

## § 415.130

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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

is prohibited under §410.26(b)(1) of this subchapter.

*Split (or shared) visit* means an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or nonphysician practitioner if furnished independently by only one of them.

*Substantive portion* means more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making except as otherwise provided in this paragraph. For critical care visits, substantive portion means more than half of the total time spent by the physician and nonphysician practitioner performing the split (or shared) visit.

(b) *Conditions of payment.* For purposes of this section, the following conditions of payment apply:

(1) *Substantive portion of split (or shared) visit.* In general, payment is made to the physician or nonphysician practitioner who performs the substantive portion of the split (or shared) visit.

(2) *Medical record documentation.* Documentation in the medical record must identify the physician and nonphysician practitioner who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

(3) *Claim modifier.* The designated modifier must be included on the claim to identify that the service was a split (or shared) visit.

[86 FR 65682, Nov. 19, 2021, as amended at 87 FR 70230, Nov. 18, 2022; 88 FR 79539, Nov. 16, 2023]

### Subpart D—Physician Services in Teaching Settings

#### §415.150 Scope.

This subpart sets forth the rules governing payment for the services of physicians in teaching settings and the criteria for determining whether the payments are made as one of the following:

(a) Services to the hospital under the reasonable cost election in §§415.160 through 415.164.

(b) Provider services through the direct GME payment mechanism in §§413.75 through 413.83 of this chapter.

(c) Physician services to beneficiaries under the physician fee schedule as set forth in part 414 of this chapter.

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

#### §415.152 Definitions.

As used in this subpart—

*Approved graduate medical education (GME) program* means one of the following:

(1) A residency program approved by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

(2) A program otherwise recognized as an “approved medical residency program” under §413.75(b) of this chapter.

*Direct medical and surgical services* means services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the cost election described in §§415.160 through 415.162.

*Nonprovider setting* means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. These include, but are not limited to, family practice or multispecialty clinics and physician offices.

*Resident* means one of the following:

(1) An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry.

(2) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, for example, individuals with temporary or restricted licenses, or uncensored graduates of foreign medical schools. For purposes of this subpart, the term *resident* is synonymous with the terms *intern* and *fellow*.

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*Teaching hospital* means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

*Teaching physician* means a physician (other than another resident) who involves residents in the care of his or her patients.

*Teaching setting* means any provider, hospital-based provider, or nonprovider settings in which Medicare payment for the services of residents is made under the direct GME payment provisions of §§ 413.75 through 413.83, or on a reasonable-cost basis under the provisions of § 409.26 or § 409.40(f) for resident services furnished in skilled nursing facilities or home health agencies, respectively.

[60 FR 63178, Dec. 8, 1995, as amended at 61 FR 59554, Nov. 22, 1996; 63 FR 26359, May 12, 1998; 70 FR 47490, Aug. 12, 2005; 74 FR 44001, Aug. 27, 2009; 75 FR 50418, Aug. 16, 2010]

### **§ 415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.**

(a) *Scope.* A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services.

(b) *Conditions.* A teaching hospital may elect to receive these payments only if—

(1) The hospital notifies its intermediary in writing of the election and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;

(2) All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or

(3) All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.

(c) *Effect of election.* If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—

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(1) Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and

(2) The intermediary pays the hospital for those services on a reasonable cost basis under the rules in § 415.162. (Payment for other physician compensation costs related to approved GME programs is made as described in § 413.78 of this chapter.)

(d) *Election declined.* If the teaching hospital does not make this election, payment is made—

(1) For physician services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and

(2) For the supervision of interns and residents as described in §§ 413.75 through 413.83.

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

### **§ 415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.**

(a) *General rule.* Payments for direct medical and surgical services of physicians furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries is made by Medicare on the basis of reasonable cost if the hospital exercises the election as provided for in § 415.160. If this election is made, the following occurs:

(1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries are paid on a reasonable-cost basis, as provided for in paragraph (b) of this section.

(2) Payment for certain medical school costs may be made as provided for in paragraph (c) of this section.

(3) Payments for services donated by volunteer physicians to beneficiaries are made to a fund designated by the organized medical staff of the teaching hospital or medical school as provided for in paragraph (d) of this section.

(b) *Reasonable cost of physician services and supervision of interns and residents.* (1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis.

(2) For purposes of this paragraph, *reasonable cost* is defined as the direct salary paid to these physicians, plus applicable fringe benefits.

(3) The costs must be allocated to the services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section.

(4) Other allowable costs incurred by the provider related to the services described in this paragraph are payable subject to the requirements applicable to all other provider services.

(c) *Reasonable costs for the services furnished by a medical school or related organization in a hospital.* An amount is payable to the hospital by CMS under the Medicare program provided that the costs would be payable if incurred directly by the hospital rather than under the arrangement. The amount must not be in excess of the reasonable costs (as defined in paragraphs (c)(1) and (c)(2) of this section) incurred by a teaching hospital for services furnished by a medical school or organization as described in §413.17 of this chapter for certain costs to the medical school (or a related organization) in furnishing services in the hospital.

(1) *Reasonable costs of physician services*—(i) *When the medical school and the hospital are related organizations.* If the medical school (or organization related to the medical school) and the hospital are related by common ownership or control as described in §413.17 of this chapter—

(A) The costs of these services are allowable costs to the hospital under the provisions of §413.17 of this chapter; and

(B) The reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital.

(ii) *When the medical school and the hospital are not related organizations.* (A) If the medical school and the hospital are not related organizations under the provisions of §413.17 of this chapter and the hospital makes payment to the medical school for the costs of those services furnished to all patients, payment is made by Medicare to the hos-

pital for the reasonable cost incurred by the hospital for its payments to the medical school for services furnished to beneficiaries.

(B) Costs incurred under an arrangement must be allocated to the full range of services furnished to the hospital by the medical school physicians on the same basis as provided for under paragraph (j) of this section, and costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided for under paragraph (g) of this section.

(C) If the medical school and the hospital are not related organizations under the provisions of §413.17 of this chapter and the hospital makes payment to the medical school only for the costs of those services furnished to beneficiaries, costs of the medical school not to exceed 105 percent of the sum of physician direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation paid by the medical school or an organization related to the medical school may be recognized as allowable costs of the medical school.

(D) These allowable medical school costs must be allocated to the full range of services furnished by the physicians of the medical school or organization related as provided by paragraph (j) of this section.

(E) Costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided by paragraph (g) of this section.

(2) *Reasonable costs of other than direct medical and surgical services.* These costs are determined in accordance with paragraph (c)(1) of this section except that—

(i) If the hospital makes payment to the medical school for other than direct medical and surgical services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries, these payments are subject to the required cost-finding and apportionment methods applicable to the cost of other hospital services (except for direct medical and surgical services furnished to beneficiaries); or

(ii) If the hospital makes payment to the medical school only for these services furnished to beneficiaries, the cost of these services is not subject to cost-finding and apportionment as otherwise provided by this subpart, and the reasonable cost paid by Medicare must be determined on the basis of the health insurance ratio(s) used in the apportionment of all other provider costs (excluding physician direct medical and surgical services furnished to beneficiaries) applied to the allowable medical school costs incurred by the medical school for the services furnished to all patients of the hospital.

(d) “*Salary equivalent*” payments for direct medical and surgical services furnished by physicians on the voluntary staff of the hospital. (1) CMS makes payments under the Medicare program to a fund as defined in § 415.164 for direct medical and surgical services furnished to beneficiaries on a regularly scheduled basis by physicians on the unpaid voluntary medical staff of the hospital (or medical school under arrangement with the hospital).

(i) These payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a payable basis.

(ii) Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time, salaried physicians (other than interns and residents) on the hospital staff or, if the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area.

(iii) This “salary equivalent” is a single hourly rate covering all physicians regardless of specialty and is applied to the actual regularly scheduled time contributed by the physicians in furnishing direct medical and surgical services to beneficiaries including supervision of interns and residents in that care.

(iv) A physician who receives any compensation from the hospital or a medical school related to the hospital

by common ownership or control (within the meaning of § 413.17 of this chapter) for direct medical and surgical services furnished to any patient in the hospital is not considered an unpaid voluntary physician for purposes of this paragraph.

(v) If, however, a physician receives compensation from the hospital or related medical school or organization only for services that are other than direct medical and surgical services, a salary equivalent payment for the physician’s regularly scheduled direct medical and surgical services to beneficiaries in the hospital may be imputed. However, the sum of the imputed value for volunteer services and the physician’s actual compensation from the hospital and the related medical school (or organization) may not exceed the amount that would have been imputed if all of the physician’s hospital and medical school services (compensated and volunteer) had been volunteer services, or paid at the rate of \$30,000 per year, whichever is less.

(2) The following examples illustrate how the allowable imputed value for volunteer services is determined. In each example, it has been assumed that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician’s compensated services.

*Example No: 1.* Dr. Jones received \$3,000 a year from Hospital X for services other than direct medical services to all patients, for example, utilization review and administrative services. Dr. Jones also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to \$10,000 for the cost reporting period. The full imputed value of Dr. Jones’ volunteer direct medical services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$3,000) does not exceed \$30,000.

*Example No: 2.* Dr. Smith received \$25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to \$10,000. Only \$5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$25,000) exceeds the \$30,000 maximum amount allowable for all of Dr. Smith’s services.

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### COMPUTATION:

Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation	\$30,000
Less compensation received from Hospital X for other than direct medical services to individual patients .....	\$25,000
Allowable amount of imputed value for the volunteer services furnished by Dr. Smith .....	\$5,000

*Example No. 3.* Dr. Brown is not compensated by Hospital X for any services furnished in the hospital. Dr. Brown voluntarily furnished direct surgical services to beneficiaries for a period of 6 months, and the imputed value of these services amounted to \$20,000. The allowable amount of the imputed value for volunteer services furnished by Dr. Brown would be limited to \$15,000 ( $\$30,000 \times 6/12$ ).

(3) The amount of the imputed value for volunteer services applicable to beneficiaries and payable to a fund is determined in accordance with the aggregate per diem method described in paragraph (g) of this section.

(4) Medicare payments to a fund must be used by the fund solely for improvement of care of hospital patients or for educational or charitable purposes (which may include but are not limited to medical and other scientific research).

(i) No personal financial gain, either direct or indirect, from benefits of the fund may inure to any of the hospital staff physicians, medical school faculty, or physicians for whom Medicare imputes costs for purposes of payment into the fund.

(ii) Expenses met from contributions made to the hospital from a fund are not included as a reimbursable cost when expended by the hospital, and depreciation expense is not allowed with respect to equipment or facilities donated to the hospital by a fund or purchased by the hospital from monies in a fund.

(e) *Requirements for payment*—(1) *Physicians on the hospital staff.* The requirements under which the costs of physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries are the same as those applicable to the cost of all other covered provider services except that the costs of these services are separately determined as provided by

this section and are not subject to cost-finding as described in §413.24 of this chapter.

(2) *Physicians on the medical school faculty.* Payment is made to a hospital for the costs of services of physicians on the medical school faculty, provided that if the medical school is not related to the hospital (within the meaning of §413.17 of this chapter, concerning cost to related organizations), the hospital does not make payment to the medical school for services furnished to all patients and the following requirements are met: If the hospital makes payment to the medical school for services furnished to all patients, these requirements do not apply. (See paragraph (c)(1)(ii) of this section.)

(i) There is a written agreement between the hospital and the medical school or organization, specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay to the medical school an amount at least equal to the reasonable cost (as defined in paragraph (c) of this section) of furnishing the services to beneficiaries.

(ii) The costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were furnished is due to CMS.

(iii) Payment for the services furnished under an arrangement would have been made to the hospital had the services been furnished directly by the hospital.

(3) *Physicians on the voluntary staff of the hospital (or medical school under arrangement with the hospital).* If the conditions for payment to a fund outlined in §415.164 are met, payments are made on a “salary equivalent” basis (as defined in paragraph (d) of this section) to a fund.

