Applying the Teaching Physician Guidelines - Retired

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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.[1]

The initiative grew out of OIG's 1995 audit of Medicare Part B billings at Clinical Practices of the University of Pennsylvania, which resulted in the government's recovery of more than $30 million. OIG reported through the review that care levels were not supported by physician medical record documentation. A similar settlement was reached with the Thomas Jefferson University Medical Center for nearly $12 million in 1996.[2,3]

The PATH audits led to the creation of compliance programs at major teaching institutions across the United States, often because those 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.

HIM professionals must understand the guidelines to accurately code and bill medical services properly and handle PATH audits. This practice brief outlines the basics of the guidelines, including the role of the trainee and teaching physician, and what HIM professionals should look for in clinical documentation to properly code and bill services.

Teaching Physician Rules

Resident services are paid directly to hospitals via the Accreditation Council for Graduate Medical Education (ACGME). Teaching physicians are paid for their involvement in the care of patients, not for time spent teaching.

According to the *Medicare Part B Reference Manual:*

> In the teaching setting, physician services provided to individual patients are considered to be the payment responsibility of the Part B carrier. Conversely, physician services that are furnished for the general benefit of patients (i.e., supervising and teaching of residents) are considered to be services to the hospital and are therefore the payment responsibility of the Part A intermediary.[4]

In other words, teaching physicians who intend to bill for their services must document their involvement in the specific care of the patient.

Take for example a resident who admits a patient to the hospital during the early hours of the morning. Later that morning the attending physician rotates through and sees and evaluates the patient.

The attending physician must first link his or her note to that of the resident's and then write a brief attestation indicating that he or she agrees with (or modifies) the resident's findings in order to bill for the admission. A case where the attending teaching physician does not agree with the resident's findings provides a teaching opportunity. However, the teaching physician bills for specific involvement in the evaluation of that patient, not for teaching the resident.

When it comes to following the teaching physician guidelines for billing, interns, residents, and fellows who fall under an approved Graduate Medical Education (GME) program are treated identically. Interns are first-year residents. Fellows are physicians in training to become specialists.

Medical students are not licensed physicians; they are students. As such, they are not treated the same as residents. Medicare does not pay for services furnished by a student, nor may the teaching physician use the student's documentation for billing purposes, with two small exceptions. The only documentation the teaching physician may refer to is the review of systems and the past medical, family, and social history elements of the history component within an evaluation and management service.

Residents are commonly seen in hospitals because teaching hospitals receive federal GME payments for resident services. Residents and fellows are involved in many aspects of patient care, including evaluation and management services, procedures, and diagnostic testing. The GME payment goes to the hospital for training the residents and is disbursed as resident salaries. Teaching physicians are paid for their direct services to the patient.

From time to time, one encounters a resident trainee in the community practice setting. Those arrangements are often set up as agreements between the teaching hospital and the physician practice.

Common Terms in the Teaching Physician Guidelines

Approved Graduate Medical Education (GME) program: a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, the Council on Dental Education of the American Dental Association, or the Council on Podiatric Medicine Education of the American Podiatric Medical Association.[1]

Critical or **key portion:** the part or parts of a service that the teaching physician determines are a critical or key portion.[2]

Physically present (physical presence): when the teaching physician is located in the same room as the patient (or a room that is subdivided with partitioned or curtained areas to accommodate multiple patients) and/or performs a face-to-face service.[3]

Resident: 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 (e.g., has a temporary or restricted license or is an unlicensed graduate of a foreign medical school). Also included in this definition are **interns** and **fellows** in GME programs recognized as approved for purposes of direct GME payments made by fiscal intermediaries. Receiving a staff or faculty appointment, participating in a fellowship, or whether a hospital includes the physician in its full-time equivalency count of residents does not by itself alter the status of "resident."[4] Within this practice brief, the terms *house officer, house staff, resident, intern,* or *fellow* may be used interchangeably.

Student: an individual who participates in an accredited educational program (e.g., medical school) that is not an approved GME program and is not considered an intern or resident. Medicare does not pay for any services furnished by a student.[5] In other words, a student is never considered to be an intern or resident.

Teaching physician: a physician, other than an intern or resident, who involves residents in the care of his or her patients. Generally, the teaching physician must be present during all critical and key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the Medical Physician Fee Schedule.[6] Within this brief, the terms *teaching physician* and *attending physician* may be used interchangeably.

Notes

1. Centers for Medicare and Medicaid Services (CMS). *Medicare Part B Reference Manual.* "Teaching Physician's Billing Guide." March 2003.
2. CMS. "Guidelines for Teaching Physicians, Interns, and Residents." July 2008. Available online www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf.
3. Ibid.

