

§ 414.20

FEDERAL REGISTER and provides an opportunity for public comment. After considering public comments, CMS publishes the final changes in the FEDERAL REGISTER.

[59 FR 63463, Dec. 8, 1994]

Subpart B—Physicians and Other Practitioners

SOURCE: 56 FR 59624, Nov. 25, 1991; 57 FR 42492, Sept. 15, 1992, unless otherwise noted.

§ 414.20 Formula for computing fee schedule amounts.

(a) *Participating supplier.* The fee schedule amount for a participating supplier for a physician service as defined in § 414.2 is computed as the product of the following amounts:

- (1) The RVUs for the service.
- (2) The GAF for the fee schedule area.
- (3) The CF.

(b) *Nonparticipating supplier.* The fee schedule amount for a nonparticipating supplier for a physician service as defined in § 414.2 is 95 percent of the fee schedule amount as calculated in paragraph (a) of this section.

[62 FR 59101, Oct. 31, 1997]

§ 414.21 Medicare payment basis.

Medicare payment is based on the lesser of the actual charge or the applicable fee schedule amount.

[62 FR 59101, Oct. 31, 1997]

§ 414.22 Relative value units (RVUs).

CMS establishes RVUs for physicians' work, practice expense, and malpractice insurance.

(a) *Physician work RVUs*—(1) *General rule.* Physician work RVUs are established using a relative value scale in which the value of physician work for a particular service is rated relative to the value of work for other physician services.

(2) *Special RVUs for anesthesia and radiology services*—(i) *Anesthesia services.* The rules for determining RVUs for anesthesia services are set forth in § 414.46.

(ii) *Radiology services.* CMS bases the RVUs for all radiology services on the relative value scale developed under section 1834(b)(1)(A) of the Act, with

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appropriate modifications to ensure that the RVUs established for radiology services that are similar or related to other physician services are consistent with the RVUs established for those similar or related services.

(b) *Practice expense RVUs.* (1) Practice expense RVUs are computed for each service or class of service by applying average historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average practice expense percentage for a service or class of services is computed as follows:

(i) Multiply the average practice expense percentage for each specialty by the proportion of a particular service or class of service performed by that specialty.

(ii) Add the products for all specialties.

(3) For services furnished beginning calendar year (CY) 1994, for which 1994 practice expense RVUs exceed 1994 work RVUs and that are performed in office settings less than 75 percent of the time, the 1994, 1995, and 1996 practice expense RVUs are reduced by 25 percent of the amount by which they exceed the number of 1994 work RVUs. Practice expense RVUs are not reduced to less than 128 percent of 1994 work RVUs.

(4) For services furnished beginning January 1, 1998, practice expense RVUs for certain services are reduced to 110 percent of the work RVUs for those services. The following two categories of services are excluded from this limitation:

(i) The service is provided more than 75 percent of the time in an office setting; or

(ii) The service is one described in section 1848(c)(2)(G)(v) of the Act, codified at 42 U.S.C. 1395w-4(c)(2)(G). Section 1848(c)(2)(G)(v) of the Act refers to the 1998 proposed resource-based practice expense RVUs (as specified in the June 18, 1997 physician fee schedule proposed rule (62 FR 33158)) for the specific site, either in-office or out-of-office, increased from its 1997 practice expense RVUs.)

(5) For services furnished beginning January 1, 1999, the practice expense RVUs are based on 75 percent of the

practice expense RVUs applicable to services furnished in 1998 and 25 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2000, the practice expense RVUs are based on 50 percent of the practice expense RVUs applicable to services furnished in 1998 and 50 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2001, the practice expense RVUs are based on 25 percent of the practice expense RVUs applicable to services furnished in 1998 and 75 percent of the relative practice expense resources involved in furnishing the service. For services furnished in 2002 and subsequent years, the practice expense RVUs are based entirely on relative practice expense resources.

(i) Usually there are two levels of practice expense RVUs that correspond to each code.

(A) *Facility practice expense RVUs.* The lower facility practice expense RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center when the physician performs procedures on the ASC approved procedures list. (The facility practice expense RVUs for a particular code may not be greater than the non-facility RVUs for the code.)

(B) *Non-facility practice expense RVUs.* The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure.

(C) *Outpatient therapy services.* Outpatient therapy services billed under the physician fee schedule are paid using the non-facility practice expense RVU component.

(ii) Only one practice expense RVU per code can be applied for each of the following services: services that have only technical component practice expense RVUs or only professional component practice expense RVUs; evalua-

tion and management services, such as hospital or nursing facility visits, that are furnished exclusively in one setting; and major surgical services.

(6)(i) CMS establishes criteria for supplemental surveys regarding specialty practice expenses submitted to CMS that may be used in determining practice expense RVUs.

(ii) Any CMS-designated specialty group may submit a supplemental survey.

(iii) CMS will consider for use in determining practice expense RVUs for the physician fee schedule survey data and related materials submitted to CMS by August 1, 2002 to determine CY 2003 practice expense RVUs and by August 1, 2003 to determine CY 2004 practice expense RVUs.

(c) *Malpractice insurance RVUs.* (1) Malpractice insurance RVUs are computed for each service or class of services by applying average malpractice insurance historical practice cost percentages to the estimated average allowed charge during the 1991 base period.

(2) The average historical malpractice insurance percentage for a service or class of services is computed as follows:

(i) Multiply the average malpractice insurance percentage for each specialty by the proportion of a particular service or class of services performed by that specialty.

(ii) Add all the products for all the specialties.

(3) For services furnished in the year 2000 and subsequent years, the malpractice RVUs are based on the relative malpractice insurance resources.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42493, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 62 FR 59102, Oct. 31, 1997; 63 FR 58910, Nov. 2, 1998; 64 FR 59441, Nov. 2, 1999; 65 FR 25668, May 3, 2000; 65 FR 65440, Nov. 1, 2000; 67 43558, June 28, 2002]

§ 414.24 Review, revision, and addition of RVUs for physician services.

(a) *Interim values for new and revised HCPCS level 1 and level 2 codes.* (1) CMS establishes interim RVUs for new services and for codes for which definitions have changed.