The policy does not encompass Medicare payment for moonlighting services furnished to inpatients in the hospital in which the resident has his or her program since we believe these services are virtually indistinguishable from the services the resident furnishes within the scope of the training program. However, when a licensed resident moonlights in another teaching hospital, the carrier must be furnished sufficient information to be sure that the moonlighting resident is not being included in the residency count (used to determine direct and indirect medical education payments) of either hospital for the period of time in question. Moreover, in this final rule, we are revising proposed § 415.202 (''Services of residents not in approved GME programs'') (formerly § 405.523) to clarify that, when an intern or resident is in an approved GME program at one hospital and is concurrently furnishing moonlighting services in another hospital that lacks an approved GME program, the services in the second hospital may be reimbursed only pursuant to 42 CFR part 414 or section 2109 of the Provider Reimbursement Manual.

Comment: Some commenters suggested that we should discard the current proposal and implement the ''philosophy'' of teaching physician immediate availability rather than presence as proposed in the February 7, 1989 proposed rule.

Response: The exception that we have added to the policy we are adopting is consistent with the philosophy to which the commenters referred.

Comment: Some commenters stated that documentation of a teaching physician's presence during a procedure would add costs to an already burdensome, bureaucratic process.

Response: The policy we are adopting cannot be enforced without some documentation of the presence of the teaching physician during procedures and the personal involvement of the teaching physician in evaluation and management services.

Comment: A few physician specialty organizations supported the proposal. In addition, a few physicians stated that the physician presence requirements reflected their standard practice. Some commenters representing surgeons stated that, while they generally supported the physician presence proposal, they objected to the requirement that the surgeons have to indicate in their operative notes when their presence began and ended since the anesthesiologist and nurses already record this information. Many other commenters objected to any restriction in the involvement of teaching surgeons in concurrent cases. Some commenters believed that third or fourth year residents were capable of performing surgical procedures with the teaching physician in the operating suite rather than in the operating room.

Response: As we stated in the proposed rule, the notation in the nurse's notes is sufficient documentation of the teaching physician's presence during surgical procedures. There is no requirement that the teaching physician personally record the information if it duplicates information available elsewhere. If the teaching physician believes the third or fourth year resident is capable of performing surgical procedures without supervision, the teaching physician should not bill Part B for the surgical services furnished by the resident.

Comment: One commenter recommended that the teaching physician be able to indicate the following general statement on all records:

I have interviewed and examined the patient, and I agree with the history and physical findings as recorded by Dr. (Resident) in his/her note of (date).

The commenter believed that this would clarify that the physician participated in the care of the patient, but not require that he or she spend valuable time repeating all of the documentation already present in the record.

Response: This statement, by itself, would not be sufficient for Part B payment if the physician was not present during the service. If the physician was present, it is not necessary for the teaching physician to repeat all of the documentation entered into the medical records by the resident. The teaching physician may countersign the resident's entries and enter additional notes as necessary to indicate his or her involvement in the service. We will address these matters in more detail in manual instructions.

Comment: One commenter believed that we should pay teaching physicians under case management CPT codes 99361 through 99373 and care plan oversight codes (CPT codes 99375 and 99376). These services include care team conferences and telephone calls for consultation or medical management with other health care professionals. In addition, the commenter suggested that we undertake a demonstration project to test the feasibility and cost-effectiveness of these payments with the goal of implementing a budget-neutral policy for the payments. The same commenter also suggested a policy under which the teaching physician could bill Medicare for each visit if the physician were present to observe every third visit furnished by the resident to the patient.

Response: Medicare does not allow separate payment for the case management codes. We consider case management services to be included in the prework and postwork of the evaluation and management codes. The suggestion seems to be a way of removing the teaching physician further from the actual performance of the service, and we do not support this outcome.

Comment: Under current policy in § 414.46(c)(1)(iii), if a teaching anesthesiologist is involved in concurrent cases, the medical direction payment rules apply, and a reduced allowance is recognized for the physician service in each concurrent case. Commenters argued that this standard is inconsistent with the standard for teaching surgical services. They indicated their understanding that the teaching surgeon can be involved in concurrent procedures and receive a full allowance for each surgical procedure.

Response: We intend to apply the physician presence standard for both surgical and anesthesia teaching services and have revised § 415.178 (''Anesthesia services'') accordingly. Under the policy we are adopting, while we require the teaching surgeon's presence during the critical portion of the service, we do not require the surgeon's presence during the opening and closing of the patient. However, during this period, the teaching surgeon may not be involved in surgical services for other patients since this would preclude his or her return to the original case. We believe that this policy is analogous to the teaching anesthesiologist policy under which, in order to receive an unreduced fee, the anesthesiologist must be present during all critical portions of the procedure and immediately available to furnish services during the entire procedure.

Comment: A carrier medical director commented that there should be a national standard on documentation of what the teaching physician actually does. The carrier medical director believed that physicians in nonteaching settings have to provide considerably more documentation than a counter-signature, and that the teaching physician should make a brief notation documenting his or her involvement in support of the level of evaluation and management code billed.

Response: We plan to address this matter in billing instructions to implement the new policy.

Final decision: We are going forward with the policy we proposed but have