Regulatory Resource

MEDICARE VIRTUAL RESIDENT SUPERVISION REQUIREMENTS

KEY TAKEAWAYS

- During the COVID-19 Public Health Emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) made changes to the Medicare billing requirements that temporarily enabled payment to teaching physicians when supervising residents virtually for both in-person and telehealth services, making it easier for individuals to receive care.
- CMS finalized permanent payment for teaching physicians virtually supervising residents rendering telehealth services (via 3-way audio-video technology) in all teaching settings.
- CMS finalized permanent payment for teaching physicians virtually supervising residents providing in-person services in rural areas.
- Payment for teaching physicians virtually supervising residents providing in-person services in urban areas expired December 31, 2023.

BACKGROUND

The supervisory relationship between teaching physicians and their residents is essential to developing quality physicians who can autonomously and effectively treat patients. Medicare reimburses teaching physicians for services rendered by residents so long as the teaching physician provides the required level of supervision of the resident. In recent years, CMS has modified Medicare physician billing policies regarding whether supervision is required in-person or may be allowed virtually.

Before the COVID-19 PHE

Prior to the COVID-19 PHE, as the general rule (with some exceptions), if a resident participates in a service rendered in a teaching setting, payment is made only if a teaching physician is physically present during the key or critical portion of any service or procedure. To satisfy the physical presence requirement, the teaching physician must be in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service. CMS also allowed payment for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident. And the teaching physician could also receive payment for psychiatric services when supervising the resident by use of a one-way-mirror, video equipment or similar device.

Primary Care Exception Before the COVID-19 PHE

Although residents are typically supervised in-person during the critical or key portions of the service by a teaching physician, the “primary care exception” allowed residents, after completing six months of residency, to render office/outpatient evaluation and management (E/M) visit services of lower and mid-level complexity (visit codes 99201, 99202, 99203, 99211, 99212, 99213) and annual wellness visits (HCPCS codes 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 patients seen by the residents, and ensure that the services rendered are appropriate.

During the COVID-19 PHE

To maintain and promote quality supervision within the bounds of public health guidelines for social distancing, Medicare permitted certain exceptions to supervision requirements that allowed teaching physicians to engage in virtual supervision. Some of these exceptions were on an interim basis throughout the COVID-19 PHE, while others have been permanently adopted through CMS rulemaking.

In-person Visit Exception: CMS allowed teaching physicians to supervise residents using audio/video real-time communications technology when the resident is rendering services in person with the patient. This policy generally required 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.

Telehealth Visit Exception: Medicare made payment to teaching physicians for services when a resident rendered telehealth services to beneficiaries while the teaching physician was present using audio/video real time communications technology. The telehealth list can be located on the CMS website.

Primary Care Exception: The primary care exception was expanded to all levels of office and outpatient E/M codes including codes of lower and mid-level complexity, 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). Audio-only technology was not included in this exception. CMS also allowed payment to teaching physicians for residents' services rendered via telehealth under the primary care exception.

Diagnostic Exception: Payment could be made to the teaching physician when residents interpret diagnostic radiology and other diagnostic tests, provided that the teaching physician is present through audio/video real-time communications technology 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.

Exclusions to COVID-19 PHE Exceptions: Notably, CMS excluded certain services from the virtual supervision policy that it believes require a level of oversight that a teaching physician could not meet virtually, including surgical, high risk, interventional, endoscopic, or other complex procedures and anesthesia services.

Current Policy

CMS extended the COVID-19 flexibility that allowed payment for virtual supervision of residents for telehealth services (3-way audio-video visits) in all training areas through the end of CY 2025. In the 2026 Physician Fee Schedule, CMS initially proposed to end payment for these services effective Dec. 31, 2025. In response to advocacy from the AAMC, our members, and other specialty societies, CMS did not finalize this policy and instead will permanently allow teaching physicians to virtually supervise residents via telehealth during key and critical portions of the service in all training locations when the service is furnished virtually (for example, a 3-way telehealth visit, with the patient, resident, and teaching physician in separate locations).

CMS also permanently finalized the COVID-19 PHE flexibility that allowed payment for virtual supervision of residents for in-person services to expand access to care in rural areas when the resident and patient are located in a rural training area. Specifically, CMS allows teaching physicians to bill for telehealth services when a resident located in a rural training site renders services to a beneficiary who is in a separate location within the same rural area or different rural area as the residency training site. In these cases, the teaching physician may be 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. CMS did not extend virtual supervision of in-person services rendered by residents in urban areas. As a result, payment for services when a resident is virtually supervised in urban areas is not allowed after Dec. 31, 2023.

