3. Payments for Supervising Physicians in Teaching Settings and for Residents in Certain Settings

In our July 26, 1995 proposed rule, we proposed to revise the regulations because of the substantial changes that have taken place in the way Medicare payments for physician services are determined (that is, the replacement of the reasonable charge system with the physician fee schedule); the length of time since the publication of the February 1989 proposed rule; and our decision to propose to replace the attending physician criteria of the February 1989 proposed rule. The details of the attending physician policy had been set forth earlier in Intermediary Letter 372, published in April 1969.

We proposed to change the attending physician criteria from those of Intermediary Letter 372 to make the criteria more flexible in terms of the individual teaching physician who may serve as the responsible physician for a particular service while ensuring that a teaching physician is present during at least some portion of each service payable by the carrier. We also proposed rules based on other Medicare policies that had been in effect for years but had never been explicitly addressed in the regulations.

a. Distinction Between Teaching Hospital and Teaching Setting

We proposed to distinguish between "teaching hospital" and "teaching setting," because the former is more directly related to intermediary payments, and the latter (although defined in terms of intermediary payments) is more directly related to carrier payments. We proposed to define "teaching hospital" as a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry. We proposed to define "teaching setting" as a provider or freestanding setting for which Medicare payment for the services of residents is made under the direct GME payment provisions of § 413.86 (hospitals, hospital-based providers, and settings, including nonprovider settings, meeting the requirements for residents in § 413.86(f)(1)(iii)), or on a reasonable cost basis under the provisions of § 409.26 or § 409.40(f) for residents' services furnished in freestanding skilled nursing facilities or home health agencies, respectively.

b. Statutory Requirements for Payment in Teaching Hospitals Not Electing Reasonable Costs for Physician Services to Individual Patients

Section 1842(b)(7) of the Act is generally premised on the use of customary charges, that is, the reasonable charge system, as the basis for Medicare payments for the services of physicians in teaching hospitals. Section 1848 of the Act, however, established the physician fee schedule as the payment methodology for physician services furnished beginning January 1, 1992 without any exception for physician services furnished in teaching settings. Therefore, we based the policies in the July 26, 1995 proposed rule on principles established in legislation on payment for physician services generally under the physician fee schedule, on payment for physician services furnished in providers, and on payment to hospitals for GME programs. With regard to payment to hospitals for GME programs, the proposal addressed activities associated with GME programs that were not payable through fiscal intermediary payment mechanisms.

c. Intermediary Letter 372 Attending Physician Criteria

The Intermediary Letter 372 attending physician criteria and related policy were developed by Medicare in 1969 as a means of documenting the involvement of teaching physicians in patient care services furnished in teaching hospitals and have been controversial ever since. It was recognized then and now that residents must furnish patient care services to develop their skills as physicians or other types of practitioners. The 'attending physician'' policy was developed as a mechanism to make Part B fee schedule payments for services in which residents were involved. The main requirement of the policy was that there would be a single attending physician who personally examined the beneficiary within a reasonable time after admission, confirmed the diagnosis and course of treatment, and was continuously involved in the care of the beneficiary throughout the stay. The attending physician policy as set forth in Intermediary Letter 372 and related issuances specifically stated that the attending physician had to be present when a major surgical procedure or a complex or dangerous medical procedure was performed, but was vague, perhaps necessarily, on the matter of the presence of the physician during other occasions of inpatient service. There was less ambiguity with regard to hospital outpatients. Part A

Intermediary Letter No. 70–7/Part B Intermediary Letter No. 70–2 (issued in January 1970), a question-and-answer on Intermediary Letter 372, indicated that the supervising physician must either personally perform the service or function as the attending physician and be present while a service is being furnished (question 14).

Medicare carriers were directed to periodically review the hospital charts for verification of the establishment of attending physician relationships and their involvement in individual services. If the chart did not substantiate a sufficient level of involvement in the care furnished, the teaching physician role was seen as supervisory in nature, rather than as an attending physician, even though the teaching physician may have had legal responsibility for the care furnished to the patient. Consequently, the fiscal intermediary for the hospital would pay Medicare's share of the salary costs of the teaching physician attributable to the supervision of residents, but the Medicare carrier would not make payment for the physician services on the basis of reasonable charges.

We believe, after years of working experience with the Intermediary Letter 372 attending physician policy, that we should replace it. The amount of postpayment review necessary to verify the establishment and continuity of the attending physician relationship from patient charts had become impractical given reductions in contractor budgets and was inconsistent with more recent congressional action. While the Congress endorsed the attending physician policy in the Conference Report accompanying ORA 1980, the Intermediary Letter 372 policy might be viewed as not entirely consistent with the payment mechanism enacted in OBRA '86 under section 1886(h) of the Act for payment of direct GME costs in teaching hospitals. For example, Intermediary Letter 372 indicated that, if a physician was not an attending physician but supervised a resident who furnished a service, the costs of the physician services were payable by the intermediary. Under section 1886(h) of the Act, if a service was determined not to be an attending physician service billable under Part B, the service could not become a provider service for purposes of additional payments made under Part A since the GME payments were prospectively determined amounts that could not be adjusted based on the individual circumstances of the delivery of individual services. Further, allocation agreements between physicians and hospitals identifying the

various activities in which the