

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).

HCFA 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.* HCFA bases the RVUs for all radiology services on the relative value scale developed under section 1834(b)(1)(A) of the Act, with 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 one of two levels of practice expense RVUs per code can be applied to each service. The lower practice expense RVUs apply to services furnished to hospital, skilled nursing

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facility, or ambulatory surgical center patients. The higher practice expense RVUs apply to services performed in a physician's office; services, other than evaluation and management services, furnished to patients in a nursing facility, in a facility or institution other than a hospital, skilled nursing facility, or ambulatory surgical center, or in the home; and other services furnished to facility patients for which the facility payment does not include physicians' practice costs.

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

(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.

[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]

§ 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) HCFA establishes interim RVUs for new services and for codes for which definitions have changed.

(2) HCFA publishes a notice in the FEDERAL REGISTER to announce interim RVUs and seek public comment on them. The RVUs are effective prospectively for services furnished begin-

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ning on the effective date specified in the notice.

(3) After considering public comments, HCFA revises, if necessary, the interim RVUs and announces those revisions in a final notice published in the FEDERAL REGISTER. Any revisions in the RVUs are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(b) *Revision of RVUs for established HCPCS level 1 and level 2 codes.* (1) HCFA publishes a proposed notice in the FEDERAL REGISTER to announce changes in RVUs for established codes and provides an opportunity for public comment no less often than every 5 years.

(2) After considering public comments, HCFA publishes a final notice in the FEDERAL REGISTER to announce revisions to RVUs.

(3) The RVU revisions are effective prospectively for services furnished beginning on the effective date specified in the final notice.

(c) *Values for local codes (HCPCS Level 3).* (1) Carriers establish relative values for local codes for services not included in HCPCS levels 1 or 2.

(2) Carriers must obtain prior approval from HCFA to establish local codes for services that meet the definition of "physician services" in § 414.2.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992]

§ 414.26 Determining the GAF.

HCFA establishes a GAF for each service in each fee schedule area.

(a) *Geographic indices.* HCFA uses the following indices to establish the GAF:

(1) An index that reflects one-fourth of the difference between the relative value of physicians' work effort in each of the different fee schedule areas as determined under § 414.22(a) and the national average of that work effort.

(2) An index that reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in each of the different fee schedule areas as determined under § 414.22(b) compared to the national average of those costs.

(3) An index that reflects the relative costs of malpractice expenses in each of the different fee schedule areas as