SPECIFIC DOCUMENTATION REQUIREMENTS FOR TEACHING PHYSICIANS ONLY

EVALUATION AND MANAGEMENT CODES

Evaluation and Management Codes (E&M) are divided into broad categories such as office visits, hospital visits, and consultations. E&M codes represent a way of identifying a provider's non-procedural services. You may ask Fee Coordination Management for a complete guide of E&M services that are in the current CPT manual.

The basic format of the levels of E&M service is the same for most categories whether it is provided in an outpatient or inpatient setting. Each level requires specific teaching physician documentation for reimbursement. Descriptions for the levels of E&M service recognize seven components used to determine the level of E&M to bill.

The first three components listed below are considered the **key components** in selecting a level of E&M service. The next three components are considered contributory factors and are supportive in nature. It is the combination of components that will determine the appropriate level of E&M service provided.

If counseling and/or coordination of care time dominates (more than 50%) of the physician/patient and/or family encounter time, then time is considered the key or controlling factor to qualify for a particular level of E&M service. The physician must document the total length of time of the encounter (face-to-face or floor time, as appropriate) and also the time spent in counseling with a summary description of the counseling and/or activities of the coordination of care.

- **History**
- **Examination**
- **Medical Decision Making**
- Nature of Presenting Problem
- Counseling
- Coordination of Care
- Time

For a given encounter, the selection of the appropriate level of E&M service should be based on "Documentation Guidelines for Evaluation and Management Services" developed by the American Medical Association (AMA) and the Center for Medicare & Medicaid Services (CMS) (Appendix E and F). If a teaching physician documents his/her presence and participation in the E&M service, the level of service may be selected based on the extent of history and/or examination and/or the complexity of the medical decision-making. For any level of E&M service, the teaching physician is required to **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.**[4]

The teaching physician must personally document in the medical record documentation may be dictated and transcribed, typed, hand-written or computer-generated.

The combined personal entries of the teaching physician and resident may constitute the documentation for the service and together must support the medical necessity of the service.[4]

Examples of E&M codes that require the above documentation requirements are Initial Hospital Care, Emergency Department Visits, New Outpatient Visits, Office and Inpatient Consultations, Subsequent Hospital Care and Established Office Visits. The CPT manual will have a complete list of all current E&M codes. The initial history and physical of an inpatient stay, should be reviewed, performed and documented by the teaching physician within 24 hours of admission.[5]

Another teaching physician must request a consultation. Consultations requested by a resident must always be co-signed by a teaching physician. Non-physician practitioners, e.g., nurse practitioners, certified nurse-midwives or physician assistants, may also request a consultation if the performance of a consultation is within the scope of practice for each provider type as dictated by State regulations.[4] The medical record documentation must include the name of the requesting provider, why the consultation is needed, the consultant's written opinion, and any services ordered or performed.

The following paragraphs give examples of documentation requirements for some common clinical scenarios for teaching physicians when providing E&M services.

ILLUSTRATION 1- The teaching physician personally performs all the required elements of an E&M service without a resident. The resident may or may not have performed the E&M service independently.

- In the absence of a note by a resident, the teaching physician must document as he/she would document an E&M service in a non-teaching setting.

- Where the resident has written notes, the teaching physician should reference the resident's note. The teaching physician must document that he/she performed the critical or key portion of the service and that he/she was directly involved in the management of the patient.

[4] CMS Carriers Manual Part 3-Claims Process- 11/22/2002
http://www.cms.gov/Transmittals/Downloads/R1780B3.pdf

[5] Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) requirement

ILLUSTRATION 2- All required elements are obtained by the resident in the presence of (i.e., jointly with) the teaching physician and the complete service is documented by the resident.

- In this situation, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient.

- The teaching physician should reference the resident's note and the two notes must then support the medical necessity and the level of service billed.

ILLUSTRATION 3- The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical/key portion(s) of the service with or without the resident present and discussed the case with the resident.

- In this case, the teaching physician must document that he/she personally saw the patient, personally performed critical/key portions of the service and participated in the management of the patient.

