

(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.* The technical component of physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient before January 1, 2001 may be paid to the laboratory on a fee schedule basis. After December 31, 2000 but before January 1, 2003, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service

Medicare beneficiary who is an inpatient or outpatient of a covered hospital, the carrier will treat the technical component as a service for which payment will be made to the laboratory under the physician fee schedule. For these two years the service will not be treated as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of the Act or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of the Act. After December 31, 2002, the technical component for physician pathology services furnished by an independent laboratory to a hospital inpatient or outpatient is paid only to the hospital.

[60 FR 63178, Dec. 8, 1995, as amended at 64 FR 59442, Nov. 2, 1999; 66 FR 55332, Nov. 1, 2001]

#### 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 § 413.86 of this chapter.

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

##### § 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 of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by