4. Ibid.
5. Ibid.
6. Ibid.

Moonlighting Residents

It is important to bear in mind that residents have completed medical school and are licensed physicians. As physicians, they may be asked to provide "services outside the scope of an approved training program (moonlighting)" where there is a need.[5] In most cases, moonlighting is only permitted if:

- It is performed outside the facility where training takes place.
- The services are identifiable physician services, the nature of which require performance by a physician in person and contribute 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.[6]

There are exceptions to this rule if the services are furnished in an outpatient department or emergency room of the hospital where the resident is being trained. The services furnished need to be separately identified from those services that are required as part of the training program.[7]

The moonlighter's services must be billed to the Part B insurance company under the physician's name and National Provider Identifier number. Thus the physician must go through the insurance company's credentialing and contracting process, not always a reasonable or efficient task. In these cases, the resident is no longer treated as a trainee but as a physician.

In 2003 ACGME imposed resident duty hour limits of 80 hours a week. The Institute of Medicine has proposed additional restrictions, which include counting moonlighting hours outside the 80-hour weekly limit. ACGME is currently soliciting comments on these recommendations.

Documentation Rules

The teaching physician guidelines do not place restrictions or rules for residents. Instead, the focus for documentation is on the professional services provided by the teaching physician. The requirements for teaching physician documentation vary with the type of service being provided.

Evaluation and management services that are billed by teaching physicians are required, at a minimum, to contain the following documentation:

- The service(s) performed by the teaching physician or the teaching physician's physical presence during the key or critical portions of the service performed by the resident
- The participation of the teaching physician in the management of the patient

The documentation and statement that attest to this are often called the "linking statement," which must be recorded by the teaching physician. Resident documentation of the teaching physician's presence and participation is not sufficient. The combined documentation of the resident and the teaching physician will constitute the documentation for the service and together must support medical necessity.

The following examples illustrate 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."

The following instances, followed by a legible countersignature or identity, illustrate insufficient documentation:

- "Agree with above…"
- "Rounded, reviewed, agree…"
- "Discussed with resident. Agree…"
- "Seen and agree…"
- "Patient seen and evaluated…"

In addition, a countersignature alone is insufficient documentation.

In these instances it is not possible to determine whether the teaching physician was present, evaluated the patient, or had any involvement in the plan of care.

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. The portions that are considered to be "key" and "critical" are determined by the teaching physician, but they must be legitimate and justifiable. This cannot be limited to opening and closing. The documentation of the teaching physician's presence may be noted by anyone, typically an operating room nurse or resident.

Any procedure that takes fewer than five minutes to complete is considered a minor procedure. In order to bill under the teaching physician guidelines, the teaching physician must be present during the entire procedure.

Interpretation of radiology and other diagnostic testing may be performed by a resident and billed by the teaching physician if the following criteria are met:

- The test is medically necessary and not merely a routine review done for teaching or validation purposes.
- If the resident documents and signs the interpretation, the teaching physician must indicate that he or she has also reviewed the image and the resident's interpretation and either agrees or edits the findings. A countersignature is not sufficient. The teaching physician does not have to be physically present during the test.[8]

When documenting for psychiatric services, the teaching psychiatrist may meet the physical presence requirement by concurrently observing services provided by the resident through a one-way mirror or via video equipment.

Audio-only equipment or subsequent videotape viewing do not meet the physical presence requirements. The teaching physician must also be a physician-the Medicare Teaching Policy does not apply to psychologists who supervise psychiatry residents.[9]

Time-based Codes and Resident Involvement

certain services are reimbursed based upon the time the physician spends with the patient. Coding for these services requires that documentation specify the time spent. When a teaching physician is involved in supervising a resident in these types of services, only the time spent by the teaching physician counts. In other words, "for procedure codes to be determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made."[1]

Critical care examples include:

- 99291, Evaluation and management of the critically ill or critically injured patient; first 30–74 minutes
- 99292, Evaluation and management of the critically ill or critically injured patient; each additional 30 minutes

If a resident is involved in the delivery of critical care, the teaching physician may bill only for the time spent delivering the care to that patient. If the teaching physician was present for only 20 minutes, then he or she may not bill for critical care because the time spent does not satisfy the 30–74 minute requirement. He or she must select another appropriate E/M (visit code) based upon documentation-not time spent delivering critical care. The

resident's time does not count. Additionally, for critical care services, the first 0–29 minutes of critical care services is not separately reportable as critical care, even if completed by the teaching physician.

Two additional examples illustrate hospital discharge day management:

- 99238, Hospital day discharge management; 30 minutes or less
- 99239, Hospital day discharge management; more than 30 minutes

Since 99238 is for 30 minutes or less, it does not necessarily require that time be documented. There are those occasions that the hospital discharge activities may take longer than 30 minutes. It is not out of the ordinary for a resident to take on many of these related activities, including documenting the final discharge summary. However, to bill for the higher level 99239, only the time spent by the attending physician counts. The attending physician or resident must document the time spent if greater than 30 minutes in order to bill for the higher level of service. By the same token, if the resident completes all discharge duties, and the attending has not personally been involved in discharging the patient (over the phone does not count), then the attending may not bill for either code.

Evaluation and Management Services

E/M codes are generally selected based upon documentation of patient history, physical examination, and medical decision making. The complexity of the patient should warrant the amount of documentation and the level of service selected to be billed. However, there are those times when time becomes a contributing factor.

