



Hospital and Physician Version

KEY CONCEPTS OUTLINE

Module 11: Physicians at Teaching Hospitals: Teaching Physician Issues

I. Teaching Physician Issues

A. Background

1. Prior to July 1, 1996, instructions for Part B billing for physician services involving residents were set forth in Medicare Intermediary Letter 372 (IL 372). The standards set out in IL-372 were widely criticized as being ambiguous. Without more specific guidance, Contractors were unable to provide uniform clarification to physicians and enforcement was minimal.
2. The “PATH Initiative”
 - a. During the period 1990-1995, the Department of Justice and the OIG-HHS began to audit Part B payments made to attending physicians in teaching settings. These audits examined attending physician physical presence, adequacy of documentation and CPT code assignment. Known as the “PATH Initiative” (“Physicians at Teaching Hospitals”), the federal Departments of Justice and Health and Human Services conducted large-scale audits of teaching hospitals and affiliated physician groups.
 - b. During these audits, the government found numerous situations in which the auditors felt that the documentation was insufficient, particularly documentation of attending physician participation in services billed to the Contractors. The government suggested that significant overpayments had been made and threatened teaching physicians and hospitals with large monetary penalties. The PATH Initiative became a significant point of controversy within the academic practice community, which complained that the requirements of IL-372 were ambiguous, that the instructions for compliance varied across Contractors nationwide and that the penalties were overly harsh.

3. In order to clarify the conditions for payment of physician services furnished in teaching settings, new regulations were adopted on July 1, 1996. The current regulations are set forth in 42 CFR Part 415.

B. General Payment Rule

1. Teaching physicians are required to participate in the services provided by a resident. Where a resident furnishes care to a patient in a teaching setting, payment for the teaching physician's services is only available in the following circumstances:
 - a. Personally furnished by a physician who is not a resident;
 - b. Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or
2. Certain E/M services furnished by a resident in certain primary care centers. *<Medicare Claims Processing Manual, Chapter 12, §100.1.1(C)>*

C. Teaching Physician Presence through Audio/Video Real-Time Communications Technology

1. General Rule

a. Rural Areas:

- (i) CMS finalized a permanent policy to permit teaching physicians to meet the requirements to bill for their services involving residents through virtual presence, but only for services furnished in residency training sites outside a metropolitan statistical area. *<42 CFR §415.172 (a)>*

b. All Other Areas

- (i) If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is
 - (a) CMS is exercising enforcement direction through December 31, 2025, allowing teaching physicians in all teaching settings to be present virtually when the resident provides Medicare telehealth services in all residency training locations through the end of CY 2025. *<MLN006347 November 2024, p.9>*

2. Evaluation and Management Services

- a. The teaching physician must be present during the portion of the E/M service that determines the level of service billed. *<42 CFR §415.172 (a)(2)>*

- (i) Exception: Primary Care Exception (to be discussed later in this outline)

3. Surgical, High-risk and Other Complex Procedures

- a. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
 - (i) The teaching physician presence is not required during the opening and closing of the surgical field. <42 CFR §415.172 (a)(1)(i)>
 - (ii) Endoscopic procedures require the teaching physician to be present during the entire viewing. <42 CFR §415.172 (a)(1)(ii)>

D. Teaching Physician Documentation Requirements <42 CFR §415.172 (2)(b)>

1. General Documentation Requirements

- a. The medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished.
- b. Physician Presence through audio/video real-time communications during the key portion of the service is applicable for residency training sites located outside of a metropolitan statistical area.
 - (i) For all teaching settings during the Public Health Emergency, the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished.
 - (ii) The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications technology.
- c. Documentation of the teaching physician's presence during procedures and evaluation can be demonstrated in the medical record/notes by the physician ; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team. <42 CFR §415.172 (b); 42 CFR 410.20(e)>

2. Billing Modifiers

- a. Services furnished by teaching physicians involving a resident meeting all requirements must be billed with an appropriate billing modifier.
 - (i) GC modifier - This service has been performed in part by a resident under the direction of a teaching physician
 - (ii) GE modifier - This service has been performed by a resident without the presence of a teaching physician under the primary care exception

3. Evaluation and Management Documentation Requirements

- a. Documentation of the teaching physician's presence during an evaluation and management service is still required; however, effective January 1, 2019, it is no longer required to be personally documented by the teaching physician.
 - (a) ... "extent of the teaching physician's participation [in an E/M service furnished by a resident in the outpatient department of a teaching hospital] may be demonstrated by the notes in the medical records made by a physician, resident, or nurse" <42 C.F.R. § 415.174(a)(6)>

E. Evaluation and Management Services

1. For E/M services, the attending physician must have been physically present during the parts of the encounter that determined the level of service billed. <42 CFR § 415.172(a)(2); *Medicare Claims Processing Manual*, Chapter 12 § 100.1.1>
 - a. If a resident admits a patient late at night, and the teaching physician doesn't see the patient until later (potentially even the next day), this can meet the requirements for billing if the teaching physician:
 - (i) Documents they personally saw the patient and participated in the management of their care. They can reference the history, exam, and medical decision making from the residents note if these areas have not changed and the teaching physician agreed with their content
 - (ii) Documents any changes in the patient's condition or care that have occurred since the initial visit by the resident
 - (iii) Bills the date of service reflecting the date the teaching physician saw the patient, not the date the resident saw the patient. < *Medicare Claims Processing Manual*, Chapter 12 § 100.1.1 (A)>

(iv) As of January 1, 2018, the Medicare Claims Processing Manual, Chapter 12 § 100.1.1 was revised regarding the teaching physician evaluation and management documentation requirements:

- (a) Teaching physicians are required to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.
- (b) Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making.
- (c) The teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed; but may verify any student documentation of them in the medical record, rather than re-documenting this work.

2. Primary Care Center Exception

- a. There is an exception for certain services provided in a “primary care center”. Under the primary care center exception, the presence of the teaching physician is not required for the provision of certain e/m services in a “primary care center”.
- b. For purposes of this exception, a “primary care center” is an outpatient department of a hospital or other ambulatory care entity for which resident time is counted in determining “Graduate Medical Education” (“GME”) payments to the hospital. <42 CFR § 415.174(a)(1); *Medicare Claims Processing Manual*, Chapter 12 § 100.1.1(C)>
- c. Allowable Services Provided by Residents in the Primary Care Center (outside of the PHE) <42 CFR § 415.174(a)(1); *Medicare Claims Processing Manual*, Chapter 12 § 100.1.1(C)>
 - (i) Those services that do not require the presence of the teaching physician are limited to the following:
 - (a) New Patient – CPT codes 99202 and 99203
 - (b) Established Patient – CPT codes 99211, 99212 and 99213
 - (c) Initial Preventive Physical Exam – CPT code G0402 <42 CFR § 415.174, *Medicare Claims Processing Manual*, Chapter 12 § 100.1.1(C)>; and

(d) Annual Wellness Visits – Initial visit G0438 and Subsequent Visit G0439
<Medicare Claims Processing Manual, Chapter 12 § 100.1.1(C)>

(ii) E/M services provided under the “primary care center” exception are reported with the -GE modifier.

(a) Note: For any service not listed above, the general teaching physician policy will apply.

d. The Guidance through COVID

(i) The March 31 COVID-19 Interim Final Rule with Comments (IFC), CMS allowed all levels of office/outpatient E/M visits to be furnished by the resident and billed by the teaching physician under the primary care exception.

(ii) The May 1st COVID-19 IFC, CMS further expanded the list of services included in the primary care exception during the PHE for COVID-19

(a) Which Policies Were Made Permanent?

1. For residency training sites that are located in rural areas (those areas outside of an OMB-defined metropolitan statistical area (MSA) CMS finalized a permanent policy to permit an expanded primary care exception.

2. CMS permanently expanded limited services under the primary care exception to include:

a. Communication-technology based services and interprofessional consults (CPT codes 99421-99423, and 99452, and HCPCS codes G2010 and G2012).

e. The following requirements must be met in order to take advantage of the Primary Care Center Exception: <Medicare Claims Processing Manual, Chapter 12 §100.1.1(C)>

(i) The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by the resident in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital’s FI/MAC. This requirement is not met when the resident is assigned to a physician’s office away from the center or makes home visits. In the case of a nonhospital entity, there must be verification of a written agreement between the hospital and the entity that meets the requirements of 42 CFR 413.78(e)(3)(ii).

- (ii) Any resident furnishing services without the presence of a teaching physician must have completed at least 6 months of an approved residency program,
 - (iii) The teaching physician must not be directing more than 4 residents at a time and immediately available to provide assistance.
 - (a) Residents with less than 6 months of residency may be included in the mix of four, but the teaching physician must be physically present for the key portion of the service. <Medicare Claims Processing Manual, Chapter 12 § 100.1.1(C)>
 - (iv) The teaching physician must:
 - (a) Have no other responsibilities at the time,
 - (b) Assume primary medical responsibility for beneficiaries seen by the resident,
 - (c) Ensure that all services furnished are reasonable and necessary,
 - (d) Review with the resident during or after each visit the medical history, examination, diagnosis, record of tests and therapies, and
 - (e) Document the extent of his/her participation in the services furnished to the beneficiary.
 - (v) The range of services furnished by residents in the primary care center must include all of the following:
 - (a) Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness,
 - (b) Coordination of care furnished by other physicians and providers, and
 - (c) Comprehensive care is not limited by organ system or diagnosis.
 - (vi) The patients must be an identifiable group of individuals who consider the center to be the continuing source of primary healthcare. The resident must be expected to generally provide care to the same group of established patients during their residency training. <42 CFR § 415.174, Medicare Claims Processing Manual, Chapter 12 § 100.1.1(C)>
- f. Teaching physician services billed in absence of the teaching physician's presence during the key portion of the service rendered in a primary care exception center must be identified by reporting modifier GE.

3. Evaluation and Management Level Selection

- a. Time – When time is used for level selection of the office/outpatient E/M visit, only the time spent by the teaching physician can be included for level selection.
 - (i) Qualifying activities, including the time the teaching physician was present with the resident, performing the activities.
- b. Primary Care Exception
 - (i) Time cannot be used for level selection. The E/M level must be based on medical decision making only.

F. Surgical, High Risk and other Complex Procedures

1. For surgical, high risk and other complex procedures, the teaching physician must be physically present during all “critical portions” of the procedure and be immediately available to furnish services during the entire service or procedure. <42 CFR § 415.172(a)(1); Medicare Claims Processing Manual, Chapter 12 § 100.1.2>
 - a. The “critical portion” of a procedure is not defined but is left to the judgment and experience of the teaching physician. <Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)>
2. For surgical services (including endoscopic operations), the following requirements must generally be met: <Medicare Claims Processing Manual, Chapter 12 § 100.1.2>
 - a. The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician’s presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence.
 - b. If the postoperative period extends beyond the patient’s discharge and the teaching surgeon is not providing the patient’s follow-up care, then the instructions on billing for less than the global package apply. (See Global Surgery chapter.)
 - c. During non-critical portions of the surgery if the teaching physician is not physically present, he/she must be immediately available to return to the procedure. If the teaching physician is nearby, but involved in a critical part of another procedure, the physician is not immediately available. If circumstances prevent a teaching physician from being immediately available, then he/she must

have made arrangements for another physician to provide supervision in order to bill for the procedure.

3. For specific types of surgeries, there may be additional requirements that must be met, as well, including the following:
 - a. For single surgeries, when the teaching surgeon is present for the entire surgery, his or her presence may be demonstrated by notes in the medical records made by the physician, resident or operating room nurse. There is no required information that the teaching surgeon must personally enter into the medical records. <42 CFR § 415.172(a)(1)(i); Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(1)>
 - b. For overlapping surgeries, the teaching physician must be present during the key portions of both surgeries. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. <Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(2)>
 - (i) In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not the anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.
 - c. For minor procedures (procedures that require five minutes or less) the teaching physician must be physically present during the entire procedure. <Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(3)>
 - d. For endoscopic procedures, the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement. <42 CFR § 415.172(a)(1)(ii); Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(5)>

G. Anesthesia Services

1. For anesthesia services furnished on or after January 1, 2010, a teaching anesthesiologist may receive reimbursement under the Medicare physician fee schedule at the regular fee level if he or she is involved in a single, or two concurrent

training procedures as described below: <42 CFR § 415.178(a); Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(4)>

- a. A resident in a single anesthesia case;
 - b. Two concurrent anesthesia cases involving residents; or
 - c. A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.
2. To qualify for payment in each of the circumstances noted above, the teaching anesthesiologist (or different anesthesiologists in the same anesthesia group) must: <42 CFR § 415.178(a); Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(4)>
 - a. Be physically present during all critical or key portions of the anesthesia service and
 - b. Be immediately available.
 - c. The teaching anesthesiologist must personally document his/her involvement in cases with residents.
3. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases. Qualified individuals include residents and CRNAs. <Medicare Claims Processing Manual, Chapter 12 § 50(C)>
 - a. Effective January 1, 2010, medical direction rules do not apply when the physician:
 - (i) Is involved in a single resident case that is performed concurrently with another case that is paid under medical direction; or
 - (ii) When the physician is involved in two concurrent cases performed by residents.
4. Certain modifiers must be reported for anesthesia services, as follows:
 - a. To indicate the service is personally performed by the anesthesiologist, the AA modifier (anesthesia services performed personally by anesthesiologist) should be reported. <Medicare Claims Processing Manual, Chapter 12 §§ 50(K), 100.1.2(A)(4)>>
 - (i) The GC modifier (these services have been performed by a resident under the direction of a teaching physician) is also reported on the claim when

appropriate. The GC modifier may not be reported by itself. <Medicare Claims Processing Manual, Chapter 12 § 50(K)>

- b. To indicate the medical direction of 2 to 4 qualified individuals, the anesthesiologist should report the medical direction QK modifier (medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals). <Medicare Claims Processing Manual, Chapter 12 § 50(K)>

- (a) Reimbursement for medically directed services is made at 50% of the physician fee schedule allowance. <Medicare Claims Processing Manual, Chapter 12 § 50(C)>

5. If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form. <Medicare Claims Processing Manual, Chapter 12 §§ 50(K), 100.1.2(A)(4)>

H. Psychiatric Services

1. For psychiatric services, the teaching physician may meet the physical presence requirements by concurrent observation of the service by use of a one-way mirror, live video or similar device. <42 CFR § 415.184; Medicare Claims Processing Manual, Chapter 12 § 100.1.3>
 - a. Audio only equipment does not meet the requirement.

I. Diagnostic Radiology and Other Diagnostic Tests

1. The interpretation must have been either performed by the teaching physician or reviewed by the teaching physician. <42 CFR § 415.180(a); Medicare Claims Processing Manual, Chapter 12 § 100.1.2 (A)(6)>>
2. If a resident prepares and signs the interpretation, the teaching physician must document that he or she personally reviewed the images¹ and interpretation with the resident, and he or she either “agrees with or edits the findings.” <42 CFR § 415.180(b); Medicare Claims Processing Manual, Chapter 12 § 100.1.2(A)(6)>

¹ Although not clear, presumably, CMS’s use of the term “images” would encompass pathology slides and the output from other diagnostic testing procedures (e.g., EKG strips).

J. Time-Based Codes

1. For procedures coded on the basis of time, the teaching physician must be present for the full period of time coded. Examples include:
 - a. Individual medical psychotherapy (CPT codes 90804 - 90829);
 - b. Critical care services (CPT codes 99291 - 99292);
 - c. Hospital discharge day management (CPT codes 99238 - 99239),
 - d. E/M services for which time is used for the visit level selection;
 - e. Prolonged services (CPT codes 99358 - 99359); and
 - f. Care plan oversight (HCPCS codes G0181 - G0182) <Medicare Claims Processing Manual, Chapter 12 § 100.1.4>

K. Other Complex or High Risk Procedures

1. In the case of procedures for which national Medicare policy, local policy, or CPT description indicates that the procedure requires the personal presence of the physician, coverage is provided only when the teaching physician is personally present for the entire procedure. <Medicare Claims Processing Manual, Chapter 12 § 100.1.5>
 - a. This includes interventional radiology and cardiology supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and trans-esophageal echocardiography.

L. Assistants-at-Surgery in Teaching Hospitals

1. Medicare generally does not cover assistants-at-surgery in teaching facilities with an approved GME program that: <42 CFR § 415.190(a); Medicare Claims Processing Manual, Chapter 12 §100 1.7>
 - a. Operate a training program related to the medical specialty required for the procedure, and
 - b. Have available a resident in the training program who can serve as an assistant-at-surgery.
2. Medicare will pay for an assistant-at-surgery in a hospital with an approved GME program, however, if a qualified resident was unavailable to perform the required

assistant-at-surgery services. <Medicare Claims Processing Manual, Chapter 12 § 100.1.7.A>

- a. In such cases, the assistant-at-surgery services are billed with modifier -82.

M. Moonlighting Residents

1. The term “services of moonlighting residents” refers to services performed by licensed residents outside the scope of their approved Graduate Medical Education (GME) program. <42 CFR § 415.208(a), Medicare Benefit Policy Manual Chapter 15 § 30.3.B>
2. For CY 2021 CMS finalized the permanent expansion of setting in which residents can moonlight to include the services of the resident that are not associated with their approved Graduate Medical Education (GME) programs and are furnished to inpatients of the hospital in which they have their training program

~~Services provided to inpatients of a hospital in which a resident’s GME program is located that are related to the GME program are not covered physician services payable under the physician fee schedule. Instead, these services are payable in the form of direct GME payments. <42 CFR §415.208 (b)(1)>~~

- a. For these services to be covered the following conditions must be met and documented in the medical record:
 - (i) The services are identifiable physician services and meet the conditions for payment of physician services to beneficiaries in providers in § 415.102(a).
 - (ii) (The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.
 - (iii) The services performed can be separately identified from those services that are required as part of the approved GME program. <CFR §415.208 (b)(i-iii)>
3. Services of residents that are not related to a resident’s approved GME program; but, are performed in the outpatient or emergency department of a hospital in which the GME program is located, are covered as physician services payable under the physician fee schedule if all of the following criteria are met: <42 CFR § 415.208(b)(2), Benefit Policy Manual, Chapter 15 §30.3. B >
 - (i) The services are identifiable physician services, and which contribute to the diagnosis or treatment of the patient’s condition.

- (ii) The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed, and
 - (iii) The services can be separately identified from those services that are required as part of the approved GME program.
- b. If all of the above criteria are met, the services of a moonlighting resident are considered to have been performed by the individual in his or her capacity as a physician, not in the capacity of a resident. In such cases, no payment is allowed for “teaching physicians” who may be involved in the resident’s services. <42 CFR § 415.208 (b)(4); Medicare Benefit Policy Manual, Chapter 15 §30.3. B>
- c. Moonlighting services of a licensed resident furnished outside the scope of the resident’s training in a hospital or other setting that does not have an approved GME program are separately payable under the Physician Fee Schedule. <42 CFR §§ 415.206(b)(1), 415.208(c); Medicare Benefit Policy Manual, Chapter 15 § 30.3.B>

Version 08/01/2019
Check for Updates



Guidelines for Teaching Physicians, Interns & Residents



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What's Changed?

- Teaching providers can submit IRIS data for the Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) reimbursement programs (pages 7, 8, and 9)
- Teaching physicians can use 2-way, interactive, audio-video telehealth when residents provide telehealth services, in all residency training locations through the end of CY 2025 (page 9)

Substantive content changes are in dark red.

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Teaching Settings: Physician Service Payments

Medicare pays for services in a teaching setting using the Medicare Physician Fee Schedule (PFS) when the services meet 1 of these criteria:

- Physicians, not residents, personally provide the service ([42 CFR 415.170\(a\)](#)).
- Residents provide the service when teaching physicians are physically present during critical or key service parts ([42 CFR 415.172\(a\)](#)). This includes telehealth services through 2-way, interactive, audio-video telehealth in residency training sites outside a metropolitan statistical area (MSA).
- Teaching physicians providing evaluation and management (E/M) services with a graduate medical education (GME) program granted a primary care exception may bill us for lower- and mid-level E/M services provided by residents ([42 CFR 415.174](#)).

Intern- or Resident-Approved Training Programs

We pay for medical and surgical services provided by interns and residents (I&Rs) training in their approved program through [direct graduate medical education](#) (DGME) and [indirect medical education](#) (IME) payments, or under certain conditions, the PFS.

DGME payments are our share of the direct cost of training I&Rs, including salaries and fringe benefits for faculty and residents. **IME** payments cover additional operating costs from treating patients, including the costs associated with using more intensive treatments and ordering more tests.

When I&Rs train in an approved program in a nonprovider setting, hospitals generally get DGME or IME payments (or both) if they meet these conditions:

- Interns or residents provide patient care in a nonprovider setting, and the hospital pays their salaries and fringe benefits (both DGME and IME payments)
- Interns or residents perform certain non-patient care activities in certain nonprovider settings, and hospitals pay their salaries and fringe benefits (only DGME payments)

If you can't count the time residents spend training in a nonprovider setting for DGME and IME payments, we generally pay under the PFS for all other medical and surgical services provided by residents. To get payment, the residents must be fully licensed in the state where they provide services.

Teaching Settings: Anesthesia Services

We use the PFS to pay teaching anesthesiologists when they involve 1 of these situations:

- Training a resident in a single anesthesia case
- Two concurrent anesthesia cases involving residents
- A single anesthesia case involving a resident concurrent to another case that meets payment conditions at the medically directed rate

For us to pay, you must meet all these conditions:

- The teaching anesthesiologist or an anesthesiologist in the same group is present during all critical or key anesthesia services or procedures
- The teaching anesthesiologist (or another anesthesiologist with whom they have an agreement) can provide anesthesia services immediately during the entire procedure

Document in the patient's medical record:

- The teaching anesthesiologist is present during all critical or key anesthesia procedure parts
- The immediate availability of another teaching anesthesiologist, as needed

Teaching Settings: Interpreting Diagnostic Radiology & Other Diagnostic Tests

We pay for the interpretation of diagnostic radiology or other diagnostic tests under the PFS when a physician other than a resident performs it.

We may also pay the PFS rate, only in residency training sites located outside an MSA, to a resident interpreting diagnostic radiology and other diagnostic tests when the teaching physician is present through audio-video telehealth. Medical records must show the physician took part in interpreting diagnostic radiology tests.



Teaching Settings: Psychiatric Services

We pay the PFS rate for psychiatric services, including documentation, under an approved GME program. During the service, the teaching physician can be present through a 1-way mirror, video equipment, or like devices.

In residency training sites outside an MSA, teaching physicians may be present through audio-video telehealth during the service when they involve residents. Medical records must show the teaching physician took part in the psychiatric services.

Intern or Resident Services Provided Outside an Approved Training Program

We consider medical and surgical intern and resident services that aren't related to their approved GME program and performed **outside the facility** where they have their GME program (also known as moonlighting) as covered physician services when they meet the **first 2** bulleted criteria below.

We also consider medical and surgical intern and resident services that aren't related to their approved GME program and performed **in an outpatient department or hospital emergency room** of the hospital where they have their GME program as covered physician services when they meet **all 3** bulleted criteria below:

- Physician services need a physician to personally help diagnose or treat
- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state where they perform the services, and services aren't performed as part of the approved GME program
- The licensed intern or resident services can be separately identified from those services required as part of the approved GME program

I&Rs provide physician services within their physician capacity, and not as I&Rs in approved GME programs.

We don't pay for teaching physician-associated moonlighting services, and we don't include the time spent providing these services in the teaching hospital's indirect GME payment full-time equivalency (FTE) count or the DGME payment.

Interns & Residents Duplicate FTEs Audit Reviews

Teaching physicians submit [IRIS](#) data for the DGME and IME reimbursement programs. You may claim only 1 FTE per resident. Many teaching physicians have rotations reported in their IRIS data that duplicate with another teaching physician. CMS is auditing these duplicates to correctly state DGME/IME FTEs reported in the affected IRIS submission and cost reports.

Interns & Residents Information System

The IRIS data includes detailed information about each I&R and the rotations used to accumulate the total FTEs reported on the filed cost reports. Submit IRIS data when you file your Medicare cost reports.

You can claim part of a resident's time spent in your facility. For example, 2 providers can claim 50% of a resident's time during the first week of a month without triggering an overlap. An overlap happens when the sum of the resident's DGME or IME utilization for the same period exceeds 100%.

Use the IRIS extensible markup language (XML) file format for cost reporting. See [IRIS-to-Cost Report Reconciliation](#) below for more information.

What to Expect from the Audit

Cost reports are subject to the I&R duplicate FTEs audit review. Myers and Stauffer LC, a CMS contractor, is the IRIS I&R duplicate review auditor.

If we find an I&R rotation overlap in your IRIS records, you'll get:

- An IRIS information request letter, and you must respond within 30 days with the information and documentation requested to support the I&R claimed time for all overlapping rotations
- A Notice of Reopening Letter for affected settled cost reports that are within the 3-year reopening period

During this review, Myers and Stauffer will work closely with your Medicare Administrative Contractors (MACs) to see if you resolved any of the overlaps during a previous desk review or audit adjustment. If resolved, the contractor will request work papers from the MACs to help resolve the overlaps.

For all IRIS rotation overlaps that the MACs didn't resolve, Myers and Stauffer will:

- Send you the IRIS overlap reports and request information to either verify or modify the affected rotations
- Review the MAC and provider supporting documentation to decide the final resolution
- Notify you of the proposed IRIS adjustments
- Allow you time for review of the proposed adjustments
- Resolve disputes with you and send the final adjustments with supporting papers to you and your MAC

Your MAC will include necessary adjustments in the Notice of Program Reimbursement or the Revised Notice of Program Reimbursement. If the cost report is settled and no adjustments are necessary, you'll get a Notice of Reopening Closure.

IRIS-to-Cost Report Reconciliation

For cost reporting periods:

- FTEs in the IRIS submission must match the FTEs on the cost report. Your MAC can reject cost reports for this period if the FTE totals don't match.
- The previous IRIS dBase database file (DBF) format is retired and replaced with an XML file format ([Indirect Medical Education and Direct Graduate Medical Education \(CMS-R-64\)](#)). XML is a more modern file structure that:
 - Allows for future extensibility
 - Maintains the core concepts of resident and assignment records
 - Captures several new fields

As part of this change, we'll post the technical specifications and documentation you need to create an IRIS XML file. You may also use IRIS vendor software listed below to prepare your IRIS submissions.

Continue to submit your IRIS files to your MAC with your cost report.

IRIS Fields

The XML format tracks the same information as the DBF format plus these items:

- Assignment IPF percentage (Psych)
- Assignment IRF percentage (Rehab)
- Assignment nonprovider site percentage
- Assignment displaced resident (True/False)
- Assignment new program (True/False)
- IME exceptions to new programs (IPPS/IPF/IRF)
- Resident non-IRP Year One Residency
- Creation software name

Most of these fields align with the [CMS-2552-10 cost report instructions](#) to support I&R FTE category distinctions. See the [IRIS XML General Instructions](#) for more information about the meaning and how to use these fields.

IRIS XML Vendors

You don't have to use software from a certified vendor to generate IRIS XML submissions. These software vendors have submitted sample files that meet the requirements of the updated format.

Table 1. IRIS XML Vendors

Software	Vendor	URL
MedHub	Ascend Learning	medhub.com
iRotations	Besler	besler.com
HFSSoft IRIS	Health Financial Systems	hfssoft.com
MyGME Fiscal Management	MyEvaluations.com	myevaluations.com/Services.aspx
New Innovations	New Innovations	New-innov.com

Email Myers and Stauffer at IRISDuplicates@mslc.com for questions about IRIS duplicate reviews.

Teaching Physicians: Billing Requirements

Teaching physicians must identify residents assisting in patient care and services on claims. Claims must follow [E/M documentation guidelines](#).

Claims must include the GC modifier on each service unless you provide the service under the primary care exception. You or another billing provider certify you meet these conditions. Teaching physicians must attest to their MAC that they meet the [E/M Services Primary Care Exception](#) section conditions.

Claims must include the GE modifier on each service provided under the primary care exception.

When total time decides the office or outpatient E/M visit level, include only teaching physician-presence time. We pay, under Medicare Part A, for the graduate medical training program separately, which includes the resident's time providing services with a teaching physician.

We continue to allow teaching physicians to use audio-video telehealth to be present in all teaching settings when the resident provides Medicare telehealth services in all residency training locations through the end of CY 2025.

Teaching Anesthesiologists: Billing Requirements

The teaching anesthesiologist who started the case and stayed with the resident during critical or key service and procedure parts (with different anesthesiologists present) must include their NPI on the claim.

Send teaching anesthesiologist claims using these modifiers:

- **AA:** Anesthesia services performed personally by an anesthesiologist
- **GC:** This service has been performed in part by a resident under the direction of a teaching physician

Time-Based Codes

For procedure codes based on time, the teaching physician must be present during that period indicated in the claim. For example, we may pay for a code specifically describing a 20–30-minute service only if the teaching physician is physically present for 20–30 minutes.

Don't add time the resident spends when the teaching physician isn't available to these:

- Time the resident and teaching physician spend with the patient
- Time the teaching physician spends alone with the patient

Time-based codes:

- Individual medical psychotherapy (CPT codes 90832–90838)
- Critical care services (CPT codes 99291–99292)
- Hospital discharge day management (CPT codes 99238–99239)
- Office or outpatient E/M visit codes when you use the total time to select the visit level

Note: When selecting the visit level, only count time the teaching physician spent performing qualifying activities listed by CPT (with or without direct patient contact on the encounter date), including the time the teaching physician is present when the resident performs those activities

- Prolonged services (CPT codes 99358–99359)
- Care plan oversight (HCPCS codes G0181–G0182)

[CPT Books](#) have more information.

Medical Records Guidelines

Physicians and residents may document their services in a patient's medical record. According to [42 CFR 415.172\(b\)](#), the teaching physician's presence during procedures and E/M services can be documented by other members of the medical team, but must be signed and dated by the physician. You must sign and date all documents with a legible signature or identity.

The medical record must demonstrate:

- The teaching physician was present when the service was provided (including telehealth services).
- The teaching physician was physically or virtually present (if present through audio-video telehealth) in residency training programs located outside an MSA. The specific part of the service that the teaching physician had a virtual presence must also be documented.

Document medical records in 1 of these ways:

- Dictated and transcribed
- Handwritten
- Typed
- Computer-generated

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You may use a documentation macro (a command in a computer or dictation application in an electronic medical record that automatically generates predetermined unedited user text) if you personally add it in a secured or password-protected system. Physicians or residents must provide enough patient-specific information to support a medical necessity determination.

In addition to the macro information, the note in the electronic medical record must describe the patient-specific services provided on that date. It's insufficient documentation if physicians and residents only use macros.

E/M Documentation Guidelines

For each encounter, use the CPT code definitions to select the E/M level service code and the documentation guidelines.

Teaching physicians billing E/M services may sign and date notes in the medical record made by other members of the medical team that demonstrate their presence and participation in the service.

The medical record must demonstrate:

- The teaching physician performed the service or was physically present during critical or key resident-provided service and procedure portions
- The teaching physician's participation in patient management

The combined medical record entries of the teaching physician and resident make up the documented service, and it must cover medical necessity. Residents can't justify medical necessity by documenting the teaching physician's presence during the service.

Students Providing E/M Documentation

Students participating in, and contributing to, a billable service must do it in the physician's or resident's physical presence and meet teaching physician billing conditions. E/M services include separately billable services, except systems review, and past family and social history.

Students may document services in the patients' medical records. Teaching physicians must verify all student medical record documentation or findings, including history, physical exam, and medical decision making (MDM).

Teaching physicians must personally perform (or re-perform) all billed physical exam and medical E/M decision-making services. They can verify student documentation in the medical record rather than re-documenting it.

E/M Services Primary Care Exception

We pay PFS rates when residents perform certain lower- and mid-level complexity E/M services and teaching physicians **aren't** present.

Under the primary care exception, in certain teaching hospital primary care centers, teaching physicians can bill certain services that residents provide independently without teaching physicians present, but the teaching physicians must review the care.

When you select time-based office or outpatient E/M visit levels, you may include only the time you spend performing qualifying activities, including your presence with the residents performing those activities. Under the primary care exception, you can't use time to select visit level. You may only use MDM to select the E/M visit level.

For dates of service on or after May 12, 2023, teaching physicians can no longer bill for office or outpatient E/M level 4–5 visits.

For residency training sites outside an MSA, you can bill some communication technology-based services and inter-professional consult services with the GE modifier. These services include:

- CPT codes 99421–99423 (codes for online digital evaluation and management) and 99452 (code for interprofessional referral service)
- HCPCS codes G2010 (code for the remote evaluation of patient video/images) and G2012 (code for virtual check-in)

Table 2. Primary Care Exception E/M Lower- & Mid-Level Services CPT Codes

New Patient	Established Patient
N/A	99211
99202	99212
99203	99213

Table 3. Primary Care Exception HCPCS Codes

HCPCS Code	Descriptor
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

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A primary care center must attest in writing that it meets residency program conditions.

To apply the [primary care exception](#), you must meet these conditions:

- You provide the services in a center that's located in a hospital outpatient department or another ambulatory care entity where the time spent by residents in patient care activities is included in determining a teaching hospital's direct DGME payments.

Note: This requirement isn't met when a resident provides physician services in an office away from the primary care center, or when they make home visits. The non-hospital entity must confirm with the MAC that it meets the conditions of a written agreement between the hospital and the entity.

- Residents must first complete more than 6 months of an approved residency program before providing billable patient care without a teaching physician's physical presence.
- You can't supervise more than 4 residents at a time, and you must be immediately available to:
 - Ensure your only responsibility is supervising residents when they perform services.
 - Have primary, patient-medical responsibility when residents see patients.
 - Ensure all care is reasonable and medically necessary.
 - Review resident care during, or immediately after, each visit. This includes a patient medical history and diagnosis review, physical exam findings, and treatment plan (for example, tests and therapies record).
 - Document the extent that you took part in patient services, direction, and review. You may also sign and date notes in the medical record made by other members of the medical team that demonstrate your participation.

