

Understanding Teaching Physician Guidelines: The Do's and the Don'ts through FAQs

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Why do we have Teaching Physician Guidelines?

- The Centers for Medicare and Medicaid Services (CMS) issue guidelines outlining how and when clinical services are coded, billed, and reimbursed for those physicians teaching interns, residents, fellows, and medical students during patient treatment.
- These guidelines took on additional urgency when in 1996 the Department of Health and Human Services Office of Inspector General (OIG) announced a “series of nationwide reviews of compliance with rules governing physicians at teaching hospitals (PATH) and other Medicare payment rules” in order to ensure that these teaching guidelines were followed.

Why do we have Teaching Physician Guidelines?

- The initiative grew out of OIG's 1995 audit of Medicare Part B billings at Clinical Practices of the University of Pennsylvania.
 - It resulted in the government's recovery of more than \$30 million.
- A similar settlement was reached with the Thomas Jefferson University Medical Center for nearly \$12 million in 1996.
- OIG reported through the review that care levels were not supported by physician medical record documentation.

Why do we have Teaching Physician Guidelines?

- The PATH audits led to the creation of compliance programs at major teaching institutions across the United States
 - These institutions were forced to pay settlements to the federal government due to abuses found when teaching physicians either did not meet the physical presence requirements when residents or fellows performed services or did not properly document their role in the billing of those services.

What is Documentation and Why is it Important?

- Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history including past and present illnesses, examinations, tests, treatments and outcomes.
- The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

What is Documentation and Why is it Important? (cont'd)

- An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What is Documentation and Why is it Important? (cont'd)

- There is a phrase used in coding circles to describe the importance of medical record documentation:

**“IF IT’S NOT DOCUMENTED
IT WASN’T DONE.”
(for professional billing purposes)**

The Medical Record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the **patient’s immediate treatment**, and to monitor his/her health care over time;
- **Communication and continuity of care** among physicians and other health care professionals involved in the patient’s care;
- Accurate and timely **claims review and payment**;

The Medical Record facilitates: (cont'd)

- Appropriate **utilization review** and quality of care evaluations;
- The collection of data that may be useful for **research and education**;
- Documentation for **risk management** and **medical malpractice cases**; and
- Establishes the basis for **professional fee billing**.

Resources

Transmittal 811 issued January 13, 2006
&
Transmittal 2247 effective June 1, 2011
by
Centers for Medicare & Medicaid Services (CMS)
clarifies documentation requirement (E/M)
services billed by teaching physicians.

Resources for Teaching Physician Guidelines

- Changes were made to the Medicare Carriers Manual by the Centers for Medicare and Medicaid Services (CMS) pursuant to Transmittal 1780 implemented on November 22, 2002.
 - Included were changes made to documentation required of teaching physicians for services performed by resident physicians, medical student contributions to documentation and performed services, and the definition of the critical or key portions of an E/M service.
- Then updates occurred pursuant to Transmittal 2247 effective June 1, 2011. View the complete transmittals:
 - [CMS Manual System Pub 100-04 Medicare Claims - Transmittal 2247](#)
 - [CMS Manual System Pub 100-04 Medicare Claims - Transmittal 811](#)
 - [Medicare Carriers Manual Part 3 - Transmittal No. 1780](#)
 - [CMS Manual System Pub 100-04 Medicare Claims - Transmittal 2303](#)

Definitions

- **Resident** means an individual who participates in an approved graduated medical education (GME) program or a physician who is not in an approved program but who is authorized to practice only in a hospital setting. **The term includes interns and fellows in GME programs.**
- **Student** means an individual who participates in an accredited educational program (e.g. a medical school). **A student is never considered to be an intern or a resident.** Medicare does not pay for any service furnished by a student.

Definitions

- **Teaching Physician** means a physician (**other than another resident**) who involves residents in the care of his/her patients.
- **Critical or key portion** means that part (or parts) of a service that the teaching physician determined is (are) a critical or key portion(s).
- The terms are interchangeable.

Definitions

- **Documentation** means notes recorded in the patient's medical records by a resident, and/or teaching physician regarding the service furnished.
- **Physically present** means that the teaching physician is located in the same room as the patient and/or performs a face-to-face service.

Top Ten Frequently Asked Questions (FAQs)

FAQ 1. Do the Teaching Physician Guidelines apply to medical students, interns, residents, and fellows?

- The Teaching Physician Guidelines apply to the care provided by interns, residents, and fellows ("residents").
- Transmittal 1780 states that, **"resident means 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."**
- The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

FAQ 1. Do the Teaching Physician Guidelines apply to medical students, interns, residents, and fellows? (cont'd)

- 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.

