

**PROVIDENCE SACRED HEART MEDICAL CENTER
GRADUATE MEDICAL EDUCATION COMMITTEE**

Teaching Physician Documentation

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INTRODUCTION

What is a Teaching Physician?

A teaching physician is a doctor who bills Medicare for services provided jointly with a resident as part of that resident's clinical training. To be able to bill for the service, the teaching physician must adhere to Medicare's guidelines regarding what constitutes appropriate documentation to show his or her presence and participation in the key portions of the service.

What Does Medicare Want?

Medicare (as part of HCFA now metamorphosed to CMS) wants us to properly chart our notes. Policies have been in place since 1968 when HCFA set the rules for billing for resident services under the supervision of a teaching physician. While we did supervise residents, we couldn't prove it to auditors by our documentation. So, in 1996, HCFA issued new guidelines which clarified the requirements for the teaching physician's participation in these services, and the level of documentation required to support this role.

While designed to clarify existing interpretations, the revised explanations of policies contained areas that continued to create confusion. Multiple medical organizations then worked with Medicare to pinpoint ambiguous areas in the revised policies. In responding to questions raised, Medicare has actually made things somewhat easier for teaching physicians. As a clinical faculty member in one of our residency programs, you should be aware of these refinements. Therefore, we want to provide you with information about the latest approaches to documenting your presence on a case as a teaching physician.

Approach to Documentation Guidelines

If appropriate chart documentation has two published examples of being correct, we choose the one with slightly more detailed documentation. Our reasoning is that we want to try to stay away from gray zones in interpretation. One more piece of advice: always date and time your notes.

The rest of this paper provides documentation guidelines for different types of services and examples where appropriate.

GUIDELINES FOR EVALUATION AND MANAGEMENT (E/M) SERVICES

If a resident has been involved in the care of a patient, the teaching physician must use a GC- modifier for billings to indicate resident involvement in the service. Without this code modifier, Medicare assumes that the teaching physician performed the service exclusively — i.e., a resident was not involved. If a teaching physician submits a bill without the GC-modifier, the teaching physician's note alone will have to support the level of service provided.

The teaching physician determines the appropriate E/M service and its level based on code definitions in the AMA's CPT and any other applicable documentation guidelines.

To bill for an E/M service, the teaching physicians must *personally* document on the chart. (Please note the word *personally*. For an E/M service, a resident charting a teaching physician's presence and participation in that service is not sufficient.)

The teaching physician must personally document that: 1) he or she performed the service or was physically present during the key or critical portion(s) of the service when performed by the resident; and 2) he or she participated in the management of the patient. (Medicare defines the "critical " or "key portion(s)" of the services as the portions of the service that determine the level of E/M service billed.)

Medicare allows the *combined content* of the resident's note and the teaching physician's personal note to support the medical necessity and level of service billed. In other words, the teaching physician may reference one resident's note. The revised regulations clearly state that the teaching physician does not need to repeat documentation already provided by a resident for E/M services. The Medicare auditors must consider the combined medical record entry of the teaching physician and resident when determining whether the documentation justifies the level of service the teaching physician billed. More than one teaching physician can not utilize a single resident's documentation.

Since multiple residents document the medical chart on the same day, the teaching physician must identify to which resident he or she is referring. The attending must refer to resident by name, or specialty, e.g., cardiology resident, if that serves to identify the individual.

A teaching physician must note that he or she personally furnished a service. Such documentation must be dated and include a legible signature.

For time-based codes such as critical care time, a physician's time spent teaching is not counted toward critical care time. Only the time spent by the teaching physician alone with the patient, and the time spent by the teaching physician and resident together with the patient, is counted toward critical care time.

For time-based codes with code descriptors of greater than 30 minutes (e.g., CPT 99239), the teaching physician must document the actual amount of time spent with the patient. Such documentation is not required for codes (e.g., CPT 99238) with code descriptors of 30 minutes or less.

Examples of Documentation for E/M Services

Scenario 1: The resident performs some or all of the required elements of an E/M service without a teaching physician present and documents the service. The teaching physician independently performs key portions 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, performed key portions of the service, and participated in managing the patient. The teaching physician's note should reference the resident's note. For payment, the combination of the teaching physician's entry and the resident's entry must support the medical necessity and level of service that the teaching physician billed.

"I interviewed and examined the patient. Discussed with Dr. [Name of resident] and agree with [his/her] findings and plan as documented in [his/her] note except [name the differences, if any, to include additional items or clarifications]."

Scenario 2: The resident performs the required E/M service elements in the presence of, or jointly with, the teaching physician and documents the service.

Even though present in the room, the teaching physician must still personally document that he or she was present when key portions of the service were performed and that he or she was directly involved in managing the patient. The teaching physician's note should reference the resident's note. For payment, the combination of the teaching physician's entry and the resident's entry must support the medical necessity and level of service that the teaching physician is billing.

