CYs 1992 and 1993, except as specified in paragraph (b) of this section, the fee schedule payment amount or prevailing charge must be phased in as specified in paragraph (d) of this section for physicians, physical therapists (PTs), occupational therapists (OTs), and all other health care practitioners who are in their first through fourth years of practice.

(b) *Exception.* The reduction required in paragraph (d) of this section does