

Centers for Medicare & Medicaid Services, HHS

§ 415.50

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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 § 415.102(a) 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 §§ 413.75 through 413.83 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.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 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 § 415.55);

(2) Physician services to patients (as described in § 415.102); 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 payable physician services to the provider (as described in § 415.55) are allowable costs to the provider under this subpart.

(d) *Allocation of all compensation to services to the provider.* Generally, the total physician compensation received by a physician is allocated among all services furnished by the physician, 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 them and personally receives the payment from or on behalf of the patients. 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 § 415.102(a),

CMS 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 patients, and services that are not payable 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, CMS establishes reasonable compensation equivalency 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 § 415.55(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 §§ 413.75 through 413.83 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.*

(1) *For cost reporting periods beginning before January 1, 2015.* CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty and type of location using the best available data.

(2) *For cost reporting periods beginning on or after January 1, 2015.* CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty 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—

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(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 reasonable compensation equivalency limit by the cost of the malpractice insurance expense related to the physician service furnished to patients 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, CMS publishes a notice in the FEDERAL REGISTER that sets forth the amount of the limits and explains how it calculated the limits.

(2) If CMS proposes to revise the methodology for establishing payment limits under this section, CMS 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 CMS updates limits by applying the most recent economic index data without revising the limit methodology, CMS publishes the revised limits in a notice in the FEDERAL REGISTER without prior publication of a proposal or public comment period.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005; 79 FR 50358, Aug. 22, 2014]

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

§ 415.100 Scope.

This subpart implements section 1887(a)(1)(A) 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 415.102 sets forth the conditions for fee schedule payment for physician services to beneficiaries in providers. 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 and 415.130 set forth additional conditions for payment for physician services in the specialties of radiology and pathology (laboratory services).

§ 415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

(a) *General rule.* If the physician furnishes services to beneficiaries in providers, the carrier pays on a fee schedule basis provided 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.

(b) *Exception.* If a physician furnishes services in a provider that do not meet the requirements in paragraph (a) of this section, but are related to beneficiary care furnished by the provider, the intermediary pays for those services, if otherwise covered. The intermediary follows the rules in §§ 415.55 and 415.60 for payment on the basis of reasonable cost or PPS, as appropriate.

(c) *Effect of billing charges for physician services to a provider.* (1) If a physician furnishes services that may be paid under the reasonable cost rules in § 415.55 or § 415.60, and paid by the intermediary, 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 §§ 413.75 through 413.83 of this chapter, neither the provider nor the physician