In a teaching hospital, physician services provided to patients are reimbursed by Medicare Part B, while physician services furnished for the general benefit of patients (e.g., supervision and teaching of residents) are considered hospital services and are reimbursed by Medicare Part A. Practices vary widely among and within teaching hospitals with respect to the degree of physician involvement in the care of patients. In some cases, teaching physicians personally direct residents in furnishing patient care services. In others, residents assume a greater degree of responsibility for the care patients receive, and teaching physicians exercise only general control over the residents’ activities.

A **teaching physician** is a physician (other than a resident) who involves residents in the care of his or her patients. A **resident** is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. An approved **Graduate Medical Education** program is a residency program approved by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatric Medicine Education of the American Podiatric Medical Association. The term **resident** includes interns and fellows enrolled in GME programs that are recognized as approved for purposes of direct GME payments made by the Medicare administrative contractor. (Interns are now called first-year residents.) Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of **resident**. Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full-time equivalency count of residents.

The most important consideration in determining if the services of a teaching physician are eligible for Medicare Part B reimbursement is the presence of the teaching physician during the key portion of any service or procedure for which payment is sought. This physical presence requirement identifies situations when the teaching physician is sufficiently involved in the service, and at the same time, it provides a standard that can be readily documented and verified. Payment for teaching physician services provided in teaching settings will be made using the physician fee schedule only if one of the following is met:

- Services are personally furnished by a physician who is not a resident.
- A teaching physician was physically present during the critical or key portions of the service that a resident performs.
- A teaching physician provides care under the conditions outlined in the **Exception for Evaluation and Management (E/M) Services Furnished in Certain Primary Care Centers** (below).

A **teaching setting** is any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the Medicare administrative contractor under the direct GME payment methodology or a freestanding skilled nursing facility (SNF) or home health agency (HHA) in which
such payments are made on a reasonable cost basis. A **non-provider setting** is a health care facility other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility for which residents provide services (e.g., family practice or multispecialty clinics and physician offices). A teaching physician is **physically present** when that teaching physician is located 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. The teaching physician determines the critical or key portion of a service.

If the requirements are met, reimbursement under Medicare Part B may be made. In all situations, the services of a resident are payable through direct GME payment or as reasonable cost payments made by the Medicare administrative contractor.

### Evaluation and Management Services

In the case of evaluation and management services (e.g., office visits and consultations), the teaching physician must be present during the key portion of the service that determines the level of service billed and must personally document his or her participation in the service in the patient’s medical records. For an encounter, the selection of the appropriate level of E/M service is determined according to the code descriptions in the AMA’s CPT coding manual and applicable documentation guidelines.

For purposes of reimbursement, the patient record must contain documentation that the teaching physician performed the service or was physically present during key or critical portions of services performed by a resident and participated in the management of the patient’s care. Upon medical review, the combined entries in the patient record by the teaching physician and the resident constitute the documentation for the service and together must support the level of E/M service billed and the medical necessity of the service. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

If the teaching physician repeats key elements of service components obtained previously and documented by the resident (e.g., patient’s complete history and physical examination), the teaching physician need not repeat documentation of these components in detail. Rather, the teaching physician’s documentation may be brief, summary-type comments that relate to the resident’s entry and that confirm or revise the key elements defined for the purpose of this section as:

- Relevant history of present illness and prior diagnostic tests
- Major finding(s) of the physical examination
- Assessment, clinical impression, or diagnosis
- Plan of care

Thus, documentation of key elements may be satisfied by combined entries in the patient record recorded by the resident and the teaching physician.

**EXAMPLE 1:** **MINIMALLY ACCEPTABLE DOCUMENTATION WHEN ALL REQUIRED ELEMENTS ARE OBTAINED PERSONALLY BY THE TEACHING PHYSICIAN WITHOUT A RESIDENT PRESENT:** The following are examples of minimally acceptable documentation when all required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service and if there are no resident notes, the teaching physician must document the E/M service as if in a nonteaching setting.

- **Admitting note:** “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”
- **Follow-up visit:** “Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.”
• **Follow-up visit:** “Hospital Day #5. I saw and examined the patient. I agree with the resident’s note except the heart murmur is louder, so I will obtain an echocardiogram to evaluate.”

**EXAMPLE 2:** **MINIMALLY ACCEPTABLE DOCUMENTATION WHEN ALL REQUIRED ELEMENTS ARE OBTAINED BY THE RESIDENT:** The following is an example of minimally acceptable documentation when all required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the teaching physician must document his or her presence during performance of critical or key portion(s) of the service and that he/she was directly involved in the management of the patient’s care. The teaching physician’s note should reference the resident’s note. The combination of entries must be adequate to substantiate the level of service billed and the medical necessity of the service.

• **Initial or follow-up visit:** “I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident’s note.”

• **Follow-up visit:** “I saw the patient with the resident and agree with the resident’s findings and plan.”

**EXAMPLE 3:** **MINIMALLY ACCEPTABLE DOCUMENTATION WHEN SELECTED REQUIRED ELEMENTS OF THE SERVICE ARE OBTAINED BY THE RESIDENT IN THE ABSENCE OF THE TEACHING PHYSICIAN AND DOCUMENTS HIS/HER SERVICE:** The following is an example of minimally acceptable documentation when selected required elements of the service (e.g., history and physical examination) are obtained by the resident in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this situation, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the combined entries of the teaching physician and resident must be adequate to substantiate the level of service billed and the medical necessity of the service. The following are examples of acceptable documentation by the teaching physician:

• “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.” (initial visit)

• “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.” (initial or follow-up visit)

• “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.” (follow-up visit)

• “I saw and evaluated the patient. Agree with resident’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.” (follow-up visit)

**EXAMPLE 4:** **UNACCEPTABLE DOCUMENTATION BY THE TEACHING PHYSICIAN:** The following are examples of unacceptable documentation by the teaching physician:

• “Agree with above”

• “Rounded, reviewed, agree”

• “Discussed with resident; agree”

• “Seen and agree”

• “Patient seen and evaluated”

• Legible countersignature or electronic authentication of resident’s note

The above documentation is not acceptable because it is impossible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.
Evaluation and Management Documentation Provided by Medical Students

Any contribution and participation of a medical student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are documented as part of an evaluation and management service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing. Students may document services in the medical record. However, the documentation of an evaluation and management service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision-making activities of the service.

A medical student is an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A medical student is not an intern or a resident. Medicare does not reimburse any service furnished by a student.

Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians who provide E/M services for a GME program that has been granted a primary care center exception may bill Medicare for lower and mid-level E/M services provided by residents. Under this exception, Medicare Part B may be billed for reasonable and necessary low to mid-level evaluation and management services when furnished by a resident without the presence of a teaching physician, if all the following criteria are met:

- The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's Medicare administrative contractor. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits.
- Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of a GME-approved residency program. The center is responsible for furnishing this information to the Medicare administrative contractor upon request.
- The teaching physician may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:
  - Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident.
  - Have the primary medical responsibility for patients cared for by the residents.
  - Ensure that the services furnished are reasonable and necessary.
  - Review the care provided by the resident during or immediately after each visit. This must include a review of the patient’s medical history, the resident’s findings on physical examination, the patient’s diagnosis, and treatment plan (i.e., record of tests and therapies).
  - Document the extent of his/her own participation in the review and direction of the services furnished to each patient.
- The patients seen must be an identifiable group of individuals who consider the center to be their primary location for health care services. The residents must generally provide care to the same group
of established patients throughout the course of their residency program. There is no requirement that the teaching physicians remain the same over any period of time.

- The range of services furnished by residents under this exception include all of the following:
  - Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness
  - Coordination of care furnished by other physicians and providers
  - Comprehensive care not limited by organ system or diagnosis

Types of residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in special situations, such as when the program furnishes comprehensive care for chronically mentally ill patients. These would include facilities in which the range of services that residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care (e.g., antibiotics prescribed as well as psychotropic drugs).

**Split/Shared Evaluation and Management Services**

Billing shared/split evaluation and management services apply to physicians and nonphysician practitioners in the same group practice. These guidelines do not apply to teaching physician services.

**Procedures**

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

**Surgery**

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the patient. The teaching physician’s presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon may determine which postoperative visits are considered “key” and require his or her presence. If the postoperative period extends beyond the patient’s discharge and the teaching surgeon is not providing the patient’s follow-up care, then instructions on billing less than the global package apply.

During nonkey portions of the surgery, if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure (e.g., the teaching surgeon cannot be performing another procedure). If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

- **Single Surgery.** When the teaching surgeon is present for the entire surgery his or her presence may be demonstrated by patient record notes documented by the surgeon, resident, or operating room nurse.

- **Two Overlapping Surgeries on Two Different Patients.** In order to bill for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin a second procedure. The teaching surgeon must personally document in the patient record that he or she was physically present during the critical or key portion of both procedures. When a teaching physician is not present during noncritical or nonkey portions of the procedure and is participating in another surgical procedure, he or she must arrange for another
qualified surgeon to immediately assist the resident in the original case should the need arise. (In the case of three concurrent surgical procedures, the role of the teaching surgeon, but not anesthesiologist, in each case is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not reimbursable by Medicare.)