When a resident is being virtually supervised, the medical record must include documentation for how and when the teaching physician was present during the key or critical portion of the services or in the case of the primary care exception, immediately after the service, when the service is virtually supervised by the teaching physician. CMS excluded certain services from the virtual supervision policy that it believes require a level of oversight that a teaching physician could not meet virtually, including surgical, high risk, interventional, endoscopic, or other complex procedures and anesthesia services. Teaching physicians should always use their professional judgment to identify any additional instances in which virtual supervision is not appropriate.

With the end of the COVID-19 PHE on May 11, 2023, the primary care exception is once again limited to services of lower and mid-level complexity (CPT codes 99201- 99203, 99211-99213 and HCPCS G0402, G0438, G0439). However, services under the primary care exception were permanently expanded 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).CMS finalized the COVID-19 PHE flexibility that allowed payment to teaching physicians when residents interpret diagnostic radiology and other diagnostic tests 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.

Below are scenarios describing virtual supervision of residents:

- In a rural area, the resident is providing services to a patient in-person, and the teaching physician is located at home and supervising virtually. (Permanent policy change to allow coverage and payment)
- In an urban area, the resident is at the hospital providing telehealth* services to a patient who is at their home, and the teaching physician is located at home and supervising virtually. (Permanent policy change to allow coverage and payment)
- In an urban area, teaching physician and resident are co-located in the same room at the hospital providing telehealth* services to a patient at home or 3rd location. (Permanent policy change to allow coverage and payment)
- Resident is in-person with the patient providing services at the hospital in an urban area. The teaching physician virtually supervises the resident via video/audio technology from home. (No longer permitted: expired December 31. 2023)

*Subject to geographic restrictions and originating site requirements under section 1834(m), unless Congress extends the telehealth waivers and flexibilities

VIRTUAL SUPERVISION OF RESIDENTS			
	Pre-COVID PHE	**During COVID-19 PHE**	**Current Policy**
Virtual Supervision of Residents in **urban areas** for **in-person services**	Not permitted	CMS allowed teaching physicians to supervise residents using audio/video real-time communications technology.	Not permitted after Dec. 31, 2023 in urban areas.
Virtual Supervision of Residents in **urban areas** for **telehealth services**	Not permitted	CMS allowed teaching physicians to supervise residents using audio/video real-time communications technology.	CMS permanently allows teaching physicians to supervise residents using audio/video real-time communications technology.
Virtual Supervision of Residents in **rural areas** for **in-person visits**	Not permitted	CMS allowed teaching physicians to supervise residents using audio/video real-time communications technology.	CMS permanently finalized the flexibility that allowed payment for virtual supervision of residents for in-person services in rural areas.
Virtual Supervision of Residents in **rural areas** for **telehealth visits**	Not permitted	CMS allowed teaching physicians to virtually supervise residents rendering telehealth services using audio/video real-time communications technology	CMS permanently finalized the flexibility that allowed payment for virtual supervision of residents rendering telehealth services using audio/video real-time communications technology in rural areas.
Primary Care Exception (PCE)	The PCE allowed residents to render E/M visit codes of lower and mid-level complexity 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.	The PCE was temporarily expanded to all levels of E/M services including codes of lower, mid-level, and higher levels of complexity. The temporary expansion included telephone E/M services, transitional care management services, online digital E/M service for an established patient, interprofessional telephone/internet/electronic health record referral services, brief communication technology-based services and remote evaluation services of recorded video and/or images submitted by an established patient.	The PCE is once again limited to E/M services of lower and mid-level complexity. However, PCE was permanently expanded to include online digital E/M services, interprofessional telephone/internet/electronic health record consultation, remote evaluation services of recorded video and/or images submitted by an established patient and brief communication technology-based service.
Radiology	CMS allowed payment for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than the resident.	CMS allowed payment for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by the teaching physician. For all teaching settings, CMS also allowed payment if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology or diagnostic test.	CMS did not extend the COVID-19 era flexibility for virtual supervision of diagnostic testing interpretations by residents in urban areas. In rural areas the COVID-19 flexibilities were made permanent.

DISCUSSION

Residents have been virtually supervised safely and effectively since the PHE, increasing access to care. The teaching physician is present virtually during key and critical portions of the service through interactive audio/video real time communications technology, and both the attending physician and resident have access to electronic health record. Teaching physicians render personal and identifiable physician services and exercise full personal control over the management of the care for which payment is sought. CMS requires that the documentation in the patient's medical record must clearly reflect how and when the teaching physician was present during the key and critical portion of the service, along with a notation describing the specific portions of the service for which the teaching physician was virtually present. After the visit, if medically necessary, the teaching physician continues to engage with the patient through phone calls, messages, video updates, study reviews, and collaboration with other providers. Below are statements from AAMC members outlining effective use of virtual supervision to improve access to care.

