able to show that the statutory requirements are met and, specifically, that substantially all of the services of the members are furnished through the group. (We discuss in a later comment which physicians qualify as "members" of a group practice.) As we have mentioned previously in this preamble, it is not our intention to unnecessarily impede associations of physicians from qualifying as a group practice, and we recognize that groups that have parttime physicians may have a more difficult time qualifying than groups that have all full-time physicians.

We agree that the 85 percent criterion should be reduced to 75 percent, and we have made that change in the definition of group practice (§ 411.351). Before deciding to make this change, we considered the implications for group practices that have part-time and contractual physicians and the possibility of establishing separate standards for rural and urban locations and the changes that will be made by the OBRA '93 provision on January 1, 1995. (Beginning on January 1, 1995, members of the group must personally conduct no less than 75 percent of the physician-patient encounters of the group practice.) We accept the point of view that a standard higher than 75 percent would be difficult for many rural group practices to meet. That is because the scarcity of physicians in rural areas generally imposes varying responsibilities that cause these physicians to devote less time to a group practice than might be the case in other areas. In order to be consistent and to eliminate whatever administrative confusion might result from different standards for rural and urban areas, we are adopting the 75 percent standard for all areas.

Comment: One commenter indicated that group practices should be allowed to select the methodology for determining the 85 percent threshold; that is, 85 percent of total physician time, or 85 percent of total group income (calculated on the basis of allowed charges, etc.), or 85 percent of all physicians' services delivered whatever method they prefer to use and are able to document.

Another commenter recommended that the Medicare allowed charges or fee schedule amounts be used as the measurement criterion for the following reasons: (1) By using such a measure, the necessary data would be readily available to Medicare carriers in the Medicare databases; (2) these measures would not impose any new record keeping obligations on physicians and group practices; and (3) if alternative measures, such as time, patients, service, or total revenue were used, physicians and group practices would be subjected to additional burdensome record keeping requirements.

A third commenter suggested that the following conditions indicate that the criteria are met: All Medicare allowed charges or fee schedule amounts for the services furnished by all physician members of the group are furnished through the group, and billed in the name of or under a number or numbers assigned to the group practice, and the amounts received are treated as receipts of the group.

Finally, another commenter recommended that we consider (1) excluding from the formula any parttime physician who does not refer work to the laboratory for Medicare patients, and (2) revising the current 85 percent formula to provide that, so long as 85 percent of Medicare laboratory work is attributed to full-time physicians (a fulltime physician being a person who bills at least 85 percent of his or her services through the group), the group practice would then be able to meet the exception.

Response: As noted, we proposed that, to meet the "substantially all" criterion, a group practice would have to be able to show that at least 85 percent of the aggregate patient care services furnished by all physician members of the group practice are furnished through the group practice. In addition, as stated in section 1877(h)(4)(B), these services must be billed in the name of the group, and receipts for the services must be treated as receipts of the group. After carefully considering the language of the statute and these comments, we decided to adopt the following approach:

We are continuing to provide that to meet the "substantially all" criterion, in the aggregate, a specific percentage of patient care services furnished by all physician members must be furnished through the group practice. As we noted in an earlier response, we are changing the percentage from 85 percent to 75 percent. The comments have revealed that there is confusion about what constitutes "patient care services" and how to measure them. To remedy this, we are clarifying in the regulation that patient care services include any tasks performed by a group practice member that address the medical needs of specific patients, whether or not they involve direct patient encounters. As a result, patient care services can involve the work of pathologists and radiologists who do not directly treat patients or a physician's time spent consulting with another physician when the patient is

not present or time spent reviewing laboratory tests.

We are also clarifying that a practice must measure patient care services by calculating the total patient care time each member spends on patient care services. We believe that this method of measuring services is an equitable one that will capture most accurately a group practice member's commitment to providing services through the practice. For example, if a member furnishes only a few services through the practice during the course of a week, but these services are surgical procedures that consume most of the physician's time that week, this fact will be reflected in the calculations.

As to the first comment, we do not believe that leaving this matter entirely to the discretion of each group practice would be feasible. It is our goal to accomplish fairness and evenhandedness across group practices by establishing a consistent and uniform approach. Leaving the matter to the discretion of each group practice would also put an additional burden on the Medicare carriers. The carriers could very well be involved in audits of group practices in the future. If we adopted the commenter's suggestion, a carrier would, on the occasion of each audit, first have to determine whether a particular method employed by a group practice is appropriate before determining whether the standard is met. Thus, we are clarifying that, to meet the substantially all criteria, 75 percent of total patient care services (measured as patient care time) of group practice physicians must be provided through the group.

It is not clear to us how using a method employing Medicare allowed charges or physician fee schedule amounts would satisfy the statutory requirements. The carriers would have this information, as the commenter stated, but section 1877(h)(4) does not say that only substantially all of a group practice's Medicare business be considered. The reference is to "* * * substantially all the services of the physicians who are members * * *." Accordingly, we believe that all services, both Medicare and non-Medicare, must be considered.

Here is an example of how our uniform total patient care time approach would work:

Ten physicians deliver services through a group practice. Eight of them devote 100 per cent of their patient care time to the group practice. One devotes 80 percent, and one 10 percent. This can be illustrated as follows: