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 eliminated the Intermediary Letter 372 requirement that the attending physician personally examine the patient and left 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 might 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 Intermediary Letter 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 clarified 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 Intermediary Letter No. 70–7/Part B Intermediary Letter No. 70–2, issued in January 1970, contained a series of questions and answers about the attending physician policy set forth in Intermediary Letter No. 372. Question 14 of that issuance addressed 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 were concerned about the integrity of the Medicare payment process, we recognized that application of this policy to the reimbursement of teaching physicians in family practice residency programs raised 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 stated in our July 26, 1995 proposed rule (60 FR 38410) that we would be 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 invited comments on the structure and content of such a rule, or a legislative proposal, along with any supportive data. We also invited 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 accepted this position and proposed 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 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 end-stage renal disease facility, a hospital-based end-stage renal disease facility, or in the patient's home). Physician services furnished to end-stage renal disease patients on or after August 7, 1990 may also be paid on the basis of the initial method as described in § 414.313. We would continue application of these physician payment methods to teaching hospitals with end-stage renal disease facilities. We would not impose any special medical record documentation requirements solely because the end-stage renal disease facility is based in a teaching hospital.

Physician fee schedule payments for covered physician services furnished to inpatients in a hospital by a physician who elects not to continue to receive payment on a monthly capitation basis through the period of the inpatient stay, or who is paid based on the initial method, would be determined according to the rules described in proposed § 415.170. Physicians would have to either personally furnish the services, or furnish the services as a teaching physician as described in proposed § 415.172.

g. Special Criteria for Anesthesia Services and Interpretation of Diagnostic Tests

Special criteria for anesthesia services involving residents appear in § 415.178. In the case of diagnostic radiology and other diagnostic tests, we make payment