Neurology

Telemedicine is a very important part of our training program. Notably, telemedicine is an expected and increasingly essential part of both acute and outpatient stroke management. Therefore, we train our fellows to be adept in both acute and outpatient stroke management using telemedicine. At this point, approximately 50-60% of their outpatient experience is telemedicine.

Because of the requirements of the vascular neurology program, the vascular neurology fellows are expected to staff with a licensed faculty member when geographically separated. Notably, at least one vascular neurology fellow is on call and is usually in the hospital; at least one vascular neurology off-call and is usually on an elective rotation with another service. This means that it is organizationally difficult and educationally detrimental for the fellows to be in the same place.

Further, and because of the academic and travel demands of the faculty, it would be limiting and currently organizationally impossible to expect faculty to be in the same place as the fellows. Notably, the faculty that staff clinic are often in a separate campus or are traveling. As such, requiring faculty to be in the same place would drastically limit the number of faculty available, would limit clinic time, and would curtail teaching.

Geriatric Psychiatry

I sometimes have a clinic where all the patients (or all but one) have virtual visits. We do synchronous supervision usually through a combination of speaking on the phone or using Zoom with the patient in the waiting room. We also always review the history and plan together with the patient on video.

Pediatric Hematology Oncology

I strongly believe this flexibility is beneficial both to direct patient care and fellow training. For context, our pediatric hematology/immune-hematology clinic provides ~60-65% of our patient visits via telehealth. The following case studies serve as examples of how virtual supervision of virtual visits is helpful to our patients and trainee education: (1) For our immuno-hematology patients that are often seen by many specialties, having the

ability for attendings to staff fellows that are at different locations has been hugely beneficial - as it allows for flexibility in the appointment time for patients, permits continuity of care longitudinally with the fellows and facilitates training in rare diseases for fellows. (2) During afterhours/weekends, we often have patient calls/critical labs that can prompt an ad-hoc virtual visit. Virtual supervision allows for the fellow and attending to jump on an ad-hoc virtual visit (nearly always from different locations) to provide immediate care to patients. These visits are crucial for triaging immediate issues and often help prevent ED visits and mitigate issues for patients efficiently. (3) For those who are feeling well enough to work from home, having the fellow and attending work from separate locations is hugely beneficial in maintaining the previously scheduled visits. If we couldn't continue visits with virtual supervision, the patient visits would otherwise need to be cancelled.

AAMC POLICY REVIEW

The AAMC appreciates that CMS finalized policy to permanently allow for the virtual supervision of residents during the key and critical portions of the telehealth service in all training areas (3-way audio-video services). We also appreciate that CMS finalized policy to permanently allow virtual supervision of in-person services in rural areas. Allowing virtual supervision increases access to care, enables training opportunities for residents, and is safe and effective. The AAMC supports the current exclusion from the virtual supervision policy of surgical, high risk, interventional and other complex procedures, endoscopies, and anesthesia services. For these services, we believe that the requirement for the physical presence of the teaching physician for the entire procedure or the key portion of the service with immediate availability throughout the procedure, is necessary for patient safety given the risks associated with these services.

RESOURCES

Statutory Authority 42 U.S.C. 1302

AAMC Telehealth Competencies Across the Learning Continuum (Mar. 2021) free for download from the AAMC store

CMS CY 2021 Physician Fee Schedule (December 28, 2020) with virtual supervision of residents discussed within Vol. 85 of the Federal Register beginning at 84577 (Dec. 28, 2020)

CMS Claims Processing Manual Transmittal 1128 with the primary care exception discussed beginning p. 23 of the manual (Mar. 4, 2022)

CMS CY 2024 Physician Fee Schedule (November 16, 2023) with virtual supervision of Residents discussed within Vol. 88 of the Federal Register beginning at 78878 (Nov. 16, 2023)

CMS CY 2025 Physician Fee Schedule (December 9, 2024) with virtual supervision of Residents discussed within Vol. 89 of the Federal Register beginning at 97764 (Dec. 9, 2024)

CMS CY 2026 Physician Fee Schedule (November 5, 2025) with virtual supervision of Residents discussed within Vol. 90 of the Federal Register beginning at 49328 (Nov. 5, 2025)

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