- In his/her note, the teaching physician should reference the resident's note. As in the previous scenario, the two notes must then support the medical necessity and the level of service billed.

Examples of minimally acceptable documentation requirements for teaching physicians for the above illustrations are as follows:

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.[4] ***OR***

I performed a history and physical exam 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.[4] ***OR***

I saw the patient with the resident and agree with the resident's finding and plan.[4]

Please see the Medicare Carriers Manual (Appendix D) for other examples of acceptable documentation statements. The manual also indicates **unacceptable** statements that are unclear whether the teaching physician was present, saw the patient or had any involvement with the plan of care.

Patient seen and evaluated, followed by a legible signature or identity; ***OR***

a legible countersignature or identity alone

The two documentation examples above do not support a teaching physician's involvement with a patient.

EXCEPTIONS TO PHYSICAL PRESENCE FOR EVALUATION AND MANAGEMENT SERVICES

Certain outpatient centers or ambulatory entities may be allowed to qualify for an exception to the physical presence rule for teaching physicians. CU Medicine has notified Medicare and Medicaid that the following primary care residency programs qualify for the exception to physical presence rule:

General Internal Medicine program
Pediatric program
Family Medicine program
Geriatrics program
Obstetrics and Gynecology program

For the E&M codes listed below, services may be furnished by a resident in the absence of the teaching physician and a claim generated in the name of the teaching physician based on that physician's supervision of the resident.

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary exception:

- G0402: Initial Preventive Physical Examination: face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

Effective January 1, 2011, the following codes are included under the primary exception:

- G0438: Initial Annual Wellness visit: face-to-face visit, services limited to once in a lifetime for beneficiaries.
- G0439: Subsequent Annual Wellness visit: face-to-face visit, services allowed once per 12 months.

The State of Colorado Medicaid program has also given CU Medicine an exemption for the physical presence requirements for the following preventive medicine codes.

When billing these codes, the teaching physician must follow the same rules as stated below.

New Patient	Established Patient
99381	99391
99382	99392
99383	99393
99384	99394

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. A center must demonstrate by maintaining records that they are complying with the primary exception conditions.

- Services must be furnished in an outpatient center or ambulatory care entity;
- Applies only to supervision of residents in primary care specialty residency programs who are delivering services in a primary care clinic;
- The resident must have completed 6 months of an approved residency program in primary care;
- The patients must be an identifiable group of patients who consider the center to be the continuing source of their health care;

When supervising a primary care exception clinic, 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. **NOTE:** CMS clarification Pub 1004-04 Medicare Claims Processing- Transmittal 2247: Date June 24, 2011 Change Request 7378. **Implementation Date July 25, 2011.** *Teaching physicians may include one resident with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the resident with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of the resident with less than 6 months in a GME approved residency program.*
Teaching physicians submitting claims under this exception 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 care provided was 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 finding 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 the services.

If a service other than those listed above is furnished, then the general documentation standards for a teaching setting need to be followed.

TIME-BASED CODES

Certain procedure codes are determined on the basis of time. The time spent by a physician may or may not be continuous for any given day. The teaching physician must be present for the total period of time for which payment is requested. For example, if a physician bills a 30-minute service, he/she must be present for the entire time. If a resident provides part of the 30-minute service in the absence of the teaching physician, the teaching physician would not bill for the entire 30-minute unit. The teaching physician must personally document direct time spent with the patient. Examples of CPT codes that fall into this category include:

- Individual medical psychotherapy codes
- Critical care service codes
- Prolonged service codes
- Care plan oversight codes
- E&M codes when counseling and/or coordination of care is more than 50% of the encounter, and time is considered the key controlling factor of the E&M service
  The teaching physician must document the **total time** and the **time** spent in counseling along with a **summary of the discussion**
- Hospital discharge day management codes

SURGERIES AND PROCEDURES

For surgical, high-risk or other complex procedures, the teaching physician must be present during all critical and key portion(s) of the procedure (as defined by the teaching physician) and be immediately available to furnish services during the entire procedure. The operative report and the procedure record should be signed and dated by the teaching physician.[6]

If a medical student performs a procedure with a teaching physician, the teaching physician must document as if he/she provided the procedure alone. The teaching physician's note should include why the procedure is being done, how the student performed, complications of the procedure if any, and the status of the patient at the completion of the procedure.

