

National Coverage Provision

Subject:

Supervising Physicians in Teaching Settings

Subject Number:

PHYS-024

HCPCS/CPT:

N/A

Modifiers:

GC	This service has been performed in part by a resident under the direction of a teaching physician.
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception.
82	Assistant Surgeon (when qualified resident surgeon not available)

Indications and Limitation of Coverage

I. Supervising Physicians in Teaching Settings

A. Definitions - For purposes of this section, the following definitions apply:

1. Resident means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
2. A student means an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or resident. **Medicare does not pay for any service furnished by a student.**
3. Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.
4. Direct medical and surgical services mean services to individual patients 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 reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary for the hospital.
5. Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

6. Teaching setting means any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding Skilled Nursing Facility (SNF) or Home Health Agency (HHA) in which such payments are made on a reasonable cost basis.
7. Critical or key portion means that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
8. Documentation means notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in specific situations regarding the service furnished. Documentation may be dictated and typed, hand-written or computer generated, and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.
 - a. 42 CFR 415.172(b) - Documentation. 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 the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.
9. Physically present means that 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.

B. Payment for Teaching Physicians

1. Pursuant to 42 CFR 415.170, payment is made for physician services provided in teaching settings using the physician fee schedule only if:
 - a. Services are personally furnished by a physician who is not a resident;
 - b. A teaching physician provides care under the conditions contained in Section C; or
 - c. A teaching physician provides care under the conditions contained in Section C.3, Exception for E/M Services Furnished in Certain Primary Care Centers, which follows.
2. In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.

C. General Documentation Instructions and Common Scenarios

1. 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 (AMA) Current Procedural Terminology (CPT) and any applicable documentation guidelines.
 - a. For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:
 - i. That they performed the service or were physically present during key or critical portions of the service when performed by the resident; and
 - ii. The participation of the teaching physician in the management of the patient.
 - b. When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.
 - c. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.
 - d. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.
 - e. Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- In the absence of a note by the resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.
- Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of service billed by the teaching physician.

Scenario 3

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

- f. *Following are examples of minimally acceptable documentation for each of these scenarios:*

Scenario 1

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(NOTE: In this scenario if there are not resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2

Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

- g. *Following are examples of unacceptable documentation:*
- i. *"Agree with above." followed by legible countersignature or identity;*
 - ii. *"Rounded, Reviewed, Agree." followed by legible countersignature or identity;*
 - iii. *"Discussed with resident. Agree." followed by legible countersignature or identity;*
 - iv. *"Seen and agree." followed by legible countersignature or identity;*
 - v. *"Patient seen and evaluated", followed by legible countersignature or identity; and*
 - vi. *A legible countersignature or identity alone.*

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

2. *E/M Service Documentation Provided By Students*

- a. *Any contribution and participation of a student 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.*
- b. *Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.*

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

- a. *Teaching physicians providing E/M services with a GME program granted in a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:*

<u><i>New Patient</i></u>	<u><i>Established Patient</i></u>
99201	99211
99202	99212
99203	99213
G0344	

- b. *Effective January 1, 2005, the following code is included under the primary care exception: G0344 – Initial preventive physical examination; face-to-face visit*

services limited to a new beneficiary during the first 6 months of Medicare enrollment.

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in section B (Payment for Teaching Physicians) 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.

- c. 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 fiscal intermediary. 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 fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in *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 six (6) months of a GME approved residency program. Centers must maintain information under the provisions at *42 CFR 413.79(a)(6).*

- d. 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. The teaching physician must:
 - i. Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;*
 - ii. Have the primary medical responsibility for patients cared for by residents;*
 - iii. Ensure that the care provided was reasonable and necessary;*
 - iv. Review the care provided by the resident 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*
 - v. Document the extent of his/her own participation in the review and direction of the services furnished to each patient.**
- e. 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 the residency training. The types of services furnished by residents under this exception include:
 - i. Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;*
 - ii. Coordination of care furnished by other physicians and providers; and*
 - iii. Comprehensive care not limited by organ system or diagnosis.**

- f. *Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.*
 - g. *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.*
4. Procedures - *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 post-operative 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 post-operative visits are considered key or critical and require his or her presence. If the post-operative 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 MCM §4824.B apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure, i.e., he or 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.*
 - i. 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.*
 - ii. 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 or 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.

iii. *Minor Procedures - For procedures that take only a few minutes (5 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.*

b. *Anesthesia - The unreduced fee schedule payment will be made if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or post-operative visits with the beneficiary is not sufficient to receive Medicare payment.*

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.