- **Minor Procedures.** For procedures that take only a few minutes (5 minutes or less) to complete (e.g., simple suture) and that involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

- **Endoscopy Procedures.** In order to bill for procedures performed through an endoscope, the teaching physician must be present during the entire viewing. The entire viewing includes the insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

### Anesthesia

The teaching physician must document in the patient record that he or she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the patient is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist (e.g., Certified Registered Nurse Anesthetist or CRNA), payment will be made as medical direction for the anesthesiologist's services. In order for a teaching physician who provides anesthesia services in a teaching hospital to receive payment from Medicare Part B, he or she must:

- Prescribe the anesthesia plan.
- Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence.
- Ensure that any procedure in the anesthesia plan that he or she does not perform is performed by a qualified individual.
- Monitor the course of anesthesia administration at frequent intervals.
- Remain physically present and available for immediate diagnosis and treatment of emergencies.

The teaching physician must direct no more than four anesthesia procedures concurrently and cannot perform any other service while he or she is directing the concurrent procedures. If the teaching physician is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the concurrent anesthesia services are considered to be physician services to the hospital and should not be billed to Medicare Part B.

A teaching physician will be reimbursed as if he or she personally performed the service, if he or she is involved in a single anesthesia procedure involving a single resident. In order to receive payment as if he or she personally performed the service, the physician cannot perform services involving other patients during the period the anesthesia resident is furnishing services in a single case. Documentation must indicate the teaching physician's presence during induction, emergence, and any other portion of the procedure payable on a time basis. The teaching physician presence is not required during the preoperative or postoperative visits with the patient.

### Other Complex or High Risk Procedures

In the case of complex or high-risk procedures for which national coverage determinations, local coverage determinations, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, Medicare administrative contractors should be billed only when the teaching
physician is present with the resident. The presence of the resident alone does not meet the teaching physician presence requirement necessary for these services. Such procedures include interventional radiologic and cardiologic supervision and interpretation, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

**Psychiatric Services**

The teaching physician will be considered “present” during each visit for which payment is sought if the teaching physician observes the key portion of the visit through a visual device (e.g., one-way mirror, video equipment, and so on). Audio-only equipment does not satisfy the physical presence requirement. Further, the teaching physician supervising the resident must be a physician (e.g., the teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs).

In the case of evaluation and management procedures, the teaching physician must personally document his or her presence and participation in the service in the medical records. The teaching physician's supervision and the resident's therapy session must be conducted simultaneously. Additionally, the teaching physician must be present for the entire length of time of a time based therapy.

For example, if the teaching physician observed 15 minutes of a 30-minute session through a one-way mirror, the teaching physician can bill for 15 minutes only.

**Time-Based Codes**

Certain CPT codes are determined on the basis of time, and the teaching physician must be present for the period of time for which the claim is made. A CPT code that specifically describes a service for 20 to 30 minutes is only payable if the teaching physician is present for 20 to 30 minutes (e.g., critical care services codes). Payment will not be made for time spent by the resident in the absence of the teaching physician.

**Radiology and Other Diagnostic Tests**

Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician. The teaching physician need not be present during the actual performance of a radiologic or other diagnostic test in order to bill for the interpretation of the test. The physician may submit a claim for payment of the interpretation when he reviews the film with the resident or by performing an independent interpretation, as long as all the following criteria are met:

- The service provided for the patient must be meaningful from the standpoint of affecting the course of treatment and not merely a routine review of a report for purposes of quality control, authorization, validation, or teaching.
- If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. A countersignature alone of the resident's interpretation by the teaching physician is not acceptable documentation.
- If the teaching physician's signature is the only signature on the interpretation, Medicare will assume that he or she personally performed the interpretation.

**Miscellaneous**

In the case of maternity services furnished to Medicare-eligible women, the physician presence requirement for both types of delivery will be applied in the same manner as it is for surgery. In order to bill Medicare for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different.
from other surgery codes in that there are separate codes for global obstetrical care (prenatal, delivery, and postpartum) and for deliveries only.

**Moonlighting**

The phrase “services of moonlighting residents” refers to services that licensed residents perform outside the scope of an approved GME program. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physicians’ services as long as they meet the bulleted items below. Similarly, medical and surgical service furnished by interns and residents that are not related to their training program and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians’ services and paid on a reasonable charge basis where all of the following criteria are met:

- The services are identifiable physicians’ services, the nature of which requires performance by the physician in person and which contributes to the diagnosis or treatment of the patient’s condition.
- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed.
- The services can be separately identified from those services that are required as part of the approved GME program. (Contracts and agreements must be available for review to ensure compliance.)

When the above criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not their capacity as interns and residents.

