mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Guidelines for Teaching Physicians, Interns & Residents

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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What's Changed?

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

Substantive content changes are in dark red.

Teaching Settings: Physician Service Payments

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

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

Intern- or Resident-Approved Training Programs

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

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

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

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

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

Teaching Settings: Anesthesia Services

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

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

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

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

Document in the patient's medical record:

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

Teaching Settings: Interpreting Diagnostic Radiology & Other Diagnostic Tests

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

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

Teaching Settings: Psychiatric Services

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

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

Intern or Resident Services Provided Outside an Approved Training Program

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

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

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

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

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

Interns & Residents Duplicate FTEs Audit Reviews

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

Interns & Residents Information System

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

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

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

What to Expect from the Audit

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

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

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

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

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

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

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

IRIS-to-Cost Report Reconciliation

For cost reporting periods:

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

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

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

IRIS Fields

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

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

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

IRIS XML Vendors

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

Table 1. IRIS XML Vendors

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

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

Teaching Physicians: Billing Requirements

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

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

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

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

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

Teaching Anesthesiologists: Billing Requirements

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

Send teaching anesthesiologist claims using these modifiers:

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

Time-Based Codes

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

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

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

Time-based codes:

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

  Note: When selecting the visit level, only count time the teaching physician spent performing qualifying activities listed by CPT (with or without direct patient contact on the encounter date), including the time the teaching physician is present when the resident performs those activities
- Prolonged services (CPT codes 99358–99359)
- Care plan oversight (HCPCS codes G0181–G0182)

CPT Books have more information.

Medical Records Guidelines

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

The medical record must demonstrate:

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

Document medical records in 1 of these ways:

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

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

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

E/M Documentation Guidelines

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

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

The medical record must demonstrate:

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

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

Students Providing E/M Documentation

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

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

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

E/M Services Primary Care Exception

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

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

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

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

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

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

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

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

Table 3. Primary Care Exception HCPCS Codes

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

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

To apply the primary care exception, you must meet these conditions:

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

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

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

The range of primary care center services residents provide includes:

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

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

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

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

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

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

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

Resources

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