the presence of a teaching physician is required in two places for concurrent major surgeries. The operative notes must indicate when the teaching physician presence in individual procedures began and ended. In the case of minor procedures, such as an endoscopy in which a body area, rather than a representation, is viewed, we would not make payment if the teaching physician was not present during the viewing. A discussion of the findings with a resident would not be sufficient. The situation is contrasted with a diagnostic procedure, such as an x-ray, in which the physician would not be expected to be present during the performance of a test and could bill for an interpretation by reviewing the film with the resident (or by performing an independent interpretation).

- In the case of services such as evaluation and management services (for example, visits and consultations), for which there are several levels of service available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service if the service had been fully furnished by the teaching physician. In other words, if the medical decisionmaking in an individual service is highly complex to an inexperienced resident, but straightforward to the teaching physician, payment is made at the lower payment level reflecting the involvement of the teaching physician in the service. We intend to promote flexibility and leave the decision to the teaching physician as to whether the teaching physician should perform hands-on care, in addition to the care furnished by the resident in the presence of the teaching physician. However, in the case of both hospital inpatient and outpatient evaluation and management services, the teaching physician must be present during the key portion of the visit.
- The presence of the physician during the service or procedure must be documented in the medical records.

The proposal eliminates the I.L. 372 requirement that the attending physician personally examine the patient and leaves the decision to the teaching physician as to whether he or she should perform an examination in addition to the resident's examination based on medical and risk management considerations rather than Medicare payment rules. For example, a beneficiary may be admitted to the hospital on a Saturday and be examined by a resident in the presence of a teaching physician on duty at the time. On Monday, another teaching physician might be designated to be the attending physician in the case. Under the proposal to eliminate the I.L. 372 attending physician criteria, the services of both teaching physicians in this example would be payable (as long as distinct services are furnished).

Under our proposal, we are clarifying that services of teaching physicians that involve the supervision of residents in the care of individual patients are payable under the physician fee schedule only if the teaching physician is present during the key portion of the service. If a teaching physician is engaged in such activities as discussions of the patient's treatment with a resident but is not present during any portion of the session with the patient, we believe that the supervisory service furnished is a teaching service as distinguished from a physician service to an individual patient.

We believe that this clarification is consistent with existing policy. Part A I.L. No. 70–7/Part B I.L. No. 70–2, issued in January 1970 and still in effect, contains a series of questions and answers about the attending physician policy set forth in I.L. No. 372. Question 14 of that issuance addresses services furnished in emergency rooms and outpatient departments and states the following:

> Q. Intermediary letter No. 372 states, ''An emergency room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff, etc.'' Is this also true in the hospital's outpatient department?
>
> A. Yes, because an attending physician relationship is not normally established with anyone other than the treating physician in an outpatient department. If the Part B bills are submitted for services performed by a physician in either the emergency room or in any part of the outpatient department, the hospital records should clearly indicate either that: The supervising physician *personally* performed the service; or he functioned as the patient's attending physician and was present at the furnishing of the service for which payment is claimed.

At the same time we are concerned about the integrity of the Medicare payment process, we recognize that application of this policy to the reimbursement of teaching physicians in family practice residency programs raises special concerns about the viability of these programs. Family practice residency programs are different from other programs because training occurs primarily in an outpatient setting, known as a family practice center. In these centers, residents are assigned a panel of patients for whom they will provide care throughout their 3 years of training. While teaching physicians supervise this care and, indeed, are present during the actual furnishing of services in some circumstances (most notably with first year residents and for more complex patient cases) a general requirement that teaching physicians be physically present during all visits to the family practice center would undermine the development of this physician/patient relationship. This requirement also would be incompatible with the way family practice centers are organized and staffed and could require the hiring of additional teaching physicians when the faculty are already in short supply.

We are willing to develop a special rule for paying teaching family physicians that takes into account the unique nature of these training programs while clarifying the appropriate level of involvement of the teaching physician in patient care in family practice centers. We invite comments on the structure and content of such a rule, or a legislative proposal, along with any supportive data. We also invite comments on whether and how such a rule might be applied to other primary care training programs.

e. Special Treatment—Psychiatric Services. During the period in which we were developing the February 1989 proposed rule, we met with representatives of psychiatric GME programs who indicated that it was inappropriate for a physician other than the treating resident to be viewed by psychiatric patients as their physician. In psychiatric programs, the teaching physician may observe a resident's treatment of patients only through one-way mirrors or video equipment. We have accepted this position and propose that, with respect to psychiatric services (including evaluation and management services) furnished under an approved psychiatric GME program, the teaching physician would be considered to be ''present'' during each visit for which payment is sought as long as the teaching physician observes the visit through visual devices and meets with the patient after the visit.

f. Physician Services Furnished to Renal Dialysis Patients in Teaching Hospitals. Effective for services furnished on or after August 1, 1983, Medicare pays for physician services to end-stage renal disease (ESRD) patients on the basis of the physician monthly capitation payment method described in § 414.314. This payment method generally applies to renal-related physician services furnished to outpatient maintenance dialysis patients, regardless of where the services are furnished (that is, in an independent ESRD facility, a hospital-based ESRD facility, or in the patient's home). Physician services furnished to ESRD patients on or after August 7,