(f) *Requirements for payment for medical school faculty services other than physician direct medical and surgical services.* If the requirements for payment for physician direct medical and surgical services furnished to beneficiaries in a teaching hospital described in paragraph (e) of this section are met, payment is made to a hospital for the costs of medical school faculty services other than physician direct

medical and surgical services furnished in a teaching hospital.

(g) *Aggregate per diem methods of apportionment*—(1) *For the costs of physician direct medical and surgical services.* The cost of physician direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined on the basis of an average cost per diem as defined in paragraph (h)(1) of this section for physician direct medical and surgical services to all patients (see §§ 415.172 through 415.184) for each of the following categories of physicians:

- (i) Physicians on the hospital staff.
- (ii) Physicians on the medical school faculty.

(2) *For the imputed value of physician volunteer direct medical and surgical services.* The imputed value of physician direct medical and surgical services furnished to beneficiaries in a teaching hospital is determined on the basis of an average per diem, as defined in paragraph (h)(1) of this section, for physician direct medical and surgical services to all patients except that the average per diem is derived from the imputed value of the physician volunteer direct medical and surgical services furnished to all patients.

(h) *Definitions.* (1) *Average cost per diem for physician direct medical and surgical services (including supervision of interns and residents) furnished in a teaching hospital to patients in each category of physician services described in paragraph (g)(1) of this section* means the amount computed by dividing total reasonable costs of these services in each category by the sum of—

- (i) Inpatient days (as defined in paragraph (h)(2) of this section); and
- (ii) Outpatient visit days (as defined in paragraph (h)(3) of this section).

(2) *Inpatient days* are determined by counting the day of admission as 3.5 days and each day after a patient's day of admission, except the day of discharge, as 1 day.

(3) *Outpatient visit days* are determined by counting only one visit day for each calendar day that a patient visits an outpatient department or multiple outpatient departments.

(i) *Application.* (1) The following illustrates how apportionment based on the aggregate per diem method for costs of

physician direct medical and surgical services furnished in a teaching hospital to patients is determined.

TEACHING HOSPITAL Y

Statistical and financial data:

Total inpatient days as defined in paragraph (h)(2) of this section and outpatient visit days as defined in paragraph (h)(3) of this section .....	75,000
Total inpatient Part A days .....	20,000
Total inpatient Part B days where Part A coverage is not available .....	1,000
Total outpatient Part B visit days .....	5,000
Total cost of direct medical and surgical services furnished to all patients by physicians on the hospital staff as determined in accordance with paragraph (i) of this section .....	\$1,500,000
Total cost of direct medical and surgical services furnished to all patients by physicians on the medical school faculty as determined in accordance with paragraph (i) of this section .....	\$1,650,000

Computation of cost applicable to program for physicians on the hospital staff:

Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff:  $\$1,500,000 \div 75,000 = \$20$  per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: \$20 per diem $\times 20,000$ .....	\$400,000
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: \$20 per diem $\times 1,000$ .....	\$20,000
Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: \$20 per diem $\times 5,000$ .....	\$100,000

Computation of cost applicable to program for physicians on the medical school faculty:

Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty:  $\$1,650,000 \div 75,000 = \$22$  per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: \$22 per diem $\times 20,000$ .....	\$440,000
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Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: \$20 per diem × 1,000 ..... \$22,000

Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: \$22 per diem × 5,000 ..... \$110,000

(2) The following illustrates how the imputed value of physician volunteer direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined.

*Example:* The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in furnishing direct medical and surgical services to patients of the hospital during a cost reporting period and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician volunteer services did not exceed the rate of \$30,000 per year per physician.

