

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.

## Centers for Medicare & Medicaid Services, HHS

## § 416.1

### 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 Intra- ocular Lenses Furnished by Ambula- tory 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.
- 416.200 Payment adjustment.

### Subpart H—Requirements Under the Am- bulatory Surgical Center Quality Re- porting (ASCQR) Program

- 416.300 Basis and scope of subpart.

- 416.305 Participation and withdrawal requirements under the ASCQR Program.
- 416.310 Data collection and submission requirements under the ASCQR Program.
- 416.315 Public reporting of data under the ASCQR Program.
- 416.320 Retention and removal of quality measures under the ASCQR Program.
- 416.325 Measure maintenance under the ASCQR Program.
- 416.330 Reconsiderations under the ASCQR Program.

AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 47 FR 34094, Aug. 5, 1982, unless otherwise noted.

## Subpart A—General Provisions and Definitions

### § 416.1 Basis and scope.

(a) *Statutory basis.* (1) Section 1832(a)(2)(F)(i) of the Act provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures specified by the Secretary under section 1833(i)(1) of the Act.

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center.

(3) Sections 1833(i)(2)(A) and (D) and 1833(a)(1)(G) of the Act specify the amounts to be paid for facility services furnished in connection with the specified surgical procedures when they are performed in an ASC.

(4) Section 1833(i)(2)(C) of the Act provides that if the Secretary has not updated amounts for ASC facility services furnished during a fiscal year through 2005 or a calendar year beginning with 2006, the amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, except that, in fiscal year 2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009, the increase shall be zero percent.

(5) Section 1833(i)(2)(E) of the Act provides that, with respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system, the payment amount shall be the lesser of the ASC payment