

**PART 414--PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES**

24. The authority citation for part 414 is revised to read as follows:

**Authority:** Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

**Subpart B--Physicians and Other Practitioners**

25. Section 414.50 is revised to read as follows:

**§414.50 Physician billing for purchased diagnostic tests.**

(a) General rule. (1) For services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special rules set forth in section 1833(h)(5)(A) of the Act), if a physician or medical group bills for the technical or professional component of a diagnostic test that was performed by an outside supplier, the payment to the physician or the medical group (less the applicable deductibles and coinsurance) for the technical or professional component of the test may not exceed the lowest of the following amounts:

(i) The supplier's net charge to the physician or medical group.

(ii) The physician's or medical group's actual charge.

(iii) The fee schedule amount for the test that would be allowed if the supplier billed directly.

(2) This provision applies regardless of whether the test or its interpretation was purchased by the physician or medical group billing for the test or the interpretation, or whether the right to bill for the test or its interpretation was reassigned to the physician or medical group billing for the test or the interpretation.

(3) For purposes of paragraph (a) of this section--

(i) The physician's or other supplier's net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the outside supplier by or through the billing physician or medical group.

(ii) An outside supplier is someone other than a full-time employee of the billing physician or medical group.

(b) Restriction on payment. (1) The physician or medical group must identify the supplier and indicate the supplier's net charge for the test. If the physician or medical group fails to provide this information, CMS makes no payment to the physician or medical group and the physician or medical group may not bill the beneficiary.

(2) Physicians and medical groups that accept Medicare assignment may bill beneficiaries for only the applicable deductibles and co-insurance.

(3) Physicians and medical groups that do not accept Medicare assignment may not bill the beneficiary more than the payment amount described in paragraph (a) of this section.

26. Section 414.65 is amended by revising paragraph (a) (1) to read as follows:

**§414.65 Payment for telehealth services.**

(a) \* \* \*

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and neurobehavioral status exam furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

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**Subpart G--Payment for New Clinical Diagnostic Laboratory Tests**