Say for instance, a patient presents who has been diagnosed with an eating disorder. The physician may take an updated history, perform a very abbreviated (if any) exam, and then spend the majority of the visit talking with the patient. In this circumstance, the physician may bill based upon time spent, with specific notations of the care provided, total time spent with the patient, and how much time was spent counseling. Note that more than 50 percent of the total time must be spent face-to-face with the patient counseling and coordinating care in order for a visit to be considered for time-based coding.

If a resident is involved in this visit, the visit may not be coded based upon resident time spent with the patient. Only face-time by the attending physician is countable. Of course, if the resident has documented any history, exam, and plan of care, the visit could then default to what the resident's documentation supports, with the appropriate involvement and written attestation of the teaching physician.

Other examples of time-based codes for which the same rules apply include prolonged services, care plan oversight, and individual medical psychotherapy (90804–90829).

Note

1. Centers for Medicare and Medicaid Services. *Medicare Part B Reference Manual*, "Teaching Physician's Billing Guide." March 2003.

Coding and Billing

As noted above, residents' services are paid to the hospital by the GME, and a teaching physician is paid for specific involvement in the care of the patient, not for time spent teaching. Physicians bill for their services as usual, except that Medicare and certain other carriers may require that they append a modifier to the CPT code to indicate that a resident was involved. One of two modifiers may be used:

- GC, the service has been performed partially by the resident under the direction of a teaching physician
- GE, the service has been performed by a resident without the presence of a teaching physician under the primary care exception rules

Neither of these modifiers affects payment to the teaching physician. They simply inform the carrier that a resident was involved in the care of the patient.

A primary care exception is when a resident can see patients for certain level office visits without a teaching physician present. The site must apply and follow certain conditions.

When a site is granted a primary care exception, certain evaluation and management services may be furnished and billed in the absence of a teaching physician. They are 99201, 99202, 99203, 99211, 99212, 99213, and, effective January 1, 2005, G0344. These codes must have the modifier GE to be billed under the primary care exception.[10]

Prior approval is not needed, but sites following the primary care exception must maintain records demonstrating that they qualify for the exception. Requirements, needed in writing to apply include:

- Services must be provided at a site 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 fiscal intermediary.
- The resident providing billable visits without the teaching physician present must have completed six months or more of a GME-approved residency program.

Programs that will most likely qualify for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Some GME programs in psychiatry may qualify in special situations, such as when the program furnishes comprehensive care for chronically mentally ill patients. These are centers in which the ranges of services the residents are trained to provide, and actually do provide, include comprehensive medical care as well as psychiatric care.

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care where they can be immediately available. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the visit was provided by the resident.
- Have the primary medical responsibility for patients cared for by the residents.
- Ensure that the care provided was reasonable and necessary.
- Review the visit and care provided by the resident during or immediately after each encounter. This must include a review of the patient's medical history, the resident's findings on physical exam, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies).
- Document his or her own participation in the review and the outcome of the services furnished to each patient encounter.

Patients under this GME exception should consider the center of care to be their primary location for healthcare visits. The residents must be expected to provide care to the same group of established patients during their residency training. The types of visits provided by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for continuing conditions, including chronic mental illness
- Coordination of care furnished by other physicians and providers
- Comprehensive care not limited by organ system, body area, or diagnosis

Documenting Care in EHRs

Understanding the teaching physician guidelines and implementing them in a hospital's electronic health record can be tricky. In order for a physician to bill for his or her services, mainly visits and procedures, the accompanying documentation must support them. Billing for teaching physician services requires including any teaching physician link to the resident's note as well as a personal attestation to the actual work done by the attending.

On paper, this was relatively simple, though sometimes messy. The teaching physician could simply write a linking statement and an attestation at the bottom of the resident's documentation. In the electronic world, it is more complicated.

Systems may not permit a teaching physician to simply add the necessary documentation and attestation at the bottom of a resident's note. Copying and pasting may become commonplace. It becomes a challenge between the physician practice, the compliance office, information systems staff, and the hospital to make certain that the systems function properly for all end users. Understanding and satisfying the teaching physician rules are a good starting point.

Notes

1. Association of American Medical Colleges. "Background Paper Physicians at Teaching Hospitals (PATH) Initiative." October 20, 1997. Available online at www.aamc.org/advocacy/library/teachphys/bckgrnd.htm.
2. Ibid.
3. Maruca, William H. "Challenging Medicare Teaching Phycisian Audits."*Physician's News Digest,* March 1997. Available online at www.physiciannews.com/law/397maruca.html.
4. Centers for Medicare and Medicaid Services (CMS). *Medicare Part B Reference Manual*. "Teaching Physician's Billing Guide." March 2003.
5. CMS. "Guidelines for Teaching Physicians, Interns, and Residents." July 2008. Available online www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf.
6. Ibid.
7. Ibid.
8. CMS. *Medicare Part B Reference Manual.*
9. Ibid.
10. CMS. CMS Manual System, Publication 100-04, Transmittal 811. January 13, 2006. Available online at www.cms.hhs.gov/transmittals/downloads/R811CP.pdf.

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