The range of primary care center services residents provide includes:

- Acute care for the same problems or chronic care for ongoing conditions, including chronic mental illness
- Coordinating care with physicians and other provider types
- Comprehensive care not limited by organ system or diagnosis

The primary care center is considered the patient's primary location for health care services. Residents generally provide care to the same patient group during their residency training.

You may include residents who completed less than 6 months in an approved GME Residency Program in the 4 residents mix under your supervision. You must be physically present during critical or key service parts. When a resident needs to complete their 6 months in an approved GME Residency Program, the primary care exception doesn't apply.

Primary care exception centers don't need prior approval, but they must keep records showing their exception status.

The residency programs most likely to qualify for the primary care exception include:

- Family practice
- General internal medicine
- Geriatric medicine
- Pediatrics
- Obstetrics
- Gynecology

Certain psychiatric GME programs may qualify as a primary care exception in special situations (like when the program provides chronically mentally ill patients comprehensive care). The range of services residents learn about and deliver at primary care centers includes comprehensive medical and psychiatric care.



Resources

- [2021 Inpatient Prospective Payment System Rule](#)
- [Duplicate Graduate Medical Education Payments](#)
- [Evaluation & Management Visits](#)
- [IRIS XML Format and Duplicate Interns and Residents FTEs Review Presentation](#)
- [Section 30.2 of the Medicare Benefit Policy Manual, Chapter 15](#)
- [Section 100 of the Medicare Claims Processing Manual, Chapter 12](#)

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Title 42 — Public Health

Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B — Medicare Program

Part 415 — Services Furnished by Physicians in Providers, Supervising Physicians in Teaching Settings, and Residents in Certain Settings

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 60 FR 63178, Dec. 8, 1995, unless otherwise noted.

Subpart D Physician Services in Teaching Settings

§ 415.150 Scope.

§ 415.152 Definitions.

§ 415.160 Election of reasonable cost payment for direct medical and surgical services of physicians in teaching hospitals: General provisions.

§ 415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.

§ 415.164 Payment to a fund.

§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

§ 415.172 Physician fee schedule payment for services of teaching physicians.

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

§ 415.176 Renal dialysis services.

§ 415.178 Anesthesia services.

§ 415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.

§ 415.184 Psychiatric services.

§ 415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

Subpart D—Physician Services in Teaching Settings

§ 415.150 Scope.

This subpart sets forth the rules governing payment for the services of physicians in teaching settings and the criteria for determining whether the payments are made as one of the following:

- (a) Services to the hospital under the reasonable cost election in §§ 415.160 through 415.164.
- (b) Provider services through the direct GME payment mechanism in §§ 413.75 through 413.83 of this chapter.

- (c) Physician services to beneficiaries under the physician fee schedule as set forth in part 414 of this chapter.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 415.152 Definitions.

As used in this subpart—

Approved graduate medical education (GME) program means one of the following:

- (1) A residency program approved by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.
- (2) A program otherwise recognized as an “approved medical residency program” under § 413.75(b) of this chapter.

Direct medical and surgical services means services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the cost election described in §§ 415.160 through 415.162.

Nonprovider setting means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. These include, but are not limited to, family practice or multispecialty clinics and physician offices.

Resident means one of the following:

- (1) An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry.
- (2) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, for example, individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. For purposes of this subpart, the term *resident* is synonymous with the terms *intern* and *fellow*.

Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.

Teaching setting means any provider, hospital-based provider, or nonprovider settings in which Medicare payment for the services of residents is made under the direct GME payment provisions of §§ 413.75 through 413.83, or on a reasonable-cost basis under the provisions of § 409.26 or § 409.40(f) for resident services furnished in skilled nursing facilities or home health agencies, respectively.

[60 FR 63178, Dec. 8, 1995, as amended at 61 FR 59554, Nov. 22, 1996; 63 FR 26359, May 12, 1998; 70 FR 47490, Aug. 12, 2005; 74 FR 44001, Aug. 27, 2009; 75 FR 50418, Aug. 16, 2010]

§ 415.160 Election of reasonable cost payment for direct medical and surgical services of

physicians in teaching hospitals: General provisions.

- (a) **Scope.** A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services.
- (b) **Conditions.** A teaching hospital may elect to receive these payments only if—
 - (1) The hospital notifies its intermediary in writing of the election and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;
 - (2) All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or
 - (3) All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.
- (c) **Effect of election.** If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—
 - (1) Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and
 - (2) The intermediary pays the hospital for those services on a reasonable cost basis under the rules in § 415.162. (Payment for other physician compensation costs related to approved GME programs is made as described in § 413.78 of this chapter.)
- (d) **Election declined.** If the teaching hospital does not make this election, payment is made—
 - (1) For physician services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and
 - (2) For the supervision of interns and residents as described in §§ 413.75 through 413.83.

[60 FR 63178, Dec. 8, 1995, as amended at 70 FR 47490, Aug. 12, 2005]

§ 415.162 Determining payment for physician services furnished to beneficiaries in teaching hospitals.

- (a) **General rule.** Payments for direct medical and surgical services of physicians furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries is made by Medicare on the basis of reasonable cost if the hospital exercises the election as provided for in § 415.160. If this election is made, the following occurs:
 - (1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries are paid on a reasonable-cost basis, as provided for in paragraph (b) of this section.
 - (2) Payment for certain medical school costs may be made as provided for in paragraph (c) of this section.
 - (3) Payments for services donated by volunteer physicians to beneficiaries are made to a fund designated by the organized medical staff of the teaching hospital or medical school as provided for in paragraph (d) of this section.
- (b) **Reasonable cost of physician services and supervision of interns and residents.**

- (1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis.
- (2) For purposes of this paragraph, *reasonable cost* is defined as the direct salary paid to these physicians, plus applicable fringe benefits.
- (3) The costs must be allocated to the services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section.
- (4) Other allowable costs incurred by the provider related to the services described in this paragraph are payable subject to the requirements applicable to all other provider services.

(c) ***Reasonable costs for the services furnished by a medical school or related organization in a hospital.*** An amount is payable to the hospital by CMS under the Medicare program provided that the costs would be payable if incurred directly by the hospital rather than under the arrangement. The amount must not be in excess of the reasonable costs (as defined in paragraphs (c)(1) and (c)(2) of this section) incurred by a teaching hospital for services furnished by a medical school or organization as described in § 413.17 of this chapter for certain costs to the medical school (or a related organization) in furnishing services in the hospital.

(1) ***Reasonable costs of physician services —***

(i) ***When the medical school and the hospital are related organizations.*** If the medical school (or organization related to the medical school) and the hospital are related by common ownership or control as described in § 413.17 of this chapter—

- (A) The costs of these services are allowable costs to the hospital under the provisions of § 413.17 of this chapter; and
- (B) The reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital.

(ii) ***When the medical school and the hospital are not related organizations.***

- (A) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school for the costs of those services furnished to all patients, payment is made by Medicare to the hospital for the reasonable cost incurred by the hospital for its payments to the medical school for services furnished to beneficiaries.
- (B) Costs incurred under an arrangement must be allocated to the full range of services furnished to the hospital by the medical school physicians on the same basis as provided for under paragraph (j) of this section, and costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided for under paragraph (g) of this section.
- (C) If the medical school and the hospital are not related organizations under the provisions of § 413.17 of this chapter and the hospital makes payment to the medical school only for the costs of those services furnished to beneficiaries, costs of the medical school not to exceed 105 percent of the sum of physician direct salaries, applicable fringe benefits,

employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation paid by the medical school or an organization related to the medical school may be recognized as allowable costs of the medical school.

(D) These allowable medical school costs must be allocated to the full range of services furnished by the physicians of the medical school or organization related as provided by paragraph (j) of this section.

(E) Costs allocated to direct medical and surgical services furnished to hospital patients must be apportioned to beneficiaries as provided by paragraph (g) of this section.

(2) **Reasonable costs of other than direct medical and surgical services.** These costs are determined in accordance with paragraph (c)(1) of this section except that—

(i) If the hospital makes payment to the medical school for other than direct medical and surgical services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries, these payments are subject to the required cost-finding and apportionment methods applicable to the cost of other hospital services (except for direct medical and surgical services furnished to beneficiaries); or

(ii) If the hospital makes payment to the medical school only for these services furnished to beneficiaries, the cost of these services is not subject to cost-finding and apportionment as otherwise provided by this subpart, and the reasonable cost paid by Medicare must be determined on the basis of the health insurance ratio(s) used in the apportionment of all other provider costs (excluding physician direct medical and surgical services furnished to beneficiaries) applied to the allowable medical school costs incurred by the medical school for the services furnished to all patients of the hospital.