### STATISTICAL AND FINANCIAL DATA:

Total salaries paid to the full-time salaried physicians by the hospital (excluding interns and residents) ..... \$800,000

Total physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks × 40 hours per week) hours per year ..... 20

Average hourly rate equivalent:  $\$800,000 \div 41,600 (2,080 \times 20)$  ..... \$19.23

Computation of total imputed value of physician volunteer services applicable to all patients:

(Total donated hours × average hourly rate equivalent):  $5,000 \times \$19.23$  ..... \$96,150

Total inpatient days (as defined in paragraph (h)(2) of this section) and outpatient visit days (as defined in paragraph (h)(3) of this section) ..... 75,000

Total inpatient Part A days ..... 20,000

Total inpatient Part B days if Part A coverage is not available ..... 1,000

Total outpatient Part B visit days ..... 5,000

Computation of imputed value of physician volunteer direct medical and surgical services furnished to Medicare beneficiaries:

Average per diem for physician direct medical and surgical services to all patients:  $\$96,150 \div 75,000 = \$1.28$  per diem

Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A:  $\$1.28$  per diem × 20,000 ..... \$25,600

Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B:  $\$1.28$  per diem × 1,000 ..... \$1,280

Imputed value of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B:  $\$1.28$  per diem × 5,000 ..... \$6,400

Total ..... \$33,280

(j) *Allocation of compensation paid to physicians in a teaching hospital.* (1) In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. (However, see paragraph (d) of this section for the computation of the “salary equivalent” payments for volunteer services furnished to patients.)

(2) This allocation must be made and must be capable of substantiation on the basis of the proportion of each physician’s time spent in furnishing each type of service to the hospital or medical school.

### § 415.164 Payment to a fund.

(a) *General rules.* Payment for certain voluntary services by physicians in teaching hospitals (as these services are described in §415.160) is made on a salary equivalent basis (as described in §415.162(d)) subject to the conditions and limitations contained in parts 405 and 413 of this chapter and this part 415, to a single fund (as defined in paragraph (b) of this section) designated by the organized medical staff of the hospital (or, if the services are furnished in the hospital by the faculty of a medical school, to a fund as may be designated by the faculty), if the following conditions are met:

(1) The hospital (or medical school) furnishing the services under arrangement with the hospital) incurs no actual cost in furnishing the services.



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(2) The hospital has an agreement with CMS under part 489 of this chapter.

(3) The intermediary, or CMS as appropriate, has received written assurances that—

(i) The payment is used solely for the improvement of care of hospital patients or for educational or charitable purposes; and

(ii) Neither the individuals who are furnished the services nor any other persons are charged for the services (and if charged, provision is made for the return of any monies incorrectly collected).

(b) *Definition of a fund.* For purposes of paragraph (a) of this section, a *fund* is an organization that meets either of the following requirements:

(1) The organization has and retains exemption, as a governmental entity or under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation.

(2) The organization is an organization of physicians who, under the terms of their employment by an entity that meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income that the physician organization derives from the physician services.

(c) *Status of a fund.* A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under Medicare except that it does not enter into an agreement with CMS under part 489 of this chapter.

### **§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.**

Services meeting the conditions for payment in § 415.102(a) furnished in teaching settings are payable under the physician fee schedule if—

(a) The services are personally furnished by a physician who is not a resident; or

(b) The services are furnished by a resident in the presence of a teaching physician except as provided in § 415.172 (concerning physician fee schedule payment for services of teaching physicians), § 415.174 (concerning an exception for services furnished in hospital

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outpatient and certain other ambulatory settings), § 415.176 (concerning renal dialysis services), and § 415.184 (concerning psychiatric services), as applicable.

### **§ 415.172 Physician fee schedule payment for services of teaching physicians.**

(a) *General rule.* If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought. In residency training sites that are located outside a metropolitan statistical area, physician fee schedule payment may also be made if a teaching physician is present during the key portion of the service, including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought. For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID–19 pandemic, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made if a teaching physician is present during the key portion of the service including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought.

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

(i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

(2) In the case of evaluation and management services, except as otherwise provided in this paragraph (a)(2), the teaching physician must be present in person during the portion of the service that determines the level of service

billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of §415.174 apply.)

(i) In residency training sites that are located outside of a metropolitan statistical area, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of §415.174 apply.)

(ii) For all teaching settings during the Public Health Emergency, as defined in §400.200 of this chapter, for the COVID-19 pandemic, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of §415.174 apply.)

(b) *Documentation.* Except as otherwise provided in this paragraph (b), except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), §§415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document that the teaching physician was present at the time the service (including a Medicare telehealth service) is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in §410.20(e) of this chapter.