FAQ 1. Do the Teaching Physician Guidelines apply to medical students, interns, residents, and fellows? (cont'd)

- "Certain fellows may not meet the definition of a 'resident' in Transmittal 1780 and may be eligible to perform, document, and bill for services without additional oversight.
- A medical student is never considered to be an intern or resident and no service furnished by a medical student qualifies as a billable service under Medicare

FAQ 1. Do the Teaching Physician Guidelines apply to medical students, interns, residents, and fellows? (cont'd)

- A medical student is never considered to be an intern or resident and no service furnished by a medical student qualifies as a billable service under Medicare.
- In addition, certain state regulations and other payer guidelines also have supervisory stipulations concerning medical students.
- Refer to local payer and state regulations for guidance.

FAQ 2. What is the basic requirement in order for the teaching physician to bill Medicare Part B for E/M service reimbursement?

- In general, Medicare will pay for physician services furnished in a teaching setting under the physician fee schedule **only** if the services are furnished:
- **Personally by a teaching physician** who is not a resident

FAQ 2. What is the basic requirement in order for the teaching physician to bill Medicare Part B for E/M service reimbursement?

- **By a resident seeing a patient in the "physical presence" of a teaching physician** who documents his or her presence during the performance of the critical or key portions of the service and discussion of the case with the resident
- **Jointly by a teaching physician and a resident, seeing the patient at different times during a visit,** provided the teaching physician independently performs the critical or key portions of the service and documents discussion of the case with the resident

FAQ 3. What are the basic documentation guidelines that the teaching physician must follow in order for his or her E/M services to be recognized by Medicare?

- For purposes of payment, the teaching physician **must at a minimum** enter a personal notation documenting his or her performance of and/or physical presence during the key or critical portions of the service (as his/her performance of and/or physical presence during the key or critical portions of the service).
- In addition, the teaching physician must document his/her participation in the management of the patient.

FAQ 3. What are the basic documentation guidelines that the teaching physician must follow in order for his or her E/M services to be recognized by Medicare?

- Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.
- Transmittal 811 provides guidance on the use of macros and electronic medical records.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #1

- The teaching physician performs all the requirements of an E/M service.
- The teaching physician must document as he or she would in a non-teaching setting or, where a resident has written notes, the teaching physician's note may reference the resident's note.
- The teaching physician must document that he or she performed, or personally supervised the resident's performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #1

- For payment, the composite of the teaching physician's entry and the resident's entry ***together*** must support the medical necessity of the billed service and the level of the service billed by the teaching physician.
- ***In the absence of a note by a resident,*** the teaching physician must document as he or she would document an E/M service in a non-teaching setting.
- In this circumstance, the teaching physician must personally perform all the requirements of an E/M service.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #2

- The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents this service.
- In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #2

- The teaching physician's note should reference the resident's note.
- For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #3

- The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his or her service.
- The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, discusses the case with the resident.
- In this instance, 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.

Transmittal 1780 offers three common scenarios for teaching physicians providing E/M services.

Common Scenario #3

- The teaching physician's note should reference the resident's note.
- For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Transmittal 811 provides guidance on the use of macros and electronic medical records

- Documentation may be dictated, typed, hand-written, or computer-generated. Documentation must be dated and include a legible signature or identity.
- Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

Transmittal 811 provides guidance on the use of macros and electronic medical records

- In the context of an electronic medical record, the term 'macro' means **a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.**

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation **IF** the teaching physician adds it personally in a secured (password protected) system.

Transmittal 811 provides guidance on the use of macros and electronic medical records

- In addition to the teaching physician's macro, either the resident or the teaching physician **must** provide customized information that is sufficient to support a medical necessity determination.
- The note in the electronic medical record **must** sufficiently describe the specific services furnished to the specific patient on the specific date.
- **It is insufficient documentation if both the resident and the teaching physician use macros only.**

FAQ 4. Has CMS provided examples of acceptable and unacceptable teaching physician documentation?

Examples of unacceptable teaching physician documentation include:

- "Agree with above" followed by legible countersignature or identity
- "Rounded, Reviewed, Agree" followed by legible countersignature or identity
- "Discussed with resident. Agree" followed by legible countersignature or identity

FAQ 4. Has CMS provided examples of acceptable and unacceptable teaching physician documentation?