If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist, payment will be made for the anesthesiologist's services as medical direction. (Payment at the Medically Directed Rate is described in AN-001, Anesthesia Services NCP.)

c. *Endoscopy Procedures - To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection a), 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.*

5. *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 or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or 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.

6. Psychiatry - The general teaching physician policy set forth in section B 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 through the 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 subsection 7 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.

7. Time-Based Codes - 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, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is 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:

- 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 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;
- e. Prolonged services (CPT codes 99358-99359), and
- f. Care plan oversight (HCPCS codes G0181-G0182).

8. Other Complex or High Risk Procedures - 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, payment will be made 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 transesophageal echocardiography.

9. Miscellaneous

- a. In the case of maternity services furnished to Medicare eligible women, the physician presence requirement will be applied for both types of delivery as you would for surgery. In order to bill Medicare 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, 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.

- b. The physician presence policy will not be applied to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.*

D. Election of Costs for Service of Physicians in Teaching Hospital

- 1. 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 for such services. A teaching hospital may make this election to receive cost payment only when all physicians who render covered Medicare services in the hospital agree in writing not to bill charges for such services or when all the physicians are employees of the hospital and, as a condition of employment, they are precluded from billing for such services. When this election is made, Medicare payments are made exclusively by the hospital's intermediary, and fee schedule payment is precluded.*
- 2. When the cost election is made for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except when the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, when each physician agrees in writing to abide by all the rules and regulations of the medical staff of the hospital (or of the fund that is qualified to receive payment for the imputed cost of donated physician's services), such an agreement suffices if required as a condition of staff privileges and the rules and regulations of the hospital, medical staff, or fund clearly preclude physician billing for the services for which costs benefits are payable. The intermediary must advise the carrier when a hospital elects cost payment for physicians' direct medical and surgical services and supply the carrier with a list of all physicians who provide services in the facility. It must be ensured that billings received from these physicians or hospitals are denied.*
- 3. Carriers will ask the intermediaries in their service area for listings of teaching hospitals that have elected cost payment and for listings of physicians whose services are payable to hospitals on a cost basis. The carrier system will be flagged to deny claims for physicians services furnished in listed hospitals and will reject claims for the services of listed physicians when hospitals are not identified on the claim form. For rejected claims, the hospitals will be determined where the physicians provided the services, denying those performed in listed hospitals, and paying those performed in hospitals that have not elected to receive cost payment. (For more information about the teaching hospital cost election, see §2148 of the Provider Reimbursement Manual, Part 1.)*

E. Services of Assistants at Surgery Furnished in Teaching Hospitals

- 1. General - Payment will not be made 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 subsections E.3, E.4, or E.5 are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed. Those affected by these instructions will be contacted to learn the circumstances in individual teaching hospitals.*

There may be some teaching hospitals in which a presumption can be applied 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. Assistant at surgery claims furnished in teaching hospitals will be processed 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 section 1842(b)(7)(D) of the Social Security Act 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 Medicare carrier."

The claim and certification will be retained for four years and post-payment reviews will be conducted as necessary. For example, situations will be investigated in which it is certified that there are never any qualified residents available, and recovery will be undertaken if warranted.

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the waiver of liability provision.

2. *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.*
3. *Exceptional Circumstances - Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, 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 your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery, even though a qualified resident is available.*
4. *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 special limitation in §15044, 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 may be made unless either of the criteria of subsection 5 is met.*

5. 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 a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, additional claims will be denied. It will be determined which procedures performed in this 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 the 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.

- F. Billing for Teaching Physician Services - Teaching Physicians who involve residents in providing care to their patients and seek payment for their physician services must comply with the policy governing teaching physicians contained in Section I, Supervising Physicians in Teaching Settings (§15016 of the Medicare Carriers Manual). Effective January 1, 1997, services rendered by the Teaching Physicians involving a resident in the care of their patients must be identified when submitting the claim on Form CMS-1500.

1. Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service.

- a. *In Item 24d of Form CMS-1500, the "GC" modifier must be entered by the physician for Teaching Physician Services rendered in compliance with all the requirements outlined in Section I, Supervising Physicians in Teaching Settings (§15016 of the Medicare Carriers Manual).*
- b. *Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service, and were immediately available during the other parts of the service.*

2. Teaching Physician Services Under the Exception to the Requirement for Presence During the Key Portion of the Service.

- a. *Certain Teaching Physicians are allowed an exception to the above policy. The exception is for the requirement that the Teaching Physician be present during the key portion of the service. Teaching Physicians who meet the requirements in Section I, Supervising Physicians in Teaching Settings (§15016) outlined for the exception to this policy must provide their local carrier with an attestation that they meet the requirements.*
- b. *Teaching Physician services being billed under the exception to the policy governing presence during the key portion of the service must be identified when submitting the Part B bill for Physician services.*
- c. *In Item 24d of Form CMS-1500, enter the "GE" modifier for all Teaching Physicians.*

Covered Diagnosis Codes, ICD-9:

N/A

Coding Guidelines:**A. General**

1. List the appropriate CPT-4 procedure code for the services performed, including any necessary modifiers and appropriate quantities in the days/units field. Modifiers direct prompt and correct payment of the claims submitted.
2. Report the patient's diagnosis or condition with an ICD-9 code. The ICD-9 code should be coded to the highest level of specificity, listing the primary condition in the first position in Item 21 on Form CMS-1500 or the electronic equivalent.
3. Services submitted without an ICD-9 diagnosis code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.
4. It is understood that any diagnosis information submitted must have (in the patient record) medical justification for the procedure. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under Section 1862(a)(1)(A).

B. Teaching Physician Services

1. Services that meet the requirement for presence during the key portion of the service.
 - a. List the modifier "-GC" in Item 24d of Form CMS-1500.
2. Claims submitted under the Exception for E/M Services Furnished in Certain Primary Care Centers.
 - a. List the modifier "-GE" in Item 24d of Form CMS-1500.

C. Services of Assistant at Surgery Furnished in Teaching Hospital

1. List the modifier "-82" in Item 24d of Form CMS-1500 for the services of an assistant surgeon. This certification is for use only when the basis for payment is the unavailability of qualified residents.

D. Anesthesia in Teaching Setting

1. List modifiers "-AAGC", if the physician is billing for the medical direction of one (1) resident and is in the room throughout the case.
2. List modifiers "-QKGC", if the physician is billing for medical direction of any combination of residents and CRNAS.

Documentation:

Records must be made available to the Carrier upon request. The patient's medical record should be legible, contain the relevant medical history and physical findings conforming to the medical criteria stated above.

Reasons for Denial:

Claim submission without appropriate diagnosis and not meeting all criteria listed in "Indications and Limitations of Coverage" section above.

Sources of Information:

42 CFR 415.170, 42 CFR 415.172, MCM 15016, MCM-3-REV-1780 [November 22,2002], MCM 4113.
*CP-REV-811, CR 3928.

History:

This NCP replaces former Wisconsin policies PHYS-024, Supervising Physician in Teaching Settings and AN-022, Anesthesiology Services in a Teaching Facility and GSURG-026, Assistants at Surgery in Teaching Hospitals. Archived policy may be requested from Freedom of Information (FOI).

Dates and Revision History:

Wisconsin, Illinois, Michigan and Minnesota

Effective Date: 05/01/2003, Anesthesia revision 1/1/2004, G0344 revision 1/1/2005, *CFR revision 08/01/2006

Date Published: 05/01/2003, Article 02/01/2006, *Article 08/01/2006

Revision Date & #: *08/01/2006, two, added 42 CFR 413.78(e)(3)(ii), 42 CFR 413.79(a)(6).
02/01/2006, one, Added G0344 and anesthesiologist involved in two concurrent anesthesia cases.

Italicized text is wording of the Centers for Medicare and Medicaid Services (CMS). This text is published from CMS documentation and is subject to the CMS implementation date.

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