For surgeries (including endoscopic operations), the teaching physician is responsible for the preoperative, operative, and post-operative 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. During non-critical or non-key portions of the surgery, if the teaching physician is not physically present, he/she must be immediately available to return to the procedure. This means that he/she 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. The teaching physician must also determine which post-operative visits are considered key or critical and require his/her presence.

There are different documentation requirements for teaching physicians when providing a single surgery compared to two overlapping surgeries.

- **Single Surgery**- When the teaching surgeon is present for the entire surgery, his/her presence may be demonstrated by notes in the medical records by the physician, resident, or operating room nurse. A note such as Dr. Teaching Surgeon was present for the entire procedure would clearly indicate the involvement of the teaching surgeon.

- **Two Overlapping Surgeries-** In order to bill for two overlapping surgeries, the teaching surgeon must be present during the critical/ key portions of both operations. Therefore, the critical/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 to become involved in a second procedure. The teaching surgeon **must personally document** in the medical record that he/she was physically present during the critical/key portions(s) of both procedures. When a teaching physician is not present during non-critical/non key portions 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 as needed.

In the case of three concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a supervisory service for the hospital and not a billable physician professional service.

[6] Rules and Regulations of Hospital Bylaws UCH

Global Services - When a global surgery is furnished, the teaching surgeon is responsible for the preoperative, operative and post-operative care of the patient. Any teaching surgeon who is part of the same service may furnish and document any portion of the global service without billing an additional charge. The teaching surgeon determines which post-operative visits are considered key or critical and require his/her presence. The CPT manual also requires physicians to participate in the post-operative care of the patient and the Rules and Regulations of the Medical Staff of University of Colorado Hospital and The Children's Hospital also require physicians to document post-operative visits.

When a global surgery fee is billed for a procedure furnished in the ambulatory or day surgery setting, the teaching physician must examine the patient pre-operatively and document the record accordingly. Documentation of outpatient visit(s) for post-op follow-up care is acceptable post-operative documentation.

Non-Global Services - If the post-operative period extends beyond the patient's discharge and the teaching physician is not providing the patient's follow-up care, the surgical service will be identified with modifiers that indicate a reduced service and it is not billed as a global service. In these cases, the teaching physician would not document post-op notes, but he/she must still document his physical presence for the procedure.

Assistant Surgeon Services - Some carriers may not make payment for the services of assistant surgeons furnished in a teaching hospital which has a training program related to that specialty, and has a resident or fellow available to perform the services. Exceptional circumstances involving multiple traumatic injuries, transplantation, or emergency life-threatening situations requiring immediate treatment may constitute an exception to this reimbursement policy. Please see Appendix D for all of the instructions and exceptions for billing requirements for assistant at surgery claims. Assistant at surgery claims furnished in teaching hospitals will require a certification by the assistant (modifier–82) that indicates a qualified resident surgeon was not available.

CMS has also clarified through communication from the AAMC that certain non-physician practitioners may work as assistant surgeons if authorized to do so by the State in which they are licensed. The non-physician practitioners that may bill as assistants are a nurse practitioner, physician assistant or clinical nurse specialist (Appendix D1). The same teaching setting rules would apply.

MINOR PROCEDURES

For procedures that take only a few minutes to complete, (CMS has defined a minor procedure as one that takes less than 5 minutes e.g., simple suture), and involve relatively little decision making once the need for the procedure is determined, the teaching physician must be present for the **entire** procedure in order to bill for the service. The documentation must show that the teaching physician either personally furnished the procedure, or personally supervised the resident for the entire procedure.
Either the resident or the teaching physician may document the physical presence of the teaching physician.

ENDOSCOPY PROCEDURES

For procedures performed through an endoscope (other than endoscopic operations), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the procedure by a monitor in another room does not meet the teaching physician presence requirement. Documentation of a teaching physician's presence during the entire procedure may be provided by either the resident or by the teaching physician.

