

and the date and time the beneficiary was received by that facility.

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§424.37 [Amended]

51. Section 424.37(a) is amended by removing the reference to “§424.36(b)” and adding in its place the reference “§424.36(b)(1) through (5).”

Subpart F--Limitations on Assignment and Reassignment of Claims

52. Section 424.80 is amended by adding paragraph (d)(3) to read as follows:

§424.80 Prohibition of reassignment of claims by suppliers.

* * * * *

(d) * * *

(3) Reassignment of the technical or professional component of diagnostic test services. If a physician or medical group bills for the technical or professional component of a diagnostic test 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), following a reassignment from a physician or other supplier who performed the technical or

professional component and who was not a full-time employee of the billing physician or medical group at the time the service was performed, each of the following conditions must be met:

(i) The payment to the billing physician, or medical group, less the applicable deductibles and coinsurance, may not exceed the lowest of the following amounts:

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

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

(C) The fee schedule amount for the service that would be allowed if the physician or other supplier billed directly.

(ii) The physician or medical group billing for the test must identify the physician or other supplier that performed the test and indicate the supplier's net charge for the test. If the physician or medical group billing for the test fails to provide this information, CMS will

not make any payment to the physician or medical group billing for the test and the billing physician or medical group can not bill the beneficiary.

(iii) To bill for the technical component of the service, the physician or medical group must directly perform the professional component of the service.

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

53. The authority citation for part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D--Optional Hospital Services

54. Section 482.56 is amended by revising paragraphs (a)(2) and (b) to read as follows:

§482.56 Condition of participation: Rehabilitation services.

(a) * * *

(2) Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record.

(b) Standard: Delivery of services. (1) Except as specified in paragraph (c)(1)(ii) of this section, physical