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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—

(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

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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

may seek payment from the carrier, beneficiary, or another insurer.

(2) If a physician furnishes services to an individual beneficiary that do not meet the applicable conditions in §§ 415.120 (concerning conditions for payment for radiology services) and 415.130 (concerning conditions for payment for physician pathology services), the carrier does not pay on a fee schedule basis.

(3) If the physician, the provider, or another entity bills the carrier or the beneficiary or another insurer for physician services furnished to the provider, as described in § 415.55(a), CMS considers the provider to which the services are furnished to have violated its provider participation agreement, and may terminate that agreement. See part 489 of this chapter for rules governing provider agreements.

(d) *Effect of physician assumption of operating costs.* If a physician or other entity enters into an agreement (such as a lease or concession) with a provider, and the physician (or entity) assumes some or all of the operating costs of the provider department in which the physician furnishes physician services, the following rules apply:

(1) If the conditions set forth in paragraph (a) of this section are met, the carrier pays for the physician services under the physician fee schedule in part 414 of this chapter.

(2) To the extent the provider incurs a cost payable on a reasonable cost basis under part 413 of this chapter, the intermediary pays the provider on a reasonable cost basis for the costs associated with producing these services, including overhead, supplies, equipment costs, and services furnished by nonphysician personnel.

(3) The physician (or other entity) is treated as being related to the provider within the meaning of § 413.17 of this chapter (concerning cost to related organizations).

(4) The physician (or other entity) must make its books and records available to the provider and the intermediary as necessary to verify the nature and extent of the costs of the services furnished by the physician (or other entity).

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

§ 415.105 Amounts of payment for physician services to beneficiaries in providers.

(a) *General rule.* The carrier determines amounts of payment for physician services to beneficiaries in providers in accordance with the general rules governing the physician fee schedule payment in part 414 of this chapter, except as provided in paragraph (b) of this section.

(b) *Application in certain settings—(1) Teaching hospitals.* The carrier applies the rules in subpart D of this part (concerning physician services in teaching settings), in addition to those in this section, in determining whether fee schedule payment should be made for physician services to individual beneficiaries in a teaching hospital.

(2) *Hospital-based ESRD facilities.* The carrier applies §§ 414.310 through 414.314 of this chapter, which set forth determination of reasonable charges under the ESRD program, to determine the amount of payment for physician services furnished to individual beneficiaries in a hospital-based ESRD facility approved under part 405 subpart U.

§ 415.110 Conditions for payment: Medically directed anesthesia services.

(a) *General payment rule.* Medicare pays for the physician's medical direction of anesthesia services for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in § 415.102(a) and the following additional conditions:

- (1) For each patient, the physician—
 - (i) Performs a pre-anesthetic examination and evaluation;
 - (ii) Prescribes the anesthesia plan;
 - (iii) Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;
 - (iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions;
 - (v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in § 414.46(c) of this chapter apply (Physician personally performs the anesthesia procedure).

(b) *Medical documentation.* The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

[63 FR 58912, Nov. 2, 1998]

§ 415.120 Conditions for payment: Radiology services.

(a) *Services to beneficiaries.* The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the services meet the conditions for fee schedule payment in § 415.102(a) and are identifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. The carrier pays for interpretations only if there is a written report prepared for inclusion in the patient's medical record maintained by the hospital.

(b) *Services to providers.* The carrier does not pay on a fee schedule basis for physician services to the provider (for example, administrative or supervisory services) or for provider services needed to produce the x-ray films or other items that are interpreted by the radiologist. However, the intermediary pays the provider for these services in

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accordance with § 415.55 for provider costs; § 415.102(d)(2) for costs incurred by a physician, such as under a lease or concession agreement; or part 412 of this chapter for payment under PPS.

§ 415.130 Conditions for payment: Physician pathology services.

(a) *Definitions.* The following definitions are used in this section.

(1) *Covered hospital* means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for this technical component directly to a Medicare carrier.

(2) *Fee-for-service Medicare beneficiaries* means those beneficiaries who are entitled to benefits under Part A or are enrolled under Part B of Title XVIII of the Act or both and are not enrolled in any of the following:

(i) A Medicare + Choice plan under Part C of Title XVIII of the Act.

(ii) A plan offered by an eligible organization under section 1876 of the Act;

(iii) A program of all-inclusive care for the elderly (PACE) under 1894 of the Act; or

(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987.

(b) *Physician pathology services.* The carrier pays for pathology services furnished by a physician to an individual beneficiary on a fee schedule basis only if the services meet the conditions for payment in § 415.102(a) and are one of the following services:

(1) Surgical pathology services.

(2) Specific cytopathology, hematology, and blood banking services that have been identified to require performance by a physician and are listed in program operating instructions.

(3) Clinical consultation services that meet the requirements in paragraph (c) of this section.

(4) Clinical laboratory interpretative services that meet the requirements of

paragraphs (c)(1), (c)(3), and (c)(4) of this section and that are specifically listed in program operating instructions.

(c) *Clinical consultation services.* For purposes of this section, clinical consultation services must meet the following requirements:

(1) Be requested by the beneficiary's attending physician.

(2) Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the beneficiary.

(3) Result in a written narrative report included in the beneficiary's medical record.

(4) Require the exercise of medical judgment by the consultant physician.

(d) *Physician pathology services furnished by an independent laboratory.* (1) The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient on or before June 30, 2012, may be paid to the laboratory by the contractor under the physician fee schedule if the Medicare beneficiary is a patient of a covered hospital as defined in paragraph (a)(1) of this section.

(2) For services furnished after June 30, 2012, an independent laboratory may not bill the Medicare contractor for the technical component of physician pathology services furnished to a hospital inpatient or outpatient.

(3) For services furnished on or after January 1, 2008, the date of service policy in § 414.510 of this chapter applies to the TC of specimens for physician pathology services.

[60 FR 63178, Dec. 8, 1995, as amended at 64 FR 59442, Nov. 2, 1999; 66 FR 55332, Nov. 1, 2001; 71 FR 69788, Dec. 1, 2006; 72 FR 66405, Nov. 27, 2007; 73 FR 69938, Nov. 19, 2008; 75 FR 73626, Nov. 29, 2010; 76 FR 73473, Nov. 28, 2011; 77 FR 69371, Nov. 16, 2012]

§ 415.140 Conditions for payment: Split (or shared) visits.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Facility setting for purposes of this section means institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services