

§ 414.48

(e) *Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases.* For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. This special payment rule also applies if the teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under the medical direction payment rules.

(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

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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; 74 FR 62006, Nov. 25, 2009]

§ 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 a physician who does not share a practice with 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 (TC) or professional component (PC) 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 performed by a physician who does not share a practice with the billing

physician or other supplier, the payment to the billing physician or other supplier (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(i) The performing supplier's net charge to the billing physician or other supplier. For purposes of this paragraph (a)(1) only, with respect to the TC, the performing supplier is the physician who supervised the TC, and with respect to the PC, the performing supplier is the physician who performed the PC.

(ii) The billing physician or other supplier's actual charge.

(iii) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

(2) The following requirements are applicable for purposes of paragraph (a)(1) of this section:

(i) The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

(ii) A performing physician shares a practice with the billing physician or other supplier if he or she furnishes substantially all (which, for purposes of this section, means "at least 75 percent") of his or her professional services through such billing physician or other supplier. The "substantially all" requirement will be satisfied if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that:

(A) For the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or

(B) The performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

(iii) A physician will be deemed to share a practice with the billing physician or other supplier with respect to the performance of the TC or PC of a diagnostic test if the physician is an owner, employee or independent contractor of the billing physician or other supplier and the TC or PC is performed in the office of the billing physician or other supplier. The "office of the billing physician or other supplier" is any medical office space, regardless of number of locations, in which the ordering physician or other ordering supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the same building (as defined in §411.351) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in §411.351 of this chapter), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. The performance of the TC includes both the conducting of the TC as well as the supervision of the TC.

(b) *Restriction on payment.* (1) The billing physician or other supplier must identify the performing supplier and indicate the performing supplier's net charge for the test. If the billing physician or other supplier fails to provide this information, CMS makes no payment to the billing physician or other supplier and the billing physician or other supplier may not bill the beneficiary.

(2) Physicians and other suppliers that accept Medicare assignment may bill beneficiaries for only the applicable deductibles and coinsurance.

(3) Physicians and other suppliers that do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

[72 FR 66400, Nov. 27, 2007, as amended at 73 FR 2432, Jan. 15, 2008; 73 FR 69935, Nov. 19, 2008]