Examples of unacceptable teaching physician documentation include:

- "Seen and agree" followed by legible countersignature or identity
- "Patient seen and evaluated" followed by legible countersignature or identity
- A legible countersignature or identity alone
- Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

FAQ 4. Has CMS provided examples of acceptable and unacceptable teaching physician documentation?

Examples of minimally acceptable documentation include:

- "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."
- "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."

FAQ 4. Has CMS provided examples of acceptable and unacceptable teaching physician documentation?

Examples of minimally acceptable documentation include:

- "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."
- On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Examples of Minimal Acceptable Documentation

- On the fifth day of an inpatient stay follow-up visit, the teaching physician writes, "I saw and examined the patient, and I agree with the resident's note except the heart murmur is louder. I will obtain an echo to evaluate."
- In an initial visit, the teaching physician states, "I saw and evaluated the patient. I reviewed the resident's note and agree that picture is more consistent with pericarditis than myocardial ischemia. Agree with resident's plan to begin NSAIDs."
- In a follow-up visit, the teaching physician writes, "I saw and evaluated the patient. Agree with resident's note, but lower extremities are not weaker. Will not do MRI of L/S spine at this time."

FAQ 5.

What is the definition of the critical or key portion(s) of a patient's evaluation?

- As defined by CMS, critical or key portion means **"that part (or parts) of a service that the teaching physician determines is (are) a critical or key portions."**
- For a given encounter, the selection of the appropriate level of Evaluation and Management (E/M) service should be determined according to the code definitions in the AMA CPT book and any applicable documentation guidelines.

FAQ 5.

What is the definition of the critical or key portion(s) of a patient's evaluation?

- Transmittal 1780 states that for the purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:
- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient

FAQ 6.

What service must be provided and documented in order for the teaching physician to bill Medicare for surgical procedures?

- For minor surgical procedures (lasting less than five minutes), the teaching physician must be physically present during the entire service.
- For major procedures (lasting more than five minutes), the teaching physician must be physically present during the "key portion(s)" of the service and **must be immediately available** to furnish service during the entire procedure.

The teaching physician must document the extent of his/her participation.

FAQ 6.

What service must be provided and documented in order for the teaching physician to bill Medicare for surgical procedures?

- **Single Surgery:**
 - Must be present during all key portions of the procedure.
 - Must be immediately available to provide services during the entire procedure.
 - Not required to be present during the opening and closing of the surgical area unless these activities are considered to be critical or key portions of the procedure.
 - During the periods of the surgery which are not key portions, the teaching physician must be immediately available to return to the procedure.

FAQ 6.

What service must be provided and documented in order for the teaching physician to bill Medicare for surgical procedures?

- **Two Overlapping Surgeries**
 - Must be present during the critical or key portions of both operations.
 - Must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures.

FAQ 6.

What service must be provided and documented in order for the teaching physician to bill Medicare for surgical procedures?

- Two Overlapping Surgeries
 - When a TP is not present during non-critical or key portion(s) of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.
 - The TP may not bill for three or more concurrent surgical procedures. These are classified as a supervisory service to an individual patient and are not payable under the physician fee schedule.

FAQ 6.

What service must be provided and documented in order for the teaching physician to bill Medicare for surgical procedures?

- Endoscopy procedures:
 - The TP must be present during the entire viewing, including 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.

FAQ 7. Must the teaching physician be present in order to appropriately bill Medicare for timed services like critical care and moderate sedation?

- Time spent by the resident, in the absence of the teaching physician, cannot be billed by the teaching physician as critical care or other time-based services.
- Time spent teaching may not be counted towards critical care time.
- Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted when reporting a time based code.

Time-Based Codes

- Time
 - May be used as the Key Factor in selecting a level of service if more than 50% of the time spent during the visit was for counseling and/or coordination of care
 - Face-to-face time with patient in outpatient setting
 - Unit/Floor time in inpatient setting
 - Total time of encounter and the extent of counseling/coordination must be documented
eg. 15/25 minutes spent = 99214

Time-Based Codes

- Teaching Physician must be present for the period of time for which the claim is made.
- Time spent by the resident in the absence of the TP should not be added to time spent by the teaching physician.

FAQ 8. What are the specific requirements for Medicare billing when a resident has been involved in the care of a patient?

- When the CMS 1500 form is filled out certain modifiers are required by Medicare to provide information in respect of teaching physician services that do not affect payment levels.
- In the case of teaching physicians, two modifiers are available and are found in the HCPCS Level II National Modifier list.
 - These modifiers are reported in the modifier column of the CMS1500 form next to the service to which they are being applied.
 - These modifiers must be added if the service of a resident is being counted for credit towards the documentation requirements of a teaching physician.
 - These modifiers must be added to all such services or procedure codes that had resident participation.

