

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 811

Department of Health &
Human Services (DHHS)

Centers for Medicare &
Medicaid Services (CMS)

Date: JANUARY 13, 2006

Change Request 3928

SUBJECT: Teaching Physician Services

I. SUMMARY OF CHANGES: Incorporating material from Transmittal 1780, dated November 22, 2002, which was inadvertently omitted from the Medicare Claims Processing Manual, Pub.100-04. Also, adding documentation requirements for electronic medical records under §100A; adding code G0344 to the primary care exception list under §100.1.1C, per the Final Rule of November 15, 2004; and updating anesthesia policy under §100.1.2A per the Final Rule of November 7, 2003.

NEW/REVISED MATERIAL:

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: February 13, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – Only One Per Row.

R/N/D	Chapter / Section / SubSection / Title
R	12/100/Teaching Physician Services
R	12/100.1/Payment for Physician Services in Teaching Settings Under the MPFS
R	12/100.1.1/Evaluation and Management (E/M) Services
R	12/100.1.2/Surgical Procedures
R	12/100.1.3/Psychiatry
R	12/100.1.4/Time-Based Codes
R	12/100.1.6/Miscellaneous
R	12/100.1.7/Assistants at Surgery in Teaching Hospitals

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 811	Date: January 13, 2006	Change Request 3928
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SUBJECT: Teaching Physician Services

I. GENERAL INFORMATION

A. Background: Transmittal 1780, dated November 22, 2002, revised the policy on supervising physicians in teaching settings. This transmittal incorporates material from Transmittal 1780 which was inadvertently omitted from the Medicare Claims Processing Manual. This transmittal also adds documentation requirements for electronic medical records under §100A; updates anesthesia policy under §100.1.2A per the Final Rule of November 7, 2003; and adds code G0344 to the primary care exception list under §100.1.1C, per the Final Rule of November 15, 2004.

B. Policy: 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.

Teaching physicians providing evaluation and management (E/M) services with a graduate medical education (GME) program granted a primary care exception may bill for lower and mid-level E/M services provided by residents for a specific list of E/M codes. This transmittal adds code G0344 to the primary care exception list under §100.1.1C, effective January 1, 2005.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3928.1	Effective for dates of service on and after January 1, 2004, contractors shall implement revised anesthesia policy.			x						
3928.2	Effective for dates of service on and after January 1, 2005, contractors shall pay for code G0344 furnished by residents who qualify for the primary care exception.			x						

III. PROVIDER EDUCATION – N/A

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	None									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 1, 2006</p> <p>Implementation Date: February 13, 2006</p> <p>Pre-Implementation Contact(s): Kenneth Marsalek, 410-786-4502</p> <p>Post-Implementation Contact(s): Kenneth Marsalek, 410-786-4502</p>	<p>No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.</p>
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100 - Teaching Physician Services

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

Definitions

For purposes of this section, the following definitions apply.

Resident - 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 only 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 FI. *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.*

Student - *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 a resident. Medicare does not pay for any service furnished by a student. See §100.1.1B for a discussion concerning E/M service documentation performed by students.*

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

Direct Medical and Surgical Services - 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 reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the FI for the hospital.

Teaching Hospital - A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching Setting - Any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the FI under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.

Critical or Key Portion - *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.*

Documentation - *Notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in the specific situations below regarding the service furnished. Documentation may be dictated and typed or 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.

In the context of an electronic medical record, the term 'macro' means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.

***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 FI.

100.1.1 - Evaluation and Management (E/M) Services

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

A. General Documentation Instructions and Common Scenarios

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) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were 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.*

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

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.

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.

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 a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching 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/she performed the critical or key portion(s) of the service, and that he/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/she was present during the performance of the critical or key portion(s) of the service and that he/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 the 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/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.

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 no 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 the 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.”

Following are examples of unacceptable documentation:

“Agree with above.”, followed by legible countersignature or identity;

“Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;

“Discussed with resident. Agree.”, followed by legible countersignature or identity;

“Seen and agree.”, followed by legible countersignature or identity;

“Patient seen and evaluated.”, followed by legible countersignature or identity; and

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.

B. E/M Service Documentation Provided By Students

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.

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.

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. 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: G0344 - Initial preventive physical examination; face-to-face visit services limited to 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 §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 FI. 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 FI 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. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;*
- 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 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*
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.*

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.

100.1.2 - Surgical Procedures

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

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 an unreduced fee schedule payment 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, *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.

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

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;

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

100.1.6 - Miscellaneous

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

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 carriers 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.

Do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

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

Carriers 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 carriers 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. Carriers 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 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.

Carriers retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, carriers 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 carrier 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.