"I was present with Dr. [Name of resident] during the history and exam. I discussed the case with [him/her] and agree with the findings and plan as documented in [his/her] note except [name the differences, if any, to include additional items or clarifications]."

Scenario 3: The service provided is a time-based code such as an ICU visit.

For time-based codes such as critical care services, the teaching physician must note the total time he or she actually spent in direct patient contact for that service. The teaching physician cannot bill time spent by the resident in the absence of the teaching physician. Time spent teaching (residents and/or medical students) may not be counted towards the critical care service time.

"I spent [amount] minutes interviewing, examining and managing the patient. Discussed with Dr. [Name of resident] and agree with [his/her] findings and plan as documented in [his/her] note except [name the differences, if any, to include additional items or clarifications]."

Scenario 4: The resident does not make any notes about a service provided.

The teaching physician must personally perform all the required elements of an E/M service and must document the same way he or she does in a non-teaching setting.

Examples of Unacceptable Documentation:

- "Agree with above.", followed by a signature.
- "Rounded, reviewed, agree.", followed by a signature.
- "Discussed with resident. Agree.", followed by a signature.
- "Seen and agree.", followed by a signature.
- "Patient seen and evaluated.", followed by a signature.

- A signature alone.

According to Medicare, this type of charting is not acceptable because it is impossible to determine whether the teaching physician was present, evaluated the patient, or had any involvement with the plan of care.

PROCEDURES

If a teaching physician bills for a procedure performed by a resident under his or her supervision, there are different documentation regulations based on the category of procedure. The three different categories of procedures are:

1. *minor procedure*: a procedure that lasts less than 5 minutes.
2. *surgery*: a procedure that lasts 5 or more minutes.
3. *endoscopy*: a procedure that involves inserting a scope into an orifice (it excludes laparoscopic surgery which falls under the surgery category).

The resident, nurse or teaching physician can chart the teaching physician's presence for a single procedure if the teaching physician is present for the entire procedure (including the opening and closing of a surgery).

GUIDELINES FOR MINOR PROCEDURES (PROCEDURES LASTING LESS THAN 5 MINUTES)

- The teaching physician must be physically present in the room for the entire procedure.
- A note by either the teaching physician, resident or nurse is sufficient to document the teaching physician's physical presence.
- Notation of "time in" and "time out" is not sufficient documentation of physical presence.

Examples of Documentation for a Minor Procedure

Scenario 1: Resident or nurse documents teaching physician presence.

"Dr. [Name of teaching physician] was present for the entire [name of procedure]."

Scenario 2: Teaching physician documents his or her own note.

"I was present for the entire [name of procedure]."

GUIDELINES FOR SURGERY (PROCEDURES LASTING 5 OR MORE MINUTES)

- The teaching physician must be present for the entire procedure (opening to closing) OR for all the key portion(s) (as determined by the teaching physician); and remain immediately available to return to the procedure.
- If the opening or closing is judged to be a key portion, the teaching physician must be present.
- "Immediately available" means the teaching physician is not involved in another procedure from which he or she cannot return; and is close enough to quickly return, if necessary.
- If the teaching physician is physically present for the entire procedure (from the opening to the closing of the surgical field), documentation by notes made by the resident, nurse, or teaching physician is sufficient. However, it is the teaching physician's responsibility to ensure that the documentation indicates his or her presence during the entire surgery.
- Notation of "time in" and "time out" is not sufficient documentation of physical presence.
- If the teaching physician is present only for the key portion(s) of the procedure, the teaching physician must *personally* enter a note which: 1) identifies the key portion(s), 2) attests to his or her physical presence during the key portion(s); and 3) reflects immediate availability to return to the procedure, or names the covering physician who was immediately available to assist if needed.
- For two overlapping surgeries, the teaching physician must be present for the critical or key portions

of both surgeries.

- All of the key portion(s) of the first procedure must be completed before the teaching physician can become involved in the second procedure.
- For two overlapping surgeries, the teaching physician must personally document in the medical record that he or she was physically present during the critical or key portion of both procedures.
- For two overlapping surgeries, when the teaching physician is not present during the non-critical portions of either surgery, he or she must arrange for another qualified physician to be immediately available to assist the resident in the other case, as needed. A resident does not qualify as another physician for this purpose.
- For two overlapping surgeries, while the guidelines contain no specific documentation requirements, the teaching physician should list the name of the covering second surgeon either in the operative dictation note or the medical record.
- If the key portion of two surgeries overlap, neither procedure is reimbursable by Medicare.
- In the case of three concurrent surgical procedures, the role of the teaching physician (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual beneficiary and Medicare will not pay.
- Where pre-operative services are included in the global surgery period, and the teaching physician determines the pre-operative services are not key or critical, his or her presence is not required.
- Where preoperative services are not included in the global surgery period, the teaching physician's presence is required during the key or critical portions of those services.
- The teaching physician may determine which post-operative visits are considered "key" and require his or her presence.
- At least one post-op visit must be documented by the teaching surgeon in order to receive the global fee reimbursement.
- If the post-operative 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.
- In the case of maternity services furnished to Medicare eligible women, the physician presence requirement is the same manner as for surgery.

Examples of Documentation for Surgery (Procedures Lasting 5 or More Minutes)

Scenario 1: Resident or nurse can document if a teaching physician is present for an entire single surgery (including opening and closing.)

"Dr. [Name of teaching physician] was present for the entire [name of surgery]."

Scenario 2: Teaching physician documents his or her own presence for an entire single surgery (including opening and closing.)

"I was present for the entire [name of surgery]."

Scenario 3: If present for the key portion(s) of a single surgery and immediately available for the noncritical portions of the case, the teaching physician must personally document this in his or her own note.

"I directly [supervised/performed] the [name key portion(s)] which [was/were] the key portion(s) of the [name of the surgery]. I was immediately available for the rest of the surgery."

Scenario 4: If present for the key portion(s) of a single surgery but not immediately available for the noncritical portions of the case, the teaching physician must personally document this in his or her own note.

"I directly [supervised/performed] the [name key portion(s)] which [was/were] the key portion(s) of the [name of the surgery]. Dr. [Name of covering physician] was available for the rest of the surgery."

Scenario 5: For two overlapping surgeries where the key portions do not overlap, the teaching physician must personally document key portions of each surgery and name of covering physician immediately available for original case if needed.

"I directly [supervised/performed] the [name key portion(s)] which [was/were] the key portion(s) of the [name of the surgery]. Dr. [Name of covering physician] was available for the rest of the surgery."

Assistant Surgeons in Teaching Hospitals with a Residency in the Surgery's Specialty

Payment under Medicare 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, an 82- modifier should be used on the assistant-at-surgery's claim form to indicate a qualified resident was unavailable for the surgery. The following signed certification statement is for use only when the basis for payment is the unavailability of qualified residents in a teaching setting.

"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 post-payment review by the Medicare carrier."

GUIDELINES FOR ENDOSCOPY

- A resident or nurse may document the presence of the teaching physician's presence for endoscopy.
- The teaching physician must be present for the entire endoscopy including scope insertion and withdrawal.
- Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

Examples of Documentation for Endoscopy

Scenario 1: Resident or nurse documents teaching physician presence.

"Dr. [Name of teaching physician] was present for the entire [name of endoscopy]."

Scenario 2: Teaching physician documents his or her own note.

"I was present for the entire [name of endoscopy]."

GUIDELINES FOR RADIOLOGY AND INTERPRETATION OF 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 radiographic or other diagnostic test in order to bill for the interpretation of the test.
- The teaching physician must personally view the image, specimen or test results and confirm the interpretation by the resident, either alone or in the presence of the resident.
- If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image, specimen or test results, and the resident's interpretation and either agrees with it or edits the findings.
- The documentation must include a written report that reflects that the teaching physician either personally examined and interpreted the results, or personally reviewed the resident's interpretation along with the original image, specimen or test.
- If the teaching physician's signature is the only signature on the report, Medicare will assume that the teaching physician personally performed the interpretation.

Examples of Documentation for Interpretation of Radiographic or Other Diagnostic Tests

"I attest that the above diagnosis is based upon my personal examination of the [name of film, specimen, image etc.] and that I have reviewed and approved this report."

GUIDELINES FOR PSYCHIATRY

- The teaching psychiatrist will be considered to be "present" during each visit for which payment is sought, as long as the teaching psychiatrist observes the key portion of the visit personally in the room or through a visual device (i.e., a one-way mirror, video equipment, etc.). Audio-only equipment does not satisfy the physical presence requirement.
- The teaching psychiatrist's supervision and the resident's therapy session must be conducted simultaneously.
- The teaching psychiatrist must be present for the entire length of time of a time based therapy. For example, if the teaching physician only watched a 15 minute portion of a 30 minute session through a one-way mirror, only 15 minutes could be billed, not the entire half hour.
- The teaching psychiatrist supervising the resident must be a physician, i.e., 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 psychiatrist must personally document his or her presence and participation in the service in the medical records.
- Certain GME programs in psychiatry may qualify for the primary care exception in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

GUIDELINES FOR ANESTHESIOLOGY

- A teaching physician will be reimbursed as if he or she personally performed the service, OR 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.
- The teaching physician must document in the medical records that he or she was present during all key portions of anesthesia.
- Documentation must indicate the teaching physician's presence during induction, emergence, and any other portion of the procedure payable on a time basis.
- The resident or other staff may document in the anesthesia report on behalf of the teaching physician indicating the teaching physician's presence during the key portions of each case.
- The teaching physician's physical presence during only the preoperative or post-operative visits with the beneficiary is not sufficient to receive Medicare payment.
- The teaching physician presence is not required during the pre-operative or post-operative visits with the patient.

- In order for a teaching physician who provides anesthesia services in a teaching hospital to receive payment, he or she must: 1) prescribe the anesthesia plan, 2) personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence, 3) ensure that any procedure in the anesthesia plan that he or she does not perