

## Resident Supervision Requirements Under Medicare

### KEY TAKEAWAYS

- During the COVID-19 public health emergency (PHE), the Center for Medicare and Medicaid Services (CMS) made changes to the Medicare billing requirements that enabled payment to teaching physicians when residents provide services to patients (in person or via telehealth) that are supervised virtually by the teaching physician, making it easier for individuals to receive care.
- After the COVID-19 PHE ends, CMS will allow payment for virtual supervision of residents by teaching physicians **only** when the patient and resident are located in a rural area. When telehealth services are provided by residents, virtual supervision by the teaching physician will only be allowed in rural areas.
- The AAMC recommends that virtual supervision qualify for payment without restriction based on rural location because it is crucial to expanding access to safe and effective care, not only in rural communities, but in all underserved communities. The supervising/billing physician is responsible for ensuring the patient receives high quality care and should determine when virtual supervision of residents is appropriate.
- The AAMC supports virtual supervision of residents during telehealth services to enhance the resident's skill and ensure the resident is appropriately trained and prepared to provide telehealth services.

### I. Resident Supervision: Introduction

The supervisory relationship between teaching physicians and their residents is essential to developing quality physicians who can autonomously and effectively treat patients. CMS, under most circumstances, requires teaching physicians to provide direct in-person supervision during residents' services in order to receive payment for those services. However, during the Covid-19 public health emergency (PHE), in order to maintain and promote quality supervision within the bounds of the Center for Disease Control and Prevention (CDC) guidelines for social distancing, Medicare permitted certain exceptions to supervision requirements that would allow teaching physicians to engage in virtual supervision. CMS has put forth some of these exceptions on an interim basis throughout the COVID-19 PHE while others have been finalized and will continue on a permanent basis.

### II. Resident Supervision: Before Covid-19 Public Health Emergency

#### General Rule Before the COVID-19 PHE:

Under the Medicare program, in certain circumstances, payment will be made under the physician fee schedule (Part B) to teaching physicians for services in which a resident is involved. These circumstances include situations in which the teaching physician is physically present during critical or key portions of the service or procedure with some limited exceptions.

For the interpretation of diagnostic radiology and other diagnostic tests, payment is made if the interpretation is performed or reviewed by a physician other than a resident. Payment for psychiatric services when the resident is involved may be made if the teaching physician observes the resident providing the service by use of a one-way-mirror, video equipment or similar device.

*Primary Care Exception Before the COVID-19 PHE:*

Although under Medicare rules residents are typically supervised in-person during the critical or key portions of the service by a teaching physician, the “primary care exception” allows residents (after completing six months of residency) to furnish office/outpatient evaluation and management (E/M) visit codes of lower and mid-level complexity (99201, 99202, 99203, 99211, 99212, 99213 and annual wellness visits (HCPCS G0402, G0438, G0439) without the presence of a teaching physician. The teaching physician must be immediately available onsite to provide the necessary direction and can only supervise four residents at a time. Under this exception, the teaching physician must also review the patient’s medical history, physical examination, diagnosis, and record of tests and therapies during or immediately after each visit. The teaching physician must have no other responsibilities at the time the residents are being supervised, assume management responsibility for the beneficiaries seen by the residents, and ensure that the services furnished are appropriate.

**III. Resident Supervision: Virtual Exceptions/Exclusions During the Covid-19 PHE**

*COVID-19 PHE Virtual Exception:*

During the COVID-19 PHE, CMS modified the resident supervision requirements to allow teaching physicians to supervise residents using audio/video real-time communications technology. This policy generally requires real-time observation (not mere availability) by the teaching physician through audio/video technology during the key or critical part of the service. Audio-only technology is not included in this modified requirement. Under all circumstances, the patient’s medical record must clearly reflect whether the teaching physician was physically or virtually present at the training site during the key portion of the service. For services during which there is a disruption to the virtual connection between the teaching physician and the resident who is with the patient, the encounter would be paused until the connection resumes, or the appointment would be rescheduled.

*COVID-19 PHE Diagnostic Exception:*

During the COVID-19 PHE when residents interpret diagnostic radiology and other diagnostic tests, payment may be made to the teaching physician provided that the teaching physician is present through audio/video real-time at the time of the interpretation. A physician other than the resident must still review the resident’s interpretation and the medical records must document the extent of the teaching physician’s participation in the interpretation or review

*COVID-19 PHE Psychiatric Exception:*

During the COVID-19 PHE, the teaching physician may supervise a resident during psychiatric services using interactive, audio/video real-time communication technology. This does not include audio-only technology. Medical records must document the extent of the teaching physician’s participation.

