for the interpretation if the physician either personally performs the interpretation or reviews the resident's interpretation.

h. Services of Residents

We proposed to incorporate into the regulations longstanding Medicare coverage and payment policy regarding the circumstances under which the services of residents are payable as physician services. These policies are in operating instructions and other issuances.

Generally, the services of residents in approved GME programs furnished in hospitals and hospital-based providers are payable through the direct GME payment methodology in § 413.86. For hospital cost reporting periods beginning on or after July 1, 1985, a teaching hospital is entitled to include residents working in the hospital and hospital-based providers in the full-time equivalency count used to compute direct GME payments. These payments are based on per-resident amounts reflecting GME costs incurred during a base period and updated by the Consumer Price Index. Further, effective July 1, 1987, under the conditions set forth in § 413.86(f)(1)(iii), a teaching hospital may elect to enter into a written agreement with another entity for the purpose of including the time spent by residents in furnishing patient care services in a setting outside the hospital in the hospital's full-time equivalency count of residents for GME purposes. The agreement must specify that the hospital compensate the resident for the services in the nonhospital setting. When an agreement is in effect, the teaching setting guidelines of proposed §§ 415.170 through 415.184 would apply to services in which physicians involve residents in the nonhospital setting. The services of residents in these settings are payable as hospital services rather than physician services. We stated that proposed § 415.200 would replace current § 405.522.

Current § 405.523 addressed payment for the services of residents who are not in approved programs. The section was applicable to the services of a physician employed by a hospital who is authorized to practice only in a hospital setting and to residents in an unapproved program. We proposed to replace this rule with new § 415.202. The proposed rule incorporated the policy currently in section 404.1.B of the Provider Reimbursement Manual (HCFA Pub. 15–1), which provides that only the costs of the residents' services are allowable as Part B costs, and that other costs, such as teaching costs, of an unapproved program are not allowable.

Current § 405.524 (''Interns' and residents' services outside the hospital'') provided for reasonable cost payments for the services of residents in freestanding skilled nursing facilities and home health agencies. We proposed to rename this section to clarify that its scope is limited to these types of providers and to include it with only minor changes into a new § 415.204.

We proposed to establish a new § 415.206 to address payment issues relating to the services of residents in nonprovider settings, such as freestanding clinics that are not part of a hospital. Paragraph (a) addresses situations when a teaching hospital and another entity have entered into a written agreement under which the time the residents spend in patient care activities in these nonhospital settings is included in the hospital's full-time equivalency count used to compute direct GME payments. If an agreement is in force, the carrier would make payments for teaching physician and other physician services under the rules in §§ 415.170 through 415.190.

If a nonprovider entity, such as a freestanding family practice or multispecialty clinic, does not enter into this type of agreement for residency training with a teaching hospital, the payment mechanism in proposed § 415.206(b) would apply in the case of services furnished by certain residents. We modified the policy on Part B billings for services furnished by licensed residents in the late 1970's in an action designed to enhance the ability of primary care residency programs to finance their training activities outside the teaching hospital setting. We revised the Medicare Carriers Manual (HCFA Pub. 14–3) to cover residents' services furnished in a setting that is not part of a hospital as physician services if the resident was fully licensed to practice by the State in which the service was performed. This policy applies whether or not the residents are functioning within the scope of their approved GME program. Under these circumstances, the resident is functioning in the capacity of a physician, and the teaching physician guidelines do not apply.

Additionally, the services of residents practicing in freestanding federally qualified health centers and rural health clinics who meet the requirements of proposed § 415.206(b) would be eligible for payment under the payment methodology for federally qualified health centers. (We would make payments for residents' services in a hospital-based entity under the provisions of § 413.86 for direct GME payments.) We proposed to allow freestanding federally qualified health centers and rural health clinics to include the costs of a service performed by a resident meeting those requirements as an allowable cost on the entity's cost report. We proposed to amend § 405.2468(b)(1), which sets forth allowable costs for federally qualified health centers and rural health clinic services, to recognize these costs. Further, a resident is considered to be a physician as defined in revised § 405.2401(b) for the purpose of determining payments to the federally qualified health centers and rural health clinics. Consistent with the payment method for federally qualified health centers and rural health clinics, payments for services furnished by residents in federally qualified health centers and rural health clinics would be paid under § 405.2462 rather than under the physician fee schedule. In other words, services of the resident would be treated in exactly the same manner as services of other physicians who are not residents in the federally qualified health center or rural health clinic. We believe that recognizing the costs of these residents in federally qualified health centers and rural health clinic settings would create more uniformity in the way these costs are treated by the Medicare program.

We proposed to establish a new § 415.208 to address carrier payments for the services of ''moonlighting'' residents. Paragraph (a) defines these services as referring to services that licensed residents perform that are outside the scope of an approved GME program. Paragraph (b) reflects the policy set forth in section 2020.8.C. of the Medicare Carriers Manual under which carriers may pay under the physician fee schedule for the services of moonlighting residents in the outpatient department or emergency department of a hospital in which they have their training program if there is a contract between the resident and the hospital indicating that the following criteria are met:

- The services are identifiable physician services and meet the criteria in § 415.102(a) (formerly § 405.550(b)).
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the services are performed.
- The services can be separately identified from those services that are required as part of the approved GME program.

Paragraph (c) indicates that the moonlighting services of a resident furnished outside the scope of an approved GME program in a hospital or other setting that does not participate in