OTHER COMPLEX OR HIGH-RISK PROCEDURES

If other complex or high-risk procedures indicated by CPT description or Medicare policy, and the procedure require personal supervision by a physician, the teaching physician must be present with the resident. The presence of the resident alone would not establish a basis for a billable service. Examples of such procedures are interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

ANESTHESIOLOGY

Anesthesiology services are billed either as "**personally performed**" or as "**medical direction**" or with the advances in modern medical technology, some procedures are now rendered with monitored anesthesia care (MAC).

For anesthesiology services to be considered "personally performed":

- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident and the service is furnished on or after January 1, 1996;
- The physician is involved in the training of the physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The services are furnished on or after January 1, 2010;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- The physician is continuously involved in one anesthesia case involving a CRNA (or AA) and the service was furnished prior to January 1, 1998. If the service was furnished on or after January 1, 1998, the service would be considered as a medically directed case;
- The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both, to support the service. The appropriate modifiers would be added.

Anesthesiology services will be billed as a medical directed service if the physician medically directs qualified individuals in two, three or four concurrent cases and the physician performs the following activities:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post anesthesia care.

Prior to January 1, 1999, the physician was required to participate in the most demanding procedures of the anesthesia plan including the induction and emergence.

For medical direction services furnished on or after January 1, 1999, the physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. Also the physician must document in the medical record that he/she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring and were present during the most demanding procedures, including induction and emergence where indicated.

For services furnished on or after January 1,1994, the physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of who could be CRNAs, AAs, interns, resident or combinations of these individuals. The medical direction rules apply to cases involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia case involving residents.

Additional, for anesthesiologists in a group practice, one physician may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician may provide post-anesthesia care while another furnishes the other component parts of the service. The medical record must indicate the services were furnished by physicians and identify the physicians who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. **However**, addressing an emergency of short duration, in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic rather than continuous monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Also while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room or handle scheduling matters of other patients.

However, if the physician leaves the immediate area of the operating suite for other than short durations, or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services to the surgical patients are supervisory in nature.

"Monitored Anesthesia Care" is a specific anesthesia service for a diagnostic or therapeutic procedure using a combination of anxiolytic, hypnotic, amnestic and analgesic drugs. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition and/or the potential need to convert to a general or regional anesthetic.

MAC should be provided by qualified anesthesia personnel in accordance with Colorado state licensure and also follow the American Society of Anesthesiologists standards for monitoring.

During MAC, the patient's oxygenation, ventilation, circulation and temperature should be evaluated. It is anticipated that newer methods of non-invasive monitoring such as pulse oximetry and capnography will be frequently relied upon. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug reactions, etc. In addition, the possibility that the surgical procedure may become more extensive or complicated would require comprehensive monitoring and/or anesthetic intervention.

CMS also states that the requirements for MAC should be the same as for general anesthesia;

- The performance of pre-anesthetic examination and evaluation;
- The prescription of the anesthesia care required;
- The completion of an anesthesia record; and
- The administration of necessary medications and the provision of indicated postoperative anesthesia care.

Appropriate documentation must be available to reflect pre- and post-anesthetic evaluations and intra-operative monitoring. Also the MAC service must be reasonable, appropriate and medically necessary. The QS modifier must be used with the MAC anesthesia services. This modifier will follow the modifier that indicates who provided the service (AA, QS).

In order to bill for minor procedures the teaching anesthesiologist must be present for the entire procedure. Either the resident or the teaching physician may provide documentation of a teaching anesthesiologist's physical presence.

INTERPRETATION OF DIAGNOSTIC/ANCILLARY SERVICES

The services performed by the teaching physician should be meaningful from the point of view of treatment and not merely a *proforma* review of the report for purposes of authorization and billing. The teaching radiologists and pathologists must personally provide interpretation of an x-ray film or pathologic findings. If a resident is involved, the teaching physician must supervise the resident's interpretation. The teaching physician must review and revise the interpretation as necessary prior to the release of the report.

If the teaching physician's signature is the only signature on the interpretation, it will indicate that he/she personally performed the interpretation. 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 or has edited the findings. An example of an appropriate statement: "Reviewed and Interpreted by". A co-signature only by the teaching physician **is not acceptable documentation** for billing an interpretation.

Any physician signing for another physician's dictation reflecting a diagnosis assumes responsibility for the entire content of the interpretation and thereby assumes liability in the event an incorrect diagnosis has been made. Therefore, it is important that in this capacity the signing physician review the original films or pathologic findings as part of the process.

Departments must have a protocol in place that allows for the controlled and secured use of electronic signatures to verify the participation of the teaching physician in a service.

PSYCHIATRY

A teaching physician may bill for psychiatric services when he/she has personally furnished the service and has appropriately documented the medical record.

For psychiatric services that involve residents, the teaching physician may meet the physical presence requirement by concurrent observation of the service through the use of a one-way mirror or video equipment. Audio-only equipment does not meet this exception to the physical presence requirement.

The teaching physician supervising the resident must be a physician, **not** a psychologist. The Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs. Medicare Carriers Manual, Section 15016 (Appendix D revised 11/2002).

Psychotherapy services use CPT codes that are determined on the basis of time. In order to bill for these time-based codes, the teaching physician must be present or concurrently viewing the service for the period of time for which the claim is made. The teaching physician's documentation must reflect the exact time for which he/she was present. The teaching physician's time does not include time spent by the resident in the absence of the teaching physician.

MODIFIERS

Modifiers are two-character codes that are added to the main procedure code to indicate that a procedure has been altered by a particular circumstance. Modifiers are important to inform third party payers of additional information about the service. Some common modifiers used in our setting are; modifier 25- separately identifiable E&M service by the same physician on the same day of a procedure, modifier 50- bilateral procedures and modifier 51- multiple procedures/services performed at the same session. For a complete listing of modifiers, please reference the most current CPT manual or contact your CU Medicine coder who is trained in the use of modifiers.

Medicare has created two modifiers that are **specific to a teaching setting**. These modifiers are *GC- performed service with resident* and *GE- service done as exception to physical presence*. These modifiers are available for selection in any of the billing systems used by the providers. The billing providers are responsible for indicating the appropriate modifier when selecting their outpatient services. The fee coordinator will apply the correct modifier for emergency and inpatient services.

FELLOWS – WHEN CAN THEY BILL?

Is Fellow in approved GME program **and/or** will receive an ABMS Board Certification?

NO:

- Fellow may bill with no restrictions within their scope of licensure
- Any Services – Inpatient or Outpatient or ED

YES – INTERNAL MOONLIGHTING

- **Billing at Provider Setting or Training Site:**
  - Must have full MD license
  - Must have signed approval for moonlighting form
- **Billing at CHC and UCH sites:**
  - Must have faculty appointment (Instructor/Fellow)
  - Will have SOM Trust malpractice
- **Moonlighting Fellows Can Bill with RESTRICTIONS**
  - ONLY in an Outpatient or ED setting
  - Approval moonlighting form must clearly state the services provided are outside the scope of the training program
  - Teaching physician rules apply to any services within the scope of the training program
    - Fellow may not bill independently

YES – EXTERNAL MOONLIGHTING

- **If in a Non-Provider Setting or Work Outside of Training Sites:**
  - Setting does not receive direct/indirect medical education payment (DME/IME) reimbursement for fellow (i.e. independent outpatient center or private physician office)
  - Must have full MD license
  - Must have signed approval for moonlighting form
  - May bill in any setting with no restrictions
  - Separate Malpractice Coverage

YES – MFM (MATERNAL FETAL MEDICINE)

- **Colorado Medicaid Exception:**
  - Must have full MD license
  - Must have faculty appointment (Instructor/Fellow)
  - May bill for any service outside scope of training program
  - Will have SOM Trust malpractice
  - Attending and Fellow must determine when services fall outside of the training program for independent billing by a MFM Fellow