(d) ***"Salary equivalent" payments for direct medical and surgical services furnished by physicians on the voluntary staff of the hospital.***

(1) CMS makes payments under the Medicare program to a fund as defined in § 415.164 for direct medical and surgical services furnished to beneficiaries on a regularly scheduled basis by physicians on the unpaid voluntary medical staff of the hospital (or medical school under arrangement with the hospital).

(i) These payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a payable basis.

(ii) Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time, salaried physicians (other than interns and residents) on the hospital staff or, if the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area.

(iii) This "salary equivalent" is a single hourly rate covering all physicians regardless of specialty and is applied to the actual regularly scheduled time contributed by the physicians in furnishing direct medical and surgical services to beneficiaries including supervision of interns and residents in that care.

- (iv) A physician who receives any compensation from the hospital or a medical school related to the hospital by common ownership or control (within the meaning of § 413.17 of this chapter) for direct medical and surgical services furnished to any patient in the hospital is not considered an unpaid voluntary physician for purposes of this paragraph.
 - (v) If, however, a physician receives compensation from the hospital or related medical school or organization only for services that are other than direct medical and surgical services, a salary equivalent payment for the physician's regularly scheduled direct medical and surgical services to beneficiaries in the hospital may be imputed. However, the sum of the imputed value for volunteer services and the physician's actual compensation from the hospital and the related medical school (or organization) may not exceed the amount that would have been imputed if all of the physician's hospital and medical school services (compensated and volunteer) had been volunteer services, or paid at the rate of \$30,000 per year, whichever is less.
- (2) The following examples illustrate how the allowable imputed value for volunteer services is determined. In each example, it has been assumed that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician's compensated services.

Example No. 1. Dr. Jones received \$3,000 a year from Hospital X for services other than direct medical services to all patients, for example, utilization review and administrative services. Dr. Jones also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to \$10,000 for the cost reporting period. The full imputed value of Dr. Jones' volunteer direct medical services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$3,000) does not exceed \$30,000.

Example No. 2. Dr. Smith received \$25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily furnished direct medical services to beneficiaries. The imputed value of the volunteer services amounted to \$10,000. Only \$5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value (\$10,000) and the compensated services (\$25,000) exceeds the \$30,000 maximum amount allowable for all of Dr. Smith's services.

Computation:

Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation	\$30,000
Less compensation received from Hospital X for other than direct medical services to individual patients	\$25,000
Allowable amount of imputed value for the volunteer services furnished by Dr. Smith	\$5,000

Example No. 3. Dr. Brown is not compensated by Hospital X for any services furnished in the hospital. Dr. Brown voluntarily furnished direct surgical services to beneficiaries for a period of 6 months, and the imputed value of these services amounted to \$20,000. The allowable

amount of the imputed value for volunteer services furnished by Dr. Brown would be limited to \$15,000 ($\$30,000 \times 6/12$).

- (3) The amount of the imputed value for volunteer services applicable to beneficiaries and payable to a fund is determined in accordance with the aggregate per diem method described in paragraph (g) of this section.
- (4) Medicare payments to a fund must be used by the fund solely for improvement of care of hospital patients or for educational or charitable purposes (which may include but are not limited to medical and other scientific research).
 - (i) No personal financial gain, either direct or indirect, from benefits of the fund may inure to any of the hospital staff physicians, medical school faculty, or physicians for whom Medicare imputes costs for purposes of payment into the fund.
 - (ii) Expenses met from contributions made to the hospital from a fund are not included as a reimbursable cost when expended by the hospital, and depreciation expense is not allowed with respect to equipment or facilities donated to the hospital by a fund or purchased by the hospital from monies in a fund.

(e) **Requirements for payment –**

- (1) **Physicians on the hospital staff.** The requirements under which the costs of physician direct medical and surgical services (including supervision of interns and residents) to beneficiaries are the same as those applicable to the cost of all other covered provider services except that the costs of these services are separately determined as provided by this section and are not subject to cost-finding as described in § 413.24 of this chapter.
- (2) **Physicians on the medical school faculty.** Payment is made to a hospital for the costs of services of physicians on the medical school faculty, provided that if the medical school is not related to the hospital (within the meaning of § 413.17 of this chapter, concerning cost to related organizations), the hospital does not make payment to the medical school for services furnished to all patients and the following requirements are met: If the hospital makes payment to the medical school for services furnished to all patients, these requirements do not apply. (See paragraph (c)(1)(ii) of this section.)
 - (i) There is a written agreement between the hospital and the medical school or organization, specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay to the medical school an amount at least equal to the reasonable cost (as defined in paragraph (c) of this section) of furnishing the services to beneficiaries.
 - (ii) The costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were furnished is due to CMS.
 - (iii) Payment for the services furnished under an arrangement would have been made to the hospital had the services been furnished directly by the hospital.
- (3) **Physicians on the voluntary staff of the hospital (or medical school under arrangement with the hospital).** If the conditions for payment to a fund outlined in § 415.164 are met, payments are made on a “salary equivalent” basis (as defined in paragraph (d) of this section) to a fund.

- (f) **Requirements for payment for medical school faculty services other than physician direct medical and surgical services.** If the requirements for payment for physician direct medical and surgical services furnished to beneficiaries in a teaching hospital described in paragraph (e) of this section are met, payment is made to a hospital for the costs of medical school faculty services other than physician direct medical and surgical services furnished in a teaching hospital.
- (g) **Aggregate per diem methods of apportionment –**
- (1) **For the costs of physician direct medical and surgical services.** The cost of physician direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined on the basis of an average cost per diem as defined in paragraph (h)(1) of this section for physician direct medical and surgical services to all patients (see §§ 415.172 through 415.184) for each of the following categories of physicians:
- (i) Physicians on the hospital staff.
- (ii) Physicians on the medical school faculty.
- (2) **For the imputed value of physician volunteer direct medical and surgical services.** The imputed value of physician direct medical and surgical services furnished to beneficiaries in a teaching hospital is determined on the basis of an average per diem, as defined in paragraph (h)(1) of this section, for physician direct medical and surgical services to all patients except that the average per diem is derived from the imputed value of the physician volunteer direct medical and surgical services furnished to all patients.
- (h) **Definitions.**
- (1) **Average cost per diem for physician direct medical and surgical services (including supervision of interns and residents) furnished in a teaching hospital to patients in each category of physician services described in paragraph (g)(1) of this section** means the amount computed by dividing total reasonable costs of these services in each category by the sum of—
- (i) Inpatient days (as defined in paragraph (h)(2) of this section); and
- (ii) Outpatient visit days (as defined in paragraph (h)(3) of this section).
- (2) **Inpatient days** are determined by counting the day of admission as 3.5 days and each day after a patient's day of admission, except the day of discharge, as 1 day.
- (3) **Outpatient visit days** are determined by counting only one visit day for each calendar day that a patient visits an outpatient department or multiple outpatient departments.
- (i) **Application.**
- (1) The following illustrates how apportionment based on the aggregate per diem method for costs of physician direct medical and surgical services furnished in a teaching hospital to patients is determined.

Teaching Hospital Y

STATISTICAL AND FINANCIAL DATA:

Total inpatient days as defined in paragraph (h)(2) of this section and outpatient visit days as	75,000
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defined in paragraph (h)(3) of this section	
Total inpatient Part A days	20,000
Total inpatient Part B days where Part A coverage is not available	1,000
Total outpatient Part B visit days	5,000
Total cost of direct medical and surgical services furnished to all patients by physicians on the hospital staff as determined in accordance with paragraph (i) of this section	\$1,500,000
Total cost of direct medical and surgical services furnished to all patients by physicians on the medical school faculty as determined in accordance with paragraph (i) of this section	\$1,650,000

Computation of cost applicable to program for physicians on the hospital staff:

Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff: $\$1,500,000 \div 75,000 = \20 per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $\$20$ per diem \times 20,000	\$400,000
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $\$20$ per diem \times 1,000	\$20,000
Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $\$20$ per diem \times 5,000	\$100,000

Computation of cost applicable to program for physicians on the medical school faculty:

Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty: $\$1,650,000 \div 75,000 = \22 per diem.

Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $\$22$ per diem \times 20,000	\$440,000
Cost of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $\$22$ per diem \times 1,000	\$22,000
Cost of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $\$22$ per diem \times 5,000	\$110,000

(2) The following illustrates how the imputed value of physician volunteer direct medical and surgical services furnished in a teaching hospital to beneficiaries is determined.

