

§414.313

42 CFR Ch. IV (10–1–23 Edition)

(3) They ordinarily must be performed by a physician.

Supervision of staff, in contrast to medical direction, is an administrative service that does not necessarily require the physician to be present at the dialysis session. It is a general activity primarily concerned with monitoring performance of and giving guidance to other health care personnel (such as nurses and dialysis technicians) who deliver services to patients.

(d) *Types of routine professional services*. Routine professional services include at least all of the following services when medically appropriate:

(1) Visits to the patient during dialysis, and review of laboratory test results, nurses' notes and any other medical documentation, as a basis for—

(i) Adjustment of the patient's medication or diet, or the dialysis procedure;

(ii) Prescription of medical supplies; and

(iii) Evaluation of the patient's psychosocial status and the appropriateness of the treatment modality.

(2) Medical direction of staff in delivering services to a patient during a dialysis session.

(3) Pre-dialysis and post-dialysis examinations, or examinations that could have been furnished on a pre-dialysis or post-dialysis basis.

(4) Insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters.

(e) *Payment for routine professional services*. Beginning August 7, 1990, routine professional services furnished by physicians may be paid under either the "initial method" of payment described in §414.313, (if all of the physicians at the facility elect the initial method) or under the "physician MCP method" described in §414.314. Physician services furnished after July 31, 1983 and before August 6, 1990, are payable only under the MCP method described in §414.314.

§414.313 Initial method of payment.

(a) *Basic rule*. Under this method, the intermediary pays the facility for routine professional services furnished by physicians. Payment is in the form of an add-on to the facility's composite

rate payment, which is described in part 413, subpart H of this subchapter.

(b) *Services for which payment is not included in the add-on payment*. (1) Physician administrative services are considered to be facility services and are paid for as part of the facility's composite rate.

(2) The carrier pays the physician or the beneficiary (as appropriate) under the reasonable charge criteria set forth in subpart E of part 405 of this chapter for the following services:

(i) Physician services that must be furnished at a time other than during the dialysis session (excluding pre-dialysis and post-dialysis examinations and examinations that could have been furnished on a pre-dialysis or post-dialysis basis), such as monthly and semi-annual examinations to review health status and treatment.

(ii) Physician surgical services other than insertion of catheters for patients who are on peritoneal dialysis and do not have indwelling catheters.

(iii) Physician services furnished to hospital inpatients who were not admitted solely to receive maintenance dialysis.

(iv) Administration of hepatitis B vaccine.

(c) *Physician election of the initial method*. (1) Each physician in a facility must submit to the appropriate carrier and intermediary that serve the facility a statement of election of the initial method of payment for all the ESRD facility patients that he or she attends.

(2) The initial method of payment applies to dialysis services furnished beginning with the second calendar month after the month in which all physicians in the facility elect the initial method and continues until the effective date of a termination of the election described in paragraph (d) of this section.

(d) *Termination of the initial method*.

(1) Physicians may terminate the initial method of payment by written notice to the carrier(s) that serves each physician and to the intermediary that serves the facility.

(2) If the notice terminating the initial method is received by the carrier(s) and intermediary—

(i) On or before November 1, the effective date of the termination is January 1 of the year following the calendar year in which the termination notice is received by the carrier(s) and intermediary; or

(ii) After November 1, the effective date of the termination is January 1 of the second year after the calendar year in which the notice is received by the carrier(s) and intermediary.

(e) *Determination of payment amount.* The factors used in determining the add-on amount are related to program experience. They are re-evaluated periodically and may be adjusted, as determined necessary by CMS, to maintain the payment at a level commensurate with the prevailing charges of other physicians for comparable services.

(f) *Publication of payment amount.* Revisions to the add-on amounts are published in the FEDERAL REGISTER in accordance with the Department's established rulemaking procedures.

[55 FR 23441, June 8, 1990, as amended at 62 FR 43674, Aug. 15, 1997]

§414.314 Monthly capitation payment method.

(a) *Basic rules.* (1) Under the monthly capitation payment (MCP) method, the carrier pays an MCP amount for each patient, to cover all professional services furnished by the physician, except those listed in paragraph (b) of this section.

(2) The carrier pays the MCP amount, subject to the deductible and coinsurance provisions, either to the physician if the physician accepts assignment or to the beneficiary if the physician does not accept assignment.

(3) The MCP method recognizes the need of maintenance dialysis patients for physician services furnished periodically over relatively long periods of time, and the capitation amounts are consistent with physicians' charging patterns in their localities.

(4) Payment of the capitation amount for any particular month is contingent upon the physician furnishing to the patient all physician services required by the patient during the month, except those listed in paragraph (b) of this section.

(5) Payment for physician administrative services (§414.310) is made to

the dialysis facility as part of the facility's composite rate (part 413, subpart H of this subchapter) and not to the physician under the MCP.

(b) *Services not included in the MCP.*

(1) Services that are not included in the MCP and which may be paid in accordance with the reasonable charge rules set forth in subpart E of part 405 of this chapter are limited to the following:

(i) Administration of hepatitis B vaccine.

(ii) Covered physician services furnished by another physician when the patient is not available to receive, or the attending physician is not available to furnish, the outpatient services as usual (see paragraph (b)(3) of this section).

(iii) Covered physician services furnished to hospital inpatients, including services related to inpatient dialysis, by a physician who elects not to continue to receive the MCP during the period of inpatient stay.

(iv) Surgical services, including dec clotting of shunts, other than the insertion of catheters for patients on maintenance peritoneal dialysis who do not have indwelling catheters.

(v) Needed physician services that are—

(A) Furnished by the physician furnishing renal care or by another physician;

(B) Not related to the treatment of the patient's renal condition; and

(C) Not furnished during a dialysis session or an office visit required because of the patient's renal condition.

(2) For the services described in paragraph (b)(1)(v) of this section, the following rules apply:

(i) The physician must provide documentation to show that the services are not related to the treatment of the patient's renal condition and that additional visits are required.

(ii) The carrier's medical staff, acting on the basis of the documentation and appropriate medical consultation obtained by the carrier, determines whether additional payment for the additional services is warranted.

(3) The MCP is reduced in proportion to the number of days the patient is—