(6) *Compensation from a physician.* (i) Compensation from a physician (or immediate family member of the physician) to an entity furnishing designated health services takes into account the volume or value of referrals only if the formula used to calculate the entity's compensation includes the physician's referrals to the entity as a variable, resulting in an increase or decrease in the entity's compensation that negatively correlates with the number or value of the physician's referrals to the entity.

(ii) Compensation from a physician (or immediate family member of the physician) to an entity furnishing designated health services takes into account the volume or value of other business generated only if the formula used to calculate the entity's compensation includes other business generated by the physician for the entity as a variable, resulting in an increase or decrease in the entity's compensation that negatively correlates with the physician's generation of other business for the entity.

(iii) For purposes of applying this paragraph (d)(6), a negative correlation between two variables exists when one variable increases as the other variable decreases, or when one variable decreases as the other variable increases.

(iv) This paragraph (d)(6) does not apply for purposes of applying the special rules in paragraphs (d)(2) and (3) of this section or the exceptions at §411.357(m), (s), (u), (v), (w), and (bb).

(e) *Special rule on compensation arrangements*—(1) *Application.* This paragraph (e) applies only to compensation arrangements as defined in section 1877 of the Act and this subpart.

(2) *Writing requirement.* In the case of any requirement in this subpart for a compensation arrangement to be in writing, such requirement may be satisfied by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties.

(3) *Signature requirement.* In the case of any signature requirement in this subpart, such requirement may be satisfied by an electronic or other signature that is valid under applicable Federal or State law.

(4) *Special rule on writing and signature requirements.* In the case of any requirement in this subpart for a compensation arrangement to be in writing and signed by the parties, the writing requirement or the signature requirement is satisfied if—

(i) The compensation arrangement between the entity and the physician fully complies with an applicable exception in this subpart except with respect to the writing or signature requirement of the exception; and

(ii) The parties obtain the required writing(s) or signature(s) within 90 consecutive calendar days immediately following the date on which the compensation arrangement became noncompliant with the requirements of the applicable exception (that is, the date on which the writing(s) or signature(s) were required under the applicable exception but the parties had not yet obtained them).

[85 FR 77656, Dec. 2, 2020, as amended at 86 FR 65667, Nov. 19, 2021]

§411.355 General exceptions to the referral prohibition related to both ownership/investment and compensation.

The prohibition on referrals set forth in §411.353 does not apply to the following types of services:

(a) *Physician services.* (1) Physician services as defined at §410.20(a) of this chapter that are furnished—

(i) Personally by another physician who is a member of the referring physician's group practice or is a physician in the same group practice (as defined at §411.351) as the referring physician; or

(ii) Under the supervision of another physician who is a member of the referring physician's group practice or is a physician in the same group practice (as defined at §411.351) as the referring physician, provided that the supervision complies with all other applicable Medicare payment and coverage rules for the physician services.

(2) For purposes of this paragraph (a), ''physician services'' include only those ''incident to'' services (as defined at §411.351) that are physician services under §410.20(a) of this chapter.

(b) *In-office ancillary services.* Services (including certain items of durable

medical equipment (DME), as defined in paragraph (b)(4) of this section, and infusion pumps that are DME (including external ambulatory infusion pumps), but excluding all other DME and parenteral and enteral nutrients, equipment, and supplies (such as infusion pumps used for PEN)), that meet the following conditions:

(1) *Individual who furnishes the service.* They are furnished personally by one of the following individuals:

(i) The referring physician.

(ii) A physician who is a member of the same group practice as the referring physician.

(iii) An individual who is supervised by the referring physician or, if the referring physician is in a group practice, by another physician in the group practice, provided that the supervision complies with all other applicable Medicare payment and coverage rules for the services.

