



Teaching Physicians, Interns, & Residents Guidelines



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Table of Contents

What's Changed?	3
Teaching Settings: Physician Service Payments	4
Medical Records Guidelines.....	7
Evaluation & Management Documentation Guidelines	8
Evaluation & Management Services Primary Care Exception	9
Resources	11

What's Changed?

- Updated teaching settings to include any telehealth service or procedure through audio/video real-time technology (page 4)
- Added content about interpreting diagnostic radiology and tests if a physician other than a resident does the interpretation or review (page 5)
- In residency training sites outside a Metropolitan Statistical Area (MSA), teaching physicians, as required, may use audio/video real-time technology when the resident does services (page 5)
- Added content about psychiatric services under an approved Graduate Medical Education (GME) Program, including documentation (page 5)
- Medicare Part A pays graduate medical training programs separately when total time determines office or outpatient Evaluation and Management (E/M) visit level, which includes the resident's time providing services with a teaching physician present (page 6)
- When total time decides the office or outpatient E/M visit level, only include teaching physician-presence time (page 6)
- After providing the service, you must document the medical record with the teaching physician's physical or virtual presence, including telehealth services, only in residency training sites outside an MSA (page 8)
- Starting January 1, 2022, teaching physicians may use only Medical Decision Making (MDM) when selecting E/M visit level for time-based office and or outpatient E/M visits under the primary care exception (page 9)
- During the PHE, we expanded the residents' services list (page 9)
- After the PHE, we'll no longer include levels 4–5 office or outpatient E/M visits in the primary care exception (page 9)
- For all teaching settings during the PHE, teaching physicians may direct care and review services each resident provides during or at once after each visit through audio/video real-time technology (page 11)

You'll find substantive content updates in dark red font.

Teaching Settings: Physician Service Payments

Medicare pays 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](#))
- Residents provide the service when teaching physicians are physically present during critical or key service parts ([42 CFR 415.172](#))
 - This includes telehealth services through 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 Medicare for lower and mid-level E/M services provided by residents ([42 CFR 415.174](#))

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

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 are training in an approved program in a nonprovider setting, hospitals generally get DGME and IME payments if these conditions are met:

- Hospitals get DGME and IME payments if interns or residents provide patient care activities in a nonprovider setting and the hospital pays their salaries and fringe benefits
- Hospitals get DGME payments if interns or residents spend time doing certain non-patient care activities in certain nonprovider settings and hospitals pay their salaries and fringe benefits

If the time residents spend training in a nonprovider setting can't be counted for DGME and IME payments, we generally pay under the Medicare PFS for the medical and surgical services provided by residents who are fully licensed in the state where the services are furnished.

Teaching Settings: Anesthesia Services

We use the PFS to pay teaching anesthesiologists when involved in 1 of these situations:

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



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

- Teaching anesthesiologist or anesthesiologist(s) in the same group is present during all critical or key anesthesia parts or procedures
- Teaching anesthesiologist (or another anesthesiologist with whom they have an agreement) is able to provide anesthesia services at once during the entire procedure

Document in the patient medical record:

- Teaching anesthesiologist's presence during all critical or key anesthesia procedure parts
- Immediate availability of another teaching anesthesiologist as needed

Teaching Settings: Interpreting Diagnostic Radiology & Other Diagnostic Tests

We pay for interpretation of diagnostic radiology or other diagnostic tests under the PFS, when done by a physician other than a resident.

We may also pay the PFS rate, **only** in residency training sites 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 psychiatric services the PFS rate under an approved GME Program, including documentation; during the service, the teaching physician's presence can be met by using a 1-way mirror, video equipment, or like device(s).