**Assistants-at-Surgery in a Teaching Hospital**

An assistant-at-surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (A nurse practitioner, physician assistant, or clinical nurse specialist authorized to provide such services under state law can also serve as an assistant-at-surgery.) The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

Payment may be made for an assistant-at-surgery in a teaching hospital if the services meet one of the following conditions. The services:

- Are required as a result of exceptional medical circumstances, (e.g., emergency, life-threatening situations such as multiple traumatic injuries that require immediate treatment).
- Are complex medical procedures performed by a team of physicians, each performing a discrete, unique function integral to the performance of a complex medical procedure that requires the special skills of more than one physician.
- Constitute concurrent medical care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.
- Are medically required and are furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon has an across-the-board policy of never using interns or residents in the surgical procedures that the surgeon performs (including preoperative and postoperative care); generally, this exception is applied to community physicians who have no involvement in the hospital’s GME program and in such situations, payment may be made for reasonable and necessary services on the same basis as in a nonteaching hospital.
- Are not related to a surgical procedure for which the CMS determines that assistants are used less than 5 percent of the time.
Payment under Medicare Part B is not available for assistants-at-surgery in hospitals with (1) a training program relating to the medical specialty required for the surgical procedure and (2) a resident in a training program relating to the specialty required for the surgery was available to serve as an assistant at surgery.

There may be some instances when no qualified residents are available to assist in surgery due to a number of factors, such as involvement in other activities, complexity of the surgery, number of residents in the program, or other valid reasons. In these instances, the following statement must be provided as an attachment to the CMS-1500 claim:

I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants-at-surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified resident was available to perform the services. I further understand that these services are subject to postpayment review by the Medicare administrative contractor.

This certification statement is for use only when the basis for payment is the unavailability of qualified residents in a teaching setting.

There are some situations when the services of physicians of different specialties are necessary during surgery and when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services.

For example, a patient's cardiac condition may require that a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant-at-surgery, and payment is made on a regular fee schedule basis.

**Critical Care**

Critical care services are time-based services. A critical care service in a teaching hospital therefore can only be billed using the time that the teaching physician was in actual attendance in work related to the individual patient's care. When a bill is submitted for any procedure code determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. Because critical care is a time-based code, the teaching physician's progress note must contain documentation of total time involved providing critical care services. Document the date and time spent with the patient on all notes. If the time and date are not legibly and unequivocally documented, the service may be subject to reduction or denial. When calculating time of a critical care service in a teaching hospital, the following should be considered:

- Time spent teaching (residents and/or medical students) may not be counted towards the critical care service time
- The teaching physician must be present for the period of time for which the claim is made
- The teaching physician cannot bill time spent by the resident in the absence of the teaching physician

Documentation supporting the services as medically necessary and reasonable must be evident in the patient's record. The presence and involvement of the teaching physician should be reflected in the medical record. The documentation should be written in such a way that it would be clear to anyone who looked at the medical record at a later date, that the involvement of the teaching physician justified the service billed. Points to remember when documenting critical care services in a teaching hospital:

- The teaching physician's countersignature of the resident's note alone does not document that a physician was present during the key portion of the service. Although it is not necessary for the teaching physician to repeat all of the documentation entered into the medical record by the resident, the teaching physician should enter additional notes to indicate his/her involvement in the service. The teaching physician's
documentation should refer to the resident’s note and provide summary comments that establish, revise, or confirm the resident’s findings and the appropriate level of service required by the patient.

- It is not acceptable for the resident to document that he/she is “rounding with” or “being supervised by” the teaching physician, or for the teaching physician to document “seen, examined and agree with the resident.” The note in the patient’s record must support the presence, activity and involvement of the teaching physician.

- When all required elements of the service (e.g., history, examination, and medical decision making) are obtained and documented by the resident in the presence of or jointly with the teaching physician, the resident’s note may document the teaching physician’s direct observation, performance, and personal input. The teaching physician’s direct personal documentation may be limited, but at a minimum must include a confirmation of each component of the resident’s documentation and the teaching physician’s presence during the service. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

**Modifiers**

Modifiers are two-character alphabetical, numerical, or alphanumeric extensions that are attached to CPT and HCPCS level II national codes (e.g., 12345-GC) to provide additional information about procedures performed and services. The following HCPCS/CPT modifiers should be reported with the applicable procedure and service codes (99201-99203, 99211-99213, G0402, G0438, and/or G0439) for teaching physician services:

- **GC**: Service has been performed in part by a resident under the direction of a teaching physician
- **GE**: Service has been performed by a resident without the presence of a teaching physician under the primary care exception. (Modifier -GE is reported for all services except ambulance services.)
- **82**: Assistant Surgeon, when qualified resident surgeon not available. (The unavailability of a qualified resident physician surgeon is a prerequisite for reporting modifier -82 with the procedure code. This modifier is used in teaching hospitals if there is no approved training program related to the medical specialty required for the surgical procedure or no qualified resident was available.)