(2) *Location where service is furnished.* They are furnished in one of the following locations:

(i) The same building (as defined at § 411.351), but not necessarily in the same space or part of the building, in which all of the conditions of paragraph (b)(2)(i)(A), (b)(2)(i)(B), *or* (b)(2)(i)(C) of this section are satisfied:

(A)(*1*) The referring physician or his or her group practice (if any) has an office that is normally open to the physician's or group's patients for medical services at least 35 hours per week; and

(*2*) The referring physician or one or more members of the referring physician's group practice regularly practices medicine and furnishes physician services to patients at least 30 hours per week. The 30 hours must include some physician services that are unrelated to the furnishing of DHS payable by Medicare, any other Federal health care payer, or a private payer, even though the physician services may lead to the ordering of DHS; or

(B)(*1*) The patient receiving the DHS usually receives physician services from the referring physician or members of the referring physician's group practice (if any);

(*2*) The referring physician or the referring physician's group practice owns or rents an office that is normally open to the physician's or group's patients for medical services at least 8 hours per week; and

(*3*) The referring physician regularly practices medicine and furnishes physician services to patients at least 6 hours per week. The 6 hours must include some physician services that are unrelated to the furnishing of DHS payable by Medicare, any other Federal health care payer, or a private payer, even though the physician services may lead to the ordering of DHS; or

(C)(*1*) The referring physician is present and orders the DHS during a patient visit on the premises as set forth in paragraph (b)(2)(i)(C)(*2*) of this section *or* the referring physician or a member of the referring physician's group practice (if any) is present while the DHS is furnished during occupancy of the premises as set forth in paragraph (b)(2)(i)(C)(*2*) of this section;

(*2*) The referring physician or the referring physician's group practice owns or rents an office that is normally open to the physician's or group's patients for medical services at least 8 hours per week; and

(*3*) The referring physician or one or more members of the referring physician's group practice regularly practices medicine and furnishes physician services to patients at least 6 hours per week. The 6 hours must include some physician services that are unrelated to the furnishing of DHS payable by Medicare, any other Federal health care payer, or a private payer, even though the physician services may lead to the ordering of DHS.

(ii) A centralized building (as defined at § 411.351) that is used by the group practice for the provision of some or all of the group practice's clinical laboratory services.

(iii) A centralized building (as defined at § 411.351) that is used by the group practice for the provision of some or all of the group practice's DHS (other than clinical laboratory services).

(3) *Billing of the service.* They are billed by one of the following:

(i) The physician performing or supervising the service.

(ii) The group practice of which the performing or supervising physician is a member under a billing number assigned to the group practice.

(iii) The group practice if the supervising physician is a ''physician in the group practice'' (as defined at §411.351) under a billing number assigned to the group practice.

(iv) An entity that is wholly owned by the performing or supervising physician or by that physician's group practice under the entity's own billing number or under a billing number assigned to the physician or group practice.

(v) An independent third party billing company acting as an agent of the physician, group practice, or entity specified in paragraphs (b)(3)(i) through (iv) of this section under a billing number assigned to the physician, group practice, or entity, provided that the billing arrangement meets the requirements of §424.80(b)(5) of this chapter. For purposes of this paragraph (b)(3), a group practice may have, and bill under, more than one Medicare billing number, subject to any applicable Medicare program restrictions.

(4) *Durable Medical Equipment.* For purposes of this paragraph (b), DME covered by the in-office ancillary services exception means canes, crutches, walkers and folding manual wheelchairs, and blood glucose monitors, that meet the following conditions:

(i) The item is one that a patient requires for the purpose of ambulating, a patient uses in order to depart from the physician's office, or is a blood glucose monitor (including one starter set of test strips and lancets, consisting of no more than 100 of each). A blood glucose monitor may be furnished only by a physician or employee of a physician or group practice that also furnishes outpatient diabetes self-management training to the patient.

(ii) The item is furnished in a building that meets the ''same building'' requirements in the in-office ancillary services exception as part of the treatment for the specific condition for which the patient-physician encounter occurred.

(iii) The item is furnished personally by the physician who ordered the DME, by another physician in the group practice, or by an employee of the physician or the group practice.

(iv) A physician or group practice that furnishes the DME meets all DME supplier standards set forth in §424.57(c) of this chapter.

(v) [Reserved]

(vi) All other requirements of the in-office ancillary services exception in this paragraph (b) are met.

(5) *Furnishing a service.* A designated health service is ''furnished'' for purposes of this paragraph (b) in the location where the service is actually performed upon a patient or where an item is dispensed to a patient in a manner that is sufficient to meet the applicable Medicare payment and coverage rules.