(1) In residency training sites that are located outside of a metropolitan statistical area only, except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis serv-

ices), and 415.184 (concerning psychiatric services), the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished. The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications technology. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in §410.20(e) of this chapter.

(2) For all teaching settings during the Public Health Emergency, as defined in §400.200 of this chapter, for the COVID-19 pandemic, except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished. The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications technology. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in §410.20(e) of this chapter.

(c) *Payment level.* In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment

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level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

[60 FR 63178, Dec. 8, 1995, as amended at 83 FR 60091, Nov. 23, 2018; 84 FR 63201, Nov. 15, 2019; 85 FR 19288, Apr. 6, 2020; 85 FR 27623, May 8, 2020; 85 FR 85036, Dec. 28, 2020]

### **§ 415.174 Exception: Evaluation and management services furnished in certain centers.**

(a) In the case of certain evaluation and management codes of lower and mid-level complexity (as specified by CMS in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met:

(1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§ 413.75 through 413.83.

(2) Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.

(3) The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—

(i) Have no other responsibilities at the time;

(ii) Assume management responsibility for those beneficiaries seen by the residents;

(iii) Ensure that the services furnished are appropriate; and

(iv) Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies.

(4) The range of services furnished by residents in the center includes all of the following:

(i) Acute care for undifferentiated problems or chronic care for ongoing conditions.

(ii) Coordination of care furnished by other physicians and providers.

(iii) Comprehensive care not limited by organ system, or diagnosis.

(5) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.

(6) The medical records must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter to each beneficiary in accordance with the documentation requirements at § 415.172(b).

(b) Nothing in paragraph (a) of this section may be construed as providing a basis for the coverage of services not determined to be covered under Medicare, such as routine physical check-ups.

(c) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, the requirements in paragraph (a)(3) of this section for a teaching physician to direct the care and then to review the services furnished by each resident during or immediately after each visit may be met through audio/video real-time communications technology.

(d) In residency training sites that are located outside of a metropolitan statistical area only, the requirements in paragraph (a)(3) of this section for a teaching physician to direct the care and then to review the services furnished by each resident during or immediately after each visit may be met through audio/video real-time communications technology.

[60 FR 63178, Dec. 8, 1995, as amended at 61 FR 59554, Nov. 22, 1996; 70 FR 47490, Aug. 12, 2005; 83 FR 60092, Nov. 23, 2018; 84 FR 63202, Nov. 15, 2019; 85 FR 19288, Apr. 6, 2020; 85 FR 27624, May 8, 2020; 85 FR 85037, Dec. 28, 2020]

### **§ 415.176 Renal dialysis services.**

In the case of renal dialysis services, physicians who are not paid under the

physician monthly capitation payment method (as described in §414.314 of this chapter) must meet the requirements of §§415.170 and 415.172 (concerning physician fee schedule payment for services of teaching physicians).

**§415.178 Anesthesia services.**

(a) *General rule.* (1) *For services furnished prior to January 1, 2010*, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in §414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010*, payment made under §414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

[74 FR 62014, Nov. 25, 2009]

**§415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.**

(a) *General rule.* Physician fee schedule payment is made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is

performed or reviewed by a physician other than a resident.

(1) In residency training sites that are located outside of a metropolitan statistical area only, physician fee schedule payment may also be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology test.

(2) For all teaching settings during the Public Health Emergency, as defined in §400.200 of this chapter, for the COVID-19 pandemic, physician fee schedule payment may also be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology or diagnostic test.

(b) [Reserved]

[85 FR 85037, Dec. 28, 2020]

**§415.184 Psychiatric services.**

(a) Physician fee schedule payment is made for psychiatric services furnished under an approved GME program if the requirements of §§415.170 and 415.172 are met, including documentation, except that the requirement for the presence of the teaching physician during the service in which a resident is involved may be met by observation of the service by use of a one-way mirror, video equipment, or similar device.

(b) In residency training sites that are located outside of a metropolitan statistical area, the requirement for the presence of the teaching physician during the service in which a resident is involved may be met through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the service.