COVID-19 PHE Primary Care Exception:

During the COVID-19 PHE the primary care exception was expanded to all levels of office and outpatient E/M codes including codes of lower and mid-level complexity (see section II.) and higher levels of complexity). In addition, it was expanded to include telephone evaluation and management services (CPT 99441-99443), transitional care management services (CPT 99495 and 99496), online digital evaluation and management service for an established patient (CPT 99422-99423), interprofessional telephone/internet/electronic health record referral services (CPT 99452), brief communication technology-based service (HCPCS G2012) and (remote evaluation of recorded video and/or images submitted by an established patient (HCPCS G2010). These services must be reviewed remotely by the teaching physician during or immediately after the service is provided using audio/video real-time technology. Audio-only technology is not included in this exception. CMS will also allow payment to teaching physicians for residents' services furnished via telehealth under the primary care exception if the services are on the list of telehealth services which can be located on the [CMS website](#).

COVID-19 PHE Resident Telehealth Exception

During the COVID-19 PHE, Medicare will make payment to teaching physicians for services when a resident furnishes telehealth services to beneficiaries while the teaching physician is present using audio/video real time communications technology. Audio-only technology is not included in this exception. Under this policy, it is possible for a resident to furnish the service at a distant site from the patient and the teaching physician to be at a third site while supervising through audio/video real-time communications technology. The list of approved telehealth services during the PHE can be located on the [CMS website](#).

Exclusions to the COVID-19 PHE Exceptions:

Some services have been excluded from this virtual supervision policy, including surgical, high risk, interventional, endoscopic, or other complex procedures and anesthesia services. For these services, CMS believes the level of personal oversight and involvement necessary from the teaching physician cannot be met virtually and requires onsite supervision. There may be other instances in which virtual supervision may not be appropriate considering potential risks to patient safety and the needs of certain patient populations. Teaching physicians should use their professional judgment to identify any additional instances in which virtual supervision is not appropriate.

COVID-19 PHE Exception Summary:

In summary, below are scenarios describing when virtual supervision would be allowed by Medicare during the PHE:

- 1) Resident is in-person with the patient providing services at the hospital. The teaching physician virtually supervises the resident via video/audio technology from home;
- 2) The resident is in their home providing telehealth services to a patient who is at their home or 3<sup>rd</sup> location, and the teaching physician is located at the hospital and supervising virtually.
- 3) The resident is at their home providing telehealth services to a patient who is at their home, and the teaching physician is located in home and supervising virtually.
- 4) Teaching physician and resident are co-located in the same room at the hospital providing telehealth services to a patient at home/3<sup>rd</sup> location.

- 5) Resident and teaching physician are both in clinical setting, but not in same room, providing telehealth to a patient at home/3<sup>rd</sup> location.

#### **IV. Resident Supervision: Medicare Policy Post- Public Health Emergency**

CMS has permitted these exceptions during the COVID-19 PHE because the concerns associated with the spread of the virus outweigh potential concerns associated with virtual supervision and telehealth services furnished by residents. However, CMS is still concerned that unlike an in-person encounter, virtual presence may not meet billing requirements as the teaching physician may not be able to render sufficient personal and identifiable physicians' services to the patient. Therefore, at the close of the COVID-19 PHE, only the exceptions below will continue.

##### Virtual Supervision Continued **only in Rural Areas:**

CMS finalized policy that allows teaching physician to meet the requirements to bill through virtual presence when furnishing services involving residents in rural training setting. The patients' medical record must include documentation of how and when the teaching physician was present during the key portion of the service or in the case of the primary care exception, immediately after the service.

##### Telehealth Exception Continued **only in Rural Areas:**

CMS has also finalized policy that allows teaching physicians to bill for telehealth services when a resident located in a rural training site furnishes services to a beneficiary who is in a separate location within the same rural area as the residency training site. A resident located in rural training site may also furnish telehealth services to a beneficiary who is located in a different rural location. In these cases, the teaching physician is present, through interactive, audio/video real-time communications technology (excluding audio-only), in a third location, either within the same rural training site as the resident or outside of that rural training site. When a resident furnishes Medicare telehealth services in a rural residency training site and the teaching physician is present using interactive, audio/video real-time communications technology (excluding audio-only), the patient's medical record must clearly reflect how and when the teaching physician was present during the key portion of the service.

##### Primary Care Exception Partially Continued:

After the COVID-19 PHE, the primary care exception will once again be limited to services of lower and mid-level complexity (CPT 99201- 99203, 99211-99213 and HCPCS G0402, G0438, G0439). However, services under the primary care exception are expanded permanently to include online digital evaluation and management services (CPT 99421–99423), interprofessional telephone/internet/electronic health record consultation (CPT 99452), remote evaluation of recorded video and/or images submitted by an established patient (HCPCS G2010) and brief communication technology-based service (HCPCS G2012).

## V. Implications

The expansion of the teaching supervision requirements to allow virtual supervision affords patients greater access to care. It also offers additional training opportunities for those located in rural areas. Although during the COVID-19 PHE, CMS was willing to allow virtual supervision of residents, it will be limiting this expansion of supervision to only rural areas in the future. CMS continues to balance using technology to increase access to care and the need to keep services personable and comprehensive for patients. Moving forward, CMS plans to continue collecting data and engaging in conversations with stakeholders to strike an effective balance between these two concerns.

It is important that institutions impacted by changes in payment after the PHE for virtual supervision and telehealth to understand and prepare for the changes that occur. Significant consequence maybe associated with failing to update Medicare billing procedures. For example, if Medicare is billed without meeting the necessary requirements, the claim may trigger false claim liability.<sup>1</sup> Likewise, if patient's coinsurance is charged when Medicare should have been billed institutions run risk of implicating the anti-kickback statutes.<sup>2</sup> To avoid the penalties associated with these implications, institution should keep up-to-date with changes in Medicare's payment rules.

## VI. AAMC Perspective:

The billing physician's is responsible for the quality of care delivered to their patients, including care provided by residents. As such, billing physicians should be responsible for determining when virtual supervision of residents is appropriate. Virtual supervision should qualify for payment without restriction based on rural location because it is crucial to expanding access to safe and effective care, not only in rural communities, but in all underserved communities These medically underserved communities outside of rural areas would greatly benefit from the expanded access to care provided by virtual supervision.

The AAMC also believes that enabling virtual supervision of resident services is crucial to expanding access to safe and effective care while enhancing the resident's skills. As part of their training, it is essential for residents to have experience with providing telehealth visits while supervised as they will be providing them in the future to their patients when they practice independently. Any risk to quality of care and utilization, can be prevented by establishing clearly outlined policies, procedures and training. Ultimately, billing occurs under the teaching physician; therefore, the teaching physicians is responsible for ensuring that all services are appropriately furnished.

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<sup>1</sup> Cohan, Allison, American Health Law Association (AHLA), *How Academic Medicine Can Stay Ahead of the Curve on Telehealth Reimbursement and Regulatory Compliance*, (May 2021), <https://www.americanhealthlaw.org/content-library/ahla-daily/article/db15b78f-c217-49dd-9c44-04b6ab82344d/from-ahla-s-health-law-connections-how-academic-me>

<sup>2</sup> *Id.*

In order to expand telehealth services successfully, AAMC emphasizes the importance of adequate training of residents, to promote personal and effective care. Residents should be trained in effective verbal and non-verbal communication via telehealth, and appropriate virtual etiquette in order to develop meaningful relationships with patients. They should be provided with effective communicative-technology, including live video platform, and audio-only technology. The platform should include a three-way calling feature to allow teaching physicians to supervise telehealth visits, and it should also include a private space for the teaching physician to communicate with the resident. Patients should always be informed when multiple physicians (such as a resident and attending physician) are participating in the visit.

In addition to the Medicare payment policies related to supervision, it is important to ensure compliance with requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME), referred to as the Common Program Requirements. The ACGME establishes a set of standards (including requirements related to supervision) for training and preparing residents to develop the skills and knowledge necessary to take personal responsibility for the individual care of patients.

Among the requirements for residency training is the residents must become competent in six areas of patient care the ACGME requires residents to obtain competency in six areas patient care, medical knowledge, interpersonal communication skills, professionalism, practice-based learning and improvement, and systems-based practice all of which play a crucial role in telehealth services. The AAMC and its Telehealth Advisory Committee have developed [core competencies](#) specifically for telehealth which serve as a roadmap for curricular and professional development, performance assessment, and improvement of health care services. Once obtained these competencies should produce well trained physicians who are able to effectively provide telehealth services and increase access to care.

### **Resources:**

Physician Fee Schedule:

<https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>

42 U.S.C. 1302:

<https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-B/part-415>

AAMC telehealth Competency:

<https://www.aamc.org/data-reports/report/telehealth-competencies>

ACGME: The milestone Guidebook

<https://www.acgme.org/Portals/0/MilestonesGuidebook.pdf>

Chapter 12, section 100 of the Medicare Claims Processing Manual (Publication 100-4)

<https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12>

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