(6) *Special rule for home care physicians.* In the case of a referring physician whose principal medical practice consists of treating patients in their private homes, the ''same building'' requirements of paragraph (b)(2)(i) of this section are met if the referring physician (or a qualified person accompanying the physician, such as a nurse or technician) provides the DHS contemporaneously with a physician service that is not a designated health service provided by the referring physician to the patient in the patient's private home. For purposes of paragraph (b)(5) of this section only, a private home does not include a nursing, long-term care, or other facility or institution, except that a patient may have a private home in an assisted living or independent living facility.

(7) *Disclosure requirement for certain imaging services.* (i) With respect to magnetic resonance imaging, computed tomography, and positron emission tomography services identified as ''radiology and certain other imaging services'' on the List of CPT/HCPCS Codes, the referring physician must provide written notice to the patient at the time of the referral that the patient may receive the same services from a person other than one described in paragraph (b)(1) of this section. Except as set forth in paragraph (b)(7)(ii) of this section, the written notice must include a list of at least 5 other suppliers (as defined at §400.202 of this chapter) that provide the services for which the individual is being referred and which are located within a 25-mile radius of the referring physician's office location at the time of the referral. The notice should be written in a

manner sufficient to be reasonably understood by all patients and should include for each supplier on the list, at a minimum, the supplier's name, address, and telephone number.

(ii) If there are fewer than 5 other suppliers located within a 25-mile radius of the physician's office location at the time of the referral, the physician must list all of the other suppliers of the imaging service that are present within a 25-mile radius of the referring physician's office location. Provision of the written list of alternate suppliers will not be required if no other suppliers provide the services for which the individual is being referred within the 25-mile radius.

(c) *Services furnished by an organization (or its contractors or subcontractors) to enrollees.* Services furnished by an organization (or its contractors or subcontractors) to enrollees of one of the following prepaid health plans (not including services provided to enrollees in any other plan or line of business offered or administered by the same organization):

(1) An HMO or a CMP in accordance with a contract with CMS under section 1876 of the Act and part 417, subparts J through M of this chapter.

(2) A health care prepayment plan in accordance with an agreement with CMS under section 1833(a)(1)(A) of the Act and part 417, subpart U of this chapter.

(3) An organization that is receiving payments on a prepaid basis for Medicare enrollees through a demonstration project under section 402(a) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or under section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 note).

(4) A qualified HMO (within the meaning of section 1310(d) of the Public Health Service Act).

(5) A coordinated care plan (within the meaning of section 1851(a)(2)(A) of the Act) offered by a Medicare Advantage organization in accordance with a contract with CMS under section 1857 of the Act and part 422 of this chapter.

(6) A MCO contracting with a State under section 1903(m) of the Act.

(7) A prepaid inpatient health plan (PIHP) or prepaid ambulance health plan (PAHP) contracting with a State under part 438 of this chapter.

(8) A health insuring organization (HIO) contracting with a State under part 438, subpart D of this chapter.

(9) An entity operating under a demonstration project under sections 1115(a), 1915(a), 1915(b), or 1932(a) of the Act.

(d) [Reserved]

(e) *Academic medical centers.* (1) Services provided by an academic medical center if all of the following conditions are met:

(i) The referring physician—

(A) Is a *bona fide* employee of a component of the academic medical center on a full-time or substantial part-time basis. (A ''component'' of an academic medical center means an affiliated medical school, faculty practice plan, hospital, teaching facility, institution of higher education, departmental professional corporation, or nonprofit support organization whose primary purpose is supporting the teaching mission of the academic medical center.) The components need not be separate legal entities;

(B) Is licensed to practice medicine in the State(s) in which he or she practices medicine;

(C) Has a *bona fide* faculty appointment at the affiliated medical school or at one or more of the educational programs at the accredited academic hospital (as defined at §411.355(e)(3)); and

(D) Provides either substantial academic services or substantial clinical teaching services (or a combination of academic services and clinical teaching services) for which the faculty member receives compensation as part of his or her employment relationship with the academic medical center. Parties should use a reasonable and consistent method for calculating a physician's academic services and clinical teaching services. A physician will be deemed to meet this requirement if he or she spends at least 20 percent of his or her professional time or 8 hours per week providing academic services or clinical teaching services (or a combination of academic services or clinical teaching services). A physician who does not spend at least 20 percent of his or her professional time or 8 hours per week

providing academic services or clinical teaching services (or a combination of academic services or clinical teaching services) is not precluded from qualifying under this paragraph (e)(1)(i)(D).