FAQ 8. What are the specific requirements for Medicare billing when a resident has been involved in the care of a patient?

- GC
This service has been performed in part by a resident under the direction of a teaching physician. (The usual circumstance in an ED with residents working under the guidance and supervision of teaching physicians.)
- GE
This service has been performed by a resident without the presence of a teaching physician under the primary care exception.

FAQ 9. What are the specific performance and documentation requirements for Medicare billing when a medical student has been involved in the care of a patient?

- An independent evaluation or procedure provided by a medical student cannot be used in determining the appropriate Medicare services.
- Any contribution and participation of a medical student to a billable service **(other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service)** must be performed in the physical presence of a resident and/or teaching physician.
- Students may also document services in the medical record; however, the teaching physician must verify and **redocument** the HPI, examination, and medical decision making of the student.

FAQ 9. What are the specific performance and documentation requirements for Medicare billing when a medical student has been involved in the care of a patient?

- An ROS, PFSH performed and documented by a medical student must be confirmed with the patient and the teaching physician must document his/her confirmation of the ROS, PFSH.
- Teaching physicians can involve students in services they personally perform.
- CMS allows the teaching physician who personally performs an evaluation or procedure to personally supervise medical student involvement.

FAQ 9. What are the specific performance and documentation requirements for Medicare billing when a medical student has been involved in the care of a patient?

- If a medical student is involved in a procedure performed by a resident, the teaching physician may supervise and bill for that procedure providing the documentation requirements described in FAQ 6 are met.
- In addition, certain state regulations and other payer guidelines also have supervisory stipulations concerning medical students.
- Refer to local payer and state regulations for guidance.

FAQ 10. What are the specific requirements for Medicare billing when a resident has been involved in interpretation of diagnostic radiology and other diagnostic test?

- Medicare pays for the interpretation of diagnostic radiology and other diagnostic test if the interpretation is performed by or reviewed with a teaching physician.
- If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he/she is indicating that he/she personally performed the interpretation.

FAQ 10. What are the specific requirements for Medicare billing when a resident has been involved in interpretation of diagnostic radiology and other diagnostic test?

- If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.
- Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

Primary Care Exception

Outpatient E/M services must be documented the same as Inpatient E/M Services

BUT.....

THERE IS AN EXCEPTION

Primary Care Exception

- What qualifies a practice for PCE?
 - When the Outpatient service is performed in the outpatient department of a hospital or another setting included in the calculation of GME **AND** the department (clinic) is operating under the Primary Care Exception (PCE).
- The following residency programs are most likely to qualify under PCE:

OB/GYN Family Practice
Pediatrics Geriatric Medicine
General Internal Medicine

Primary Care Exception

- Allows teaching physicians providing E/M services to bill for the following lower and mid-level E/M services provided by Residents **IN THE ABSENCE** of a Teaching Physician.

Medicare

New Patient

99201

99202

99203

G0402 – IPPE (Welcome to Medicare)

G0438 – Annual Wellness Visit – First

G0439 – Annual Wellness Visit - Subsequent

Established Patient

99211

99212

99213

Primary Care Exception

Medicaid

<u>New Patient</u>	<u>Established Patient</u>
99201	99211
99202	99212
99203	99213
99381	99391
99382	99392
99383	99393
99384	99394

Primary Care Exception

- A primary care center must attest in writing that all of the following conditions are met for a particular residency program **and** the following guidelines must be adhered to:
 - The Resident must:
 - Have at least six (6) months in approved GME program
 - The Teaching Physician must:
 - Direct the care from such proximity as to constitute immediate availability;
 - Not supervise more than four (4) residents at any given time;
 - Not have other responsibilities (including the supervision of other personnel) at the time the service was proved by the resident;

Primary Care Exception

- The Teaching Physician must:
 - Have primary medical responsibility for the patients cared by the residents;
 - Ensure that the care provided is reasonable and necessary;
 - Review the case with the resident during or immediately following 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; and
 - Document the extent of his/her own participation in the review and direction of services furnished to each patient.

Primary Care Exception

- The primary care center is considered the patients' primary location for health care services.
- Residents must be expected to generally furnish care to the same group of established patients during their residency training.
- The types of services furnished by residents under the primary care exception include:
 - Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness;
 - Coordination of care furnished by other physicians and providers; and
 - Comprehensive care not limited by organ system or diagnosis.

Thank you for your attendance!



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