



## Guidelines for Teaching Physicians, Interns, & Residents



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## What's Changed?

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- Added basic information about telehealth services flexibilities after the COVID-19 public health emergency (PHE) ended (page 4)
- Added information about teaching physicians in residency training sites located outside a metropolitan statistical area (MSA) and care they provide through audio-video real-time communications technology after the PHE (pages 7, 9, & 11)

Substantive content changes are in dark red.

## 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 real-time technology 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](#))

During the COVID-19 public health emergency (PHE), we used emergency waiver and other regulatory authorities so you could provide more services to your patients via [telehealth](#). Section 4113 of the [Consolidated Appropriations Act, 2023](#), extended many of these flexibilities through December 31, 2024, and made some of them permanent.

## Intern- or Resident-Approved Training Programs

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

When interns and residents 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 Medicare PFS for all other medical and surgical services provided by residents in a nonprovider setting. 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
- 2 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 real-time technology. 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 via a 1-way mirror, video equipment, or like devices.

In residency training sites outside an MSA, teaching physicians may be present through audio-video real-time technology 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 (Moonlighting)

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 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

Interns and residents provide physician services within their physician capacity, and not as interns and residents 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 direct GME payment.

## 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 met these conditions.
  - Teaching physicians must attest to their Medicare Administrative Contractor (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.
  - For dates of service before May 12, 2023 (during the COVID-19 PHE), you were able to include the teaching physician's time when they were present through audio-video real-time technology in the total visit level selection time.

- For dates of service on or after May 12, 2023, only teaching physicians in residency training sites located outside an MSA may direct, manage, and review care provided by residents through audio-video real-time communications technology.

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.

## 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 90804–90829)
- 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
  - 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.

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## Medical Records Guidelines

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Physicians and residents may document their services in a patient's medical record. You must sign and date all documents with a legible signature or identity. You may document medical records in 1 of these ways:

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

In residency programs located outside an MSA only, you must document the patient's medical record with the teaching physician's physical or virtual presence (if present through audio-video real-time technology), including telehealth services. Medical records must note the specific service part performed during the physician's presence, through audio-video real-time technology.

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.

Besides 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

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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 must personally document:

- You performed the service or were physically present during critical or key resident-provided service and procedure portions
- You participate in patient management

Your combined medical record entries (you and the 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’ll 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.
- Starting January 1, 2022, 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 before May 12, 2023 (during the COVID-19 PHE), residents at primary care centers could provide patients an expanded set of services, including E/M office or outpatient visit levels 4–5, phone E/M, care management, and some communication technology-based services. Teaching physicians could send these resident service claims, in the absence of a teaching physician, using the GE modifier. **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 and 99452
  - HCPCS codes G2010 and G2012

Table 1. Primary Care Exception E/M Lower- & Mid-Level Services CPT Codes

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

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**Table 2. 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

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.
  - 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 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.
- 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.

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

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 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.

For visits in all teaching settings with dates of service before May 12, 2023 (during the COVID-19 PHE), teaching physicians could direct care and review services each resident provided during, or immediately after, each visit through audio-video real-time technology. **For dates of service on or after May 12, 2023, only teaching physicians in residency training sites located outside an MSA may meet the presence for the key portion requirement through audio-video real-time communications technology.**

## Resources

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- [Evaluation & Management Visits](#)
- [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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