(ii) The compensation paid to the referring physician must meet all of the following conditions:

(A) The total compensation paid by each academic medical center component to the referring physician is set in advance.

(B) In the aggregate, the compensation paid by all academic medical center components to the referring physician does not exceed fair market value for the services provided.

(C) The total compensation paid by each academic medical center component is not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician within the academic medical center.

(D) If any compensation paid to the referring physician is conditioned on the physician's referrals to a particular provider, practitioner, or supplier, the arrangement satisfies the conditions of §411.354(d)(4).

(iii) The academic medical center must meet all of the following conditions:

(A) All transfers of money between components of the academic medical center must directly or indirectly support the missions of teaching, indigent care, research, or community service.

(B) The relationship of the components of the academic medical center must be set forth in one or more written agreements or other written documents that have been adopted by the governing body of each component. If the academic medical center is one legal entity, this requirement will be satisfied if transfers of funds between components of the academic medical center are reflected in the routine financial reports covering the components.

(C) All money paid to a referring physician for research must be used solely to support *bona fide* research or teaching and must be consistent with the terms and conditions of the grant.

(2) The ''academic medical center'' for purposes of this section consists of—

(i) An accredited medical school (including a university, when appropriate) or an accredited academic hospital (as defined at paragraph (e)(3) of this section);

(ii) One or more faculty practice plans affiliated with the medical school, the affiliated hospital(s), or the accredited academic hospital; and

(iii) One or more affiliated hospitals in which a majority of the physicians on the medical staff consists of physicians who are faculty members and a majority of all hospital admissions is made by physicians who are faculty members. The hospital for purposes of this paragraph (e)(2)(iii) may be the same hospital that satisfies the requirement of paragraph (e)(2)(i) of this section. For purposes of this paragraph (e)(2)(iii), a faculty member is a physician who is either on the faculty of the affiliated medical school or on the faculty of one or more of the educational programs at the accredited academic hospital. In meeting this paragraph (e)(2)(iii), faculty from any affiliated medical school or accredited academic hospital education program may be aggregated, and residents and non-physician professionals need not be counted. Any faculty member may be counted, including courtesy and volunteer faculty. For purposes of determining whether the majority of physicians on the medical staff consists of faculty members, the affiliated hospital must include or exclude all individual physicians with the same class of privileges at the affiliated hospital (for example, physicians holding courtesy privileges).

(3) An accredited academic hospital for purposes of this section means a hospital or a health system that sponsors four or more approved medical education programs.

(f) *Implants furnished by an ASC.* Implants furnished by an ASC, including, but not limited to, cochlear implants, intraocular lenses, and other implanted prosthetics, implanted prosthetic devices, and implanted DME that meet the following conditions:

(1) The implant is implanted by the referring physician or a member of the referring physician's group practice in an ASC that is certified by Medicare under part 416 of this chapter and with

which the referring physician has a financial relationship.

(2) The implant is implanted in the patient during a surgical procedure paid by Medicare to the ASC as an ASC procedure under § 416.65 of this chapter.

(3) [Reserved]

(4) [Reserved]

(5) The exception set forth in this paragraph (f) does not apply to any financial relationships between the referring physician and any entity other than the ASC in which the implant is furnished to, and implanted in, the patient.

(g) *EPO and other dialysis-related drugs.* EPO and other dialysis-related drugs that meet the following conditions:

(1) The EPO and other dialysis-related drugs are furnished in or by an ESRD facility. For purposes of this paragraph (g)(1), ''EPO and other dialysis-related drugs'' means certain outpatient prescription drugs that are required for the efficacy of dialysis and identified as eligible for this exception on the List of CPT/HCPCS Codes; and ''furnished'' means that the EPO or dialysis-related drugs are administered to a patient in the ESRD facility or, in the case of EPO or Aranesp (or equivalent drug identified on the List of CPT/HCPCS Codes) only, are dispensed by the ESRD facility for use at home.

(2) [Reserved]

(3) [Reserved]

(4) The exception set forth in this paragraph (g) does not apply to any financial relationship between the referring physician and any entity other than the ESRD facility that furnishes the EPO and other dialysis-related drugs to the patient.

(h) *Preventive screening tests and vaccines.* (1) Preventive screening tests and vaccines that meet the following conditions:

(i) The preventive screening test or vaccine is listed on the List of CPT/HCPCS Codes as a code to which the exception in this paragraph is applicable.