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 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 needing a physician to personally help diagnosing or treating
- Fully licensed intern or resident to practice medicine, osteopathy, dentistry, or podiatry by the state where they do services, and services aren't done as part of the approved GME Program
- 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 teaching physician-associated moonlighting services, and 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 aiding in patient care and services on claims. Claims must follow [Evaluation and Management \(E/M\) 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) they meet the [Evaluation & Management 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, only include teaching physician-presence time. We pay the graduate medical training program separately, which includes the resident's time providing services with a teaching physician, under Medicare Part A. During the PHE, you may include the teaching physician's time when they're present through audio/video real-time technology in the total visit level selection time.**

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 done personally by anesthesiologist
- **GC:** This service has been done in part by a resident under the direction of a teaching physician

Time-Based Codes

When you make the claim, we require the teaching physician's presence during time-based procedure codes. For example, we may pay a code specifically describing a 20–30 minute service only if the teaching physician is physically present 20–30 minutes.

Don't add time the resident spends when the teaching physician wasn't available to time the resident and teaching physician spends with the patient, or 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 and 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 doing qualifying activities listed by CPT (with or without direct patient contact on the encounter date), including the teaching time present when the resident does 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. 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

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After providing the service, you must document the medical record with the teaching physician's physical or virtual presence (if present through audio/video real-time technology), including telehealth services, **only** in residency training sites outside an MSA. Medical records must note the specific service part done 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 if physicians and residents only use macros documentation.

Evaluation & Management 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 must personally document:

- You did the service or were physically present during critical or key resident-provided service and procedure portions
- You take part in patient management

Your joint medical record entries (you and the resident) make up the documented service and it must cover medical necessity. Residents may not justify medical necessity by documenting the teaching physician's presence during the service.

Students Providing Evaluation & Management Documentation

- Students taking part 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 or past family and social history.
- Students may document services in the patient medical records. Teaching physicians must verify all student medical record documentation or findings, including history, physical exam, and medical decision-making.
- Teaching physicians must personally do (or re-do) all billed physical exam and medical E/M decision-making services. They can verify any student documentation in the medical record rather than re-documenting it.

Evaluation & Management Services Primary Care Exception

- We'll pay PFS rates when residents do certain 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 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 and or outpatient E/M visit levels, you may include only the time you spend doing qualifying activities, including your presence with the residents doing those activities. Under the primary care exception, you can't use time to select visit level. You may only use Medical Decision Making (MDM) to select the E/M visit level.
- During the COVID-19 PHE, we expanded the residents' services list. Residents at primary care centers may 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. These expanded CPT code service sets include 99204–99205, 99214–99215, 99495–99496, 99421–99423, 99452, 99441–99443 and HCPCS codes G2010 and G2012. Teaching physicians may send these resident services claims in the absence of a teaching physician using the GE modifier.
- After the PHE ends, you can't include levels 4–5 office or outpatient E/M visits in the primary care exception.

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

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Table 2. HCPCS Primary Care Exception 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 it meets particular residency program conditions. To apply the exception, you must meet these conditions:

- We include the resident patient services in a hospital outpatient department or another ambulatory primary care center entity in deciding a teaching hospital's DGME payments.
- When residents provide physician services in an office away from the primary care center or when they make home visits, the primary care center exception doesn't apply. The non-hospital entity must have the MAC confirm it meets the written agreement conditions 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 at once must be available to:
 - Make sure your only responsibility is supervising residents when they do services.
 - Have primary, patient-medical responsibility when residents see patients.
 - Make sure all care is reasonable and medically necessary.
 - Review resident care during or at once 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 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 approval before, but they must keep records showing their exception status.

The range of primary care center services residents provide includes:

- Same acute care or chronic conditions' ongoing care problems, including chronic mental illness
- Coordinating care with physicians and other provider-types
- Comprehensive care not limited by organ system or diagnosis

Residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, obstetrics, and or 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 include comprehensive medical and psychiatric care.

For all teaching settings during the PHE, teaching physicians may direct care and review services each resident provides during or at once after each visit through audio/video real-time technology.

Resources

- [Evaluation & Management Visits](#)
- [Section 30.2 of Medicare Benefit Policy Manual, Chapter 15](#)
- [Section 100 of Medicare Claims Processing Manual, Chapter 12](#)

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