Example: The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in furnishing direct medical and surgical services to patients of the hospital during a cost reporting period and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician volunteer services did not exceed the rate of \$30,000 per year per physician.

Statistical and financial data:

Total salaries paid to the full-time salaried physicians by the hospital (excluding interns and residents)	\$800,000
Total physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks × 40 hours per week) hours per year	20
Average hourly rate equivalent: $\$800,000 \div 41,600$ (2,080 × 20)	\$19.23

Computation of total imputed value of physician volunteer services applicable to all patients:

(Total donated hours × average hourly rate equivalent): $5,000 \times \$19.23$	\$96,150
Total inpatient days (as defined in paragraph (h)(2) of this section) and outpatient visit days (as defined in paragraph (h)(3) of this section)	75,000
Total inpatient Part A days	20,000
Total inpatient Part B days if Part A coverage is not available	1,000
Total outpatient Part B visit days	5,000

Computation of imputed value of physician volunteer direct medical and surgical services furnished to Medicare beneficiaries:

Average per diem for physician direct medical and surgical services to all patients: $\$96,150 \div 75,000 = \1.28 per diem

Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part A: $\$1.28$ per diem × 20,000	\$25,600
Imputed value of physician direct medical and surgical services furnished to inpatient beneficiaries covered under Part B: $\$1.28$ per diem × 1,000	\$1,280
Imputed value of physician direct medical and surgical services furnished to outpatient beneficiaries covered under Part B: $\$1.28$ per diem × 5,000	\$6,400
Total	\$33,280

(j) *Allocation of compensation paid to physicians in a teaching hospital.*

- (1) In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. (However, see paragraph (d) of this section for the computation of the "salary equivalent" payments for volunteer services furnished to patients.)
- (2) This allocation must be made and must be capable of substantiation on the basis of the proportion of each physician's time spent in furnishing each type of service to the hospital or medical school.

§ 415.164 Payment to a fund.

- (a) **General rules.** Payment for certain voluntary services by physicians in teaching hospitals (as these services are described in § 415.160) is made on a salary equivalent basis (as described in § 415.162(d)) subject to the conditions and limitations contained in parts 405 and 413 of this chapter and this part 415,

to a single fund (as defined in paragraph (b) of this section) designated by the organized medical staff of the hospital (or, if the services are furnished in the hospital by the faculty of a medical school, to a fund as may be designated by the faculty), if the following conditions are met:

- (1) The hospital (or medical school furnishing the services under arrangement with the hospital) incurs no actual cost in furnishing the services.
 - (2) The hospital has an agreement with CMS under part 489 of this chapter.
 - (3) The intermediary, or CMS as appropriate, has received written assurances that—
 - (i) The payment is used solely for the improvement of care of hospital patients or for educational or charitable purposes; and
 - (ii) Neither the individuals who are furnished the services nor any other persons are charged for the services (and if charged, provision is made for the return of any monies incorrectly collected).
- (b) **Definition of a fund.** For purposes of paragraph (a) of this section, a *fund* is an organization that meets either of the following requirements:
- (1) The organization has and retains exemption, as a governmental entity or under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation.
 - (2) The organization is an organization of physicians who, under the terms of their employment by an entity that meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income that the physician organization derives from the physician services.
- (c) **Status of a fund.** A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under Medicare except that it does not enter into an agreement with CMS under part 489 of this chapter.

§ 415.170 Conditions for payment on a fee schedule basis for physician services in a teaching setting.

Services meeting the conditions for payment in § 415.102(a) furnished in teaching settings are payable under the physician fee schedule if—

- (a) The services are personally furnished by a physician who is not a resident; or
- (b) The services are furnished by a resident in the presence of a teaching physician except as provided in § 415.172 (concerning physician fee schedule payment for services of teaching physicians), § 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), § 415.176 (concerning renal dialysis services), and § 415.184 (concerning psychiatric services), as applicable.

§ 415.172 Physician fee schedule payment for services of teaching physicians.

- (a) **General rule.** If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought. In residency training sites that are located outside a metropolitan statistical area, physician fee schedule payment may also be made if a teaching physician is present during the key portion of the service, including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought. For all teaching

settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made if a teaching physician is present during the key portion of the service including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought.

- (1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
 - (i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.
 - (ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.
- (2) In the case of evaluation and management services, except as otherwise provided in this paragraph (a)(2), the teaching physician must be present in person during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)
 - (i) In residency training sites that are located outside of a metropolitan statistical area, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)
 - (ii) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)
- (b) **Documentation.** Except as otherwise provided in this paragraph (b), except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), §§ 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document that the teaching physician was present at the time the service (including a Medicare telehealth service) is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.
 - (1) In residency training sites that are located outside of a metropolitan statistical area only, except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished. The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications

technology. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

- (2) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished. The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications technology. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

- (c) **Payment level.** In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

[60 FR 63178, Dec. 8, 1995, as amended at 83 FR 60091, Nov. 23, 2018; 84 FR 63201, Nov. 15, 2019; 85 FR 19288, Apr. 6, 2020; 85 FR 27623, May 8, 2020; 85 FR 85036, Dec. 28, 2020]

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

- (a) In the case of certain evaluation and management codes of lower and mid-level complexity (as specified by CMS in program instructions), carriers may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met:
 - (1) The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§ 413.75 through 413.83.
 - (2) Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.
 - (3) The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must—
 - (i) Have no other responsibilities at the time;
 - (ii) Assume management responsibility for those beneficiaries seen by the residents;
 - (iii) Ensure that the services furnished are appropriate; and
 - (iv) Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies.
 - (4) The range of services furnished by residents in the center includes all of the following:
 - (i) Acute care for undifferentiated problems or chronic care for ongoing conditions.

- (ii) Coordination of care furnished by other physicians and providers.
- (iii) Comprehensive care not limited by organ system, or diagnosis.
- (5) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.
- (6) The medical records must document the extent of the teaching physician's participation in the review and direction of services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter to each beneficiary in accordance with the documentation requirements at § 415.172(b).
- (b) Nothing in paragraph (a) of this section may be construed as providing a basis for the coverage of services not determined to be covered under Medicare, such as routine physical check-ups.
- (c) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, the requirements in paragraph (a)(3) of this section for a teaching physician to direct the care and then to review the services furnished by each resident during or immediately after each visit may be met through audio/video real-time communications technology.
- (d) In residency training sites that are located outside of a metropolitan statistical area only, the requirements in paragraph (a)(3) of this section for a teaching physician to direct the care and then to review the services furnished by each resident during or immediately after each visit may be met through audio/video real-time communications technology.

[60 FR 63178, Dec. 8, 1995, as amended at 61 FR 59554, Nov. 22, 1996; 70 FR 47490, Aug. 12, 2005; 83 FR 60092, Nov. 23, 2018; 84 FR 63202, Nov. 15, 2019; 85 FR 19288, Apr. 6, 2020; 85 FR 27624, May 8, 2020; 85 FR 85037, Dec. 28, 2020]

§ 415.176 Renal dialysis services.

In the case of renal dialysis services, physicians who are not paid under the physician monthly capitation payment method (as described in § 414.314 of this chapter) must meet the requirements of §§ 415.170 and 415.172 (concerning physician fee schedule payment for services of teaching physicians).

§ 415.178 Anesthesia services.

- (a) **General rule.**
 - (1) *For services furnished prior to January 1, 2010*, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.
 - (2) *For services furnished on or after January 1, 2010*, payment made under § 414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure

involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

- (b) **Documentation.** Documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

[74 FR 62014, Nov. 25, 2009]

§ 415.180 Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests.

- (a) **General rule.** Physician fee schedule payment is made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident.
 - (1) In residency training sites that are located outside of a metropolitan statistical area only, physician fee schedule payment may also be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology test.
 - (2) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, physician fee schedule payment may also be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology or diagnostic test.

- (b) [Reserved]

[85 FR 85037, Dec. 28, 2020]

§ 415.184 Psychiatric services.

- (a) Physician fee schedule payment is made for psychiatric services furnished under an approved GME program if the requirements of §§ 415.170 and 415.172 are met, including documentation, except that the requirement for the presence of the teaching physician during the service in which a resident is involved may be met by observation of the service by use of a one-way mirror, video equipment, or similar device.
- (b) In residency training sites that are located outside of a metropolitan statistical area, the requirement for the presence of the teaching physician during the service in which a resident is involved may be met through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the service.
- (c) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, the requirement for the presence of the teaching physician during the service in which a resident is involved may also be met through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the service.

[85 FR 85037, Dec. 28, 2020]

§ 415.190 Conditions of payment: Assistants at surgery in teaching hospitals.

