

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 CMS 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 furnished in hospitals by residents in approved GME programs 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 service. The payment methodology for services of residents in hospitals and hospital-based providers is set forth in §§ 413.75 through 413.83 of this chapter.

(b) *Exception.* For low and mid-level evaluation and management services furnished under certain conditions in centers located in hospital outpatient departments and other ambulatory settings, see § 415.174.

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

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

§ 415.202 Services of residents not in approved GME programs.

(a) *General rules.* For services of a physician employed by a hospital who is authorized to practice only in a hospital setting and for the services of a resident who is not in any approved GME program, payment is made to the hospital on a Part B reasonable cost

basis regardless of whether the services are furnished to hospital inpatients or outpatients.

(b) *Payment.* For services described in paragraph (a) of this section, payment is made under Part B 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 skilled nursing facilities and home health agencies.

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

(2) *Home health agency.* A participating home health agency 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 home health agency is affiliated or under common control if these services are furnished as part of the home health visits for a Medicare beneficiary. (Nevertheless, see §§ 413.75 through 413.83 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 skilled nursing facility or home health agency 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.

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

§ 415.206

42 CFR Ch. IV (10–1–23 Edition)

§ 415.206 Services of residents in non-provider 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 § 413.78 regarding patient care activities and training of residents are met, the time residents spend in non-provider 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 non-provider 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 non-provider 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.

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

§ 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 teaching 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 §§ 413.75 through 413.83 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 criteria in paragraphs (b)(2)(i) through (iii) of this section are met. The services of residents that are not related to their approved GME programs and are furnished to inpatients of a hospital in which they have their training program are covered as physician services and payable under the physician fee schedule if criteria in paragraphs (b)(2)(i) through (iii) of this section are met. The medical record must include documentation to demonstrate in each case that these criteria are satisfied.

(i) The services are identifiable physician services and meet the conditions for payment of physician services to beneficiaries in providers in § 415.102(a).

(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 (§§413.75 through 413.83 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).

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005; 85 FR 19289, Apr. 6, 2020; 85 FR 85037, Dec. 28, 2020]

PART 416—AMBULATORY SURGICAL SERVICES

Subpart A—General Provisions and Definitions

Sec.

416.1 Basis and scope.

416.2 Definitions.

Subpart B—General Conditions and Requirements

416.25 Basic requirements.

416.26 Qualifying for an agreement.

416.30 Terms of agreement with CMS.

416.35 Termination of agreement.

Subpart C—Specific Conditions for Coverage

416.40 Condition for coverage—Compliance with State licensure law.

416.41 Condition for coverage—Governing body and management.

416.42 Condition for coverage—Surgical services.

416.43 Conditions for coverage—Quality assessment and performance improvement.

416.44 Condition for coverage—Environment.

416.45 Condition for coverage—Medical staff.

416.46 Condition for coverage—Nursing services.

416.47 Condition for coverage—Medical records.

416.48 Condition for coverage—Pharmaceutical services.

416.49 Condition for coverage—Laboratory and radiologic services.

416.50 Condition for coverage—Patient rights.

416.51 Conditions for coverage—Infection control.

416.52 Conditions for coverage—Patient admission, assessment and discharge.

416.54 Condition for coverage—Emergency preparedness.

Subpart D—Scope of Benefits for Services Furnished Before January 1, 2008

416.60 General rules.

416.61 Scope of facility services.

416.65 Covered surgical procedures.

416.75 Performance of listed surgical procedures on an inpatient hospital basis.

416.76 Applicability.

Subpart E—Prospective Payment System for Facility Services Furnished Before January 1, 2008

416.120 Basis for payment.

416.121 Applicability.

416.125 ASC facility services payment rate.

416.130 Publication of revised payment methodologies.

416.140 Surveys.

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

416.160 Basis and scope.

416.161 Applicability of this subpart.

416.163 General rules.

416.164 Scope of ASC services.

416.166 Covered surgical procedures.

416.167 Basis of payment.

416.171 Determination of payment rates for ASC services.

416.172 Adjustments to national payment rates.

416.173 Publication of revised payment methodologies and payment rates.

416.174 Payment for non-opioid pain management drugs and biologicals that function as supplies in surgical procedures.

416.178 Limitations on administrative and judicial review.

416.179 Payment and coinsurance reduction for devices replaced without cost or when full or partial credit is received.

Subpart G—Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Service Centers

416.180 Basis and scope.

416.185 Process for establishing a new class of new technology IOLs.

416.190 Request for review of payment amount.

416.195 Determination of membership in new classes of new technology IOLs.