(ii) The preventive screening test or vaccine is covered by Medicare.

(iii) The preventive screening test or vaccine is subject to a CMS-mandated frequency limit.

(2) During such period as the vaccine is not subject to a CMS-mandated frequency limit, paragraph (h)(1)(iii) of this section does not apply to a COVID–19 vaccine identified on the List of CPT/HCPCS Codes as a code to which the exception in this paragraph is applicable.

(i) *Eyeglasses and contact lenses following cataract surgery.* Eyeglasses and contact lenses that are covered by Medicare when furnished to patients following cataract surgery that meet the following conditions:

(1) The eyeglasses or contact lenses are provided in accordance with the coverage and payment provisions set forth in §§ 410.36(a)(2)(ii) and 414.228 of this chapter, respectively.

(2) [Reserved]

(j) *Intra-family rural referrals.* (1) Services provided pursuant to a referral from a referring physician to his or her immediate family member or to an entity furnishing DHS with which the immediate family member has a financial relationship, if all of the following conditions are met:

(i) The patient who is referred resides in a rural area as defined at § 411.351 of this subpart;

(ii) Except as provided in paragraph (j)(1)(iii) of this section, in light of the patient's condition, no other person or entity is available to furnish the services in a timely manner within 25 miles of or 45 minutes transportation time from the patient's residence;

(iii) In the case of services furnished to patients where they reside (for example, home health services or DME), no other person or entity is available to furnish the services in a timely manner in light of the patient's condition; and

(2) The referring physician or the immediate family member must make reasonable inquiries as to the availability of other persons or entities to furnish the DHS. However, neither the referring physician nor the immediate family member has any obligation to inquire as to the availability of persons or entities located farther than 25 miles of or 45 minutes transportation time from (whichever test the referring

physician utilized for purposes of paragraph (j)(1)(ii)) the patient's residence.

[85 FR 77656, Dec. 2, 2020, as amended at 86 FR 65668, Nov. 19 2021]

§411.356 Exceptions to the referral prohibition related to ownership or investment interests.

For purposes of §411.353, the following ownership or investment interests do not constitute a financial relationship:

(a) *Publicly traded securities.* Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) that at the time the DHS referral was made could be purchased on the open market and that meet the requirements of paragraphs (a)(1) and (2) of this section.

(1) They are either—

(i) Listed for trading on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis;

(ii) Traded under an automated interdealer quotation system operated by the National Association of Securities Dealers; or

(iii) Listed for trading on an electronic stock market or over-the-counter quotation system in which quotations are published on a daily basis and trades are standardized and publicly transparent.

(2) They are in a corporation that had stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years. ''Stockholder equity'' is the difference in value between a corporation's total assets and total liabilities.

(b) *Mutual funds.* Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if the company had, at the end of its most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding $75 million.

(c) *Specific providers.* Ownership or investment interest in the following entities, for purposes of the services specified:

(1) A rural provider, in the case of DHS furnished in a rural area (as defined at §411.351 of this part) by the provider. A ''rural provider'' is an entity that furnishes substantially all (not less than 75 percent) of the DHS that it furnishes to residents of a rural area and, for the 18-month period beginning on December 8, 2003 (or such other period as Congress may specify), is not a specialty hospital, and in the case where the entity is a hospital, the hospital meets the requirements of §411.362 no later than September 23, 2011.

(2) A hospital that is located in Puerto Rico, in the case of DHS furnished by such a hospital.

(3) A hospital that is located outside of Puerto Rico, in the case of DHS furnished by such a hospital, if—

(i) The referring physician is authorized to perform services at the hospital;

(ii) Effective for the 18-month period beginning on December 8, 2003 (or such other period as Congress may specify), the hospital is not a specialty hospital;

(iii) The ownership or investment interest is in the entire hospital and not merely in a distinct part or department of the hospital; and

(iv) The hospital meets the requirements described in §411.362 not later than September 23, 2011.

[85 FR 77656, Dec. 2, 2020]

§411.357 Exceptions to the referral prohibition related to compensation arrangements.

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if the arrangement meets the following requirements:

(1) The lease arrangement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The duration of the lease arrangement is at least 1 year. To meet this requirement, if the lease arrangement is terminated with or without cause, the parties may not enter into a new lease arrangement for the same space