physicians were involved for purposes of determining the appropriate payment amounts had no effect on GME payments in an individual hospital cost reporting period. The costs that were allocated during the GME base period were carried forward regardless of changes in the physician activities.

Moreover, the Intermediary Letter 372 policy left it to individual carriers to determine coverage of the services based on customary practices in the area or on the competence of individual residents. For example, a sentence in Intermediary Letter 372.A. reads as follows:

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

While this policy might have been appropriate 30 years ago in the early days of Medicare, we stated in our proposed rule (60 FR 38409) that we believe it is inappropriate to base the determination of whether a carrier will pay several thousand dollars or zero dollars for a surgical procedure on this standard, which could result in a wide disparity of policy from area to area regarding when payment is made.

Another problem with the Intermediary Letter 372 policy was reliance on a single physician to be the attending physician for the beneficiary throughout the inpatient stay. The only exception permitting an attending physician relationship for only a portion of a stay was if the portion was a distinct segment of the patient's course of treatment, such as the postoperative period. Another example from Intermediary Letter 372 reads as follows:

A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patients' attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

We stated in our proposed rule (60 FR 38409) that we believe that this emphasis on a single teaching physician serving as the attending physician through the stay was no longer necessary, and that we should provide teaching hospitals and GME programs with flexibility in the determination of the responsible teaching physician in an individual case. We no longer believe the Intermediary Letter 372 requirement that a single physician be recognized by

the beneficiary as his or her personal physician through a period of hospitalization reflects current realities. Further, the existing attending physician regulation might operate at cross-purposes with managed care arrangements that often employ treatment teams.

The Intermediary Letter 372 requirements for continuity of care might be difficult for carriers to verify from reviews of medical records, might be interpreted in different ways by different carriers, and might be counterproductive and burdensome in the delivery of services to the patient. We believe the proposed policy would address potential sources of misunderstanding and abuse that have been longstanding Medicare program concerns. For example, Intermediary Letter 372 required the attending physician to personally examine the patient, review the history and record of test results, etc. From discussions with carrier medical directors, it is our understanding that some carriers considered the requirements to be met if the teaching physician first saw the patient 1 or 2 days after admission. In those situations, the carrier might pay for an admission history and physical performed by a resident on Saturday while the teaching physician did not actually see and examine the patient until Monday. Other carriers would maintain that, to pay for the admission history and physical as an attending physician, the teaching physician would have to see the patient on the day the service was performed.

We believe that the most important consideration should be the presence of the teaching physician during the key portion of the service or procedure being furnished by the resident, and that requiring both an attending physician relationship and the presence of that same physician during every billable service is no longer warranted. Thus, under our proposal, carriers would no longer pay for services such as admission evaluation and management services unless a teaching physician was present during the key portion of the service.

d. Carrier Payment for Services of Teaching Physicians—General

We proposed to eliminate the Intermediary Letter 372 attending physician criteria from the determination of whether payment should be made for the services of physicians in teaching settings. We recognize that the term "attending physician" is used in academic medicine to denote the responsible physician, and we believe that hospitals

and GME programs should be free to designate any physician to be the attending physician of the patients in the teaching setting. We proposed to require the following conditions for services of teaching physicians (physicians who involve residents in the care of their patients) in both inpatient and outpatient settings to be payable under the physician fee schedule:

• A teaching physician (a physician other than a resident or fellow in an approved program) must be present for a key portion of the time during the performance of the service for which

payment is sought.

- In the case of surgery or a dangerous or complex procedure, the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure. We specified that the teaching physician presence requirement is not met when 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 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.