- (a) ***Basis, purpose, and scope.*** This section describes the conditions under which Medicare pays on a fee schedule basis for the services of an assistant at surgery in a teaching hospital. This section is based on section 1842(b)(7)(D)(I) of the Act and applies only to hospitals with an approved GME residency program. Except as specified in paragraph (c) of this section, fee schedule payment is not available for assistants at surgery in hospitals with—
- (1) A training program relating to the medical specialty required for the surgical procedure; and
 - (2) A resident in a training program relating to the specialty required for the surgery available to serve as an assistant at surgery.
- (b) ***Definition. Assistant at surgery*** means a physician who actively assists the physician in charge of a case in performing a surgical procedure.
- (c) ***Conditions for payment for assistants at surgery.*** Payment on a fee schedule basis is made for the services of an assistant at surgery in a teaching hospital only if the services meet one of the following conditions:
- (1) Are required as a result of exceptional medical circumstances.
 - (2) Are complex medical procedures performed by a team of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician.
 - (3) Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.
 - (4) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon does not use interns and residents in the surgical procedures that the surgeon performs (including preoperative and postoperative care).
 - (5) Are not related to a surgical procedure for which CMS determines that assistants are used less than 5 percent of the time.

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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Physically Present - The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.



100.1 - Payment for Physician Services in Teaching Settings Under the MPFS

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

Pursuant to 42 CFR 415.170, services furnished in teaching settings are paid under the physician fee schedule if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or
- Certain E/M services furnished by a resident under the conditions contained in §100.01.C.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the A/B MAC (A).

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)



A. General Documentation Requirements

Evaluation and Management (E/M) Services -- For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) book and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

B. E/M Service Documentation Provided By Students

Any contribution and participation of students to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in

the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.



C. Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. Effective January 1, 2022, teaching physicians may use only medical decision making (MDM) for purposes of E/M visit level selection when billing the Medicare program under the physician fee schedule for office/outpatient E/M visits under this primary care exception. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: HCPCS code G0402 (Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment).

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).

Set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in

patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's A/B MAC (A). This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the A/B MAC (A) that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program.

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the residents;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the residents during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and,
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

The patient medical record must document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

100.1.2 - Surgical Procedures

(Rev. 2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence. If the postoperative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §40 apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he/she must be immediately available to return to the procedure, i.e., he/she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

1. Single Surgery

When the teaching surgeon is present for the entire surgery, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

2. Two Overlapping Surgeries

In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

3. Minor Procedures



For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

4. Anesthesia



Medicare pays at the regular fee schedule level if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he/she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist and the service is furnished prior to January 1, 2010, Medicare pays for the anesthesiologist's services as medical direction.

In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident. The teaching anesthesiologist can bill base units if he/she is present with the resident throughout pre and post anesthesia care. The teaching anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For anesthesia services furnished on or after January 1, 2010, payment may be made under the Medicare physician fee schedule at the regular fee schedule level if the teaching anesthesiologist is involved in the training of a resident in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. To

qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary.

If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form.

The teaching anesthesiologist should use the "AA" modifier and the "GC" certification modifier to report such cases. See §50 B. and §0 K.

5. Endoscopy Procedures

To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection A, above), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

6. Interpretation of Diagnostic Radiology and Other Diagnostic Tests

Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician. If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he/she is indicating that he/she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

100.1.3 - Psychiatry

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

The general teaching physician policy set forth in §100.1 applies to psychiatric services. For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy to the physical presence requirement. In the case of time-based services such as individual medical psychotherapy, see §100.1.4, below. Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

100.1.4 - Time-Based Codes

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90804 - 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);

E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;

- Office/outpatient E/M visit codes for which total time is used for the visit level selection. For purposes of selecting visit level, only count time spent by the teaching physician performing qualifying activities listed by CPT (with or without direct patient contact on the date of the encounter), including the time the teaching physician is present when the resident is performing such activities;
- Prolonged services (CPT codes 99358-99359); and
- Care plan oversight (HCPCS codes G0181 - G0182).

100.1.5 - Other Complex or High-Risk Procedures

(Rev. 1, 10-01-03)



In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and trans-esophageal echocardiography.

100.1.6 - Miscellaneous

(Rev. 1458, Issued: 02-22-08, Effective: 03-24-08, Implementation: 03-24-08)

In the case of maternity services furnished to women who are eligible for Medicare, apply the physician presence requirement for both types of delivery as A/B MACs (B) would for surgery. In order to bill for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, delivery, and postpartum) and for deliveries only. In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

In the case of end stage renal related visits furnished under the monthly capitation payment method (MCP), the physician presence policy as discussed in §100.1 applies. Patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visit. The teaching physician may utilize the resident's notes, however the teaching physician must document his or her physical presence during the visit(s) furnished by the resident and that he or she reviewed the resident's notes. The teaching physician could document these criteria as part of an extensive once a month MCP note.

100.1.7 - Assistants at Surgery in Teaching Hospitals

(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)

A. General

A/B MACs (B) do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of one of subsections C, D, or E are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed.

Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which A/B MACs (B) can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. A/B MACs (B) process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

I understand that §1842(b)(7)(D) of the Act (follow the link and select the applicable title) generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).

A/B MACs (B) retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, A/B MACs (B) investigate situations in which it is always certified that there are no qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied based on these instructions do not qualify for payment under the limitation on liability provision.

B. Definition

An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery). The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

C. Exceptional Circumstances

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §20.4.3 notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (e.g., emergency, life-threatening situations such as multiple traumatic injuries) which require immediate treatment. There may be other situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

D. Physicians Who Do Not Involve Residents in Patient Care

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the limitations in §20.4.3, above, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a nonteaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection E is met.

E. Multiple Physician Specialties Involved in Surgery

Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §20.4.3 is not applied. If payment is made on the basis of a single team fee, additional claims are denied. The A/B MAC (B) will determine which procedures performed in the service area require a team approach to surgery. Team surgery is paid for on a “By Report” basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient’s treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient’s cardiac condition may require a cardiologist be present to monitor the patient’s condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

100.1.8 - Physician Billing in the Teaching Setting

(Rev. 2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)



A. A/B MAC (B) Claims

The method by which services performed in a teaching setting must be billed is determined by the manner in which reimbursement is made for such services. For A/B MACs (B), the shared system suspends claims submitted by a teaching physician, for review.



B. Billing Modifiers

Effective January 1, 1997, services furnished by teaching physicians involving a resident in the care of their patients must be identified as such on the claim. To be payable, claims for services furnished by teaching physicians involving a resident must comply with the requirements in sections 100.1 through 100.1.6 of this chapter, as applicable. Claims for services meeting these requirements must show either the GC or GE modifier as appropriate and described below.



1. Teaching Physician Services that Meet the Requirement for Presence During the Key/Critical Portion of the Service

Claims for teaching physician services in compliance with the requirements outlined in sections 100.1 -100.1.6 of this chapter must include a GC modifier for each service, unless the service is furnished under the primary care center exception described in section 100.1.1C (refer to number 2, below). When a physician (or other appropriate

billing provider) places the GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in sections 100.1 through 100.1.6.



2. Teaching Physician Services Under the Exception for E/M Services Furnished in Primary Care Centers

Teaching physicians who meet the requirements in section 100.1.1C of this chapter must provide their A/B MAC (B) with an attestation that they meet the requirements. Claims for services furnished by teaching physicians under the primary care center exception must include the GE modifier on the claim for each service furnished under the primary care center exception.

100.2 - Interns and Residents

(Rev. 1, 10-01-03)

B3-2020.8, B3-8030



An attending physician's services to beneficiaries in a teaching setting are covered under the supplementary medical insurance program. Many physicians rendering such services are on the faculty of a medical school or have arrangements with providers to supervise and teach interns and residents. Payment may be made for professional services to a beneficiary by an "attending" physician where the attending physician provides personal identifiable direction to interns or residents who are participating in the care of this patient.

See the Medicare Benefit Policy Manual, Chapter 15, for services furnished by interns and residents within and outside the scope of an approved training program.

110 - Physician Assistant (PA) Services Payment Methodology

(Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

See chapter 15, section 190 of the Medicare Benefit Policy Manual, pub. 100-02, for coverage policy for physician assistant (PA) services.

Physician assistant services are paid at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. There is a separate payment policy for paying for PA assistant-at-surgery services. See section 110.2 of this chapter.

110.1 - Global Surgical Payments

(Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

When a PA furnishes services to a patient during a global surgical period, A/B MACs (B) shall determine the level of PA involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims. PA services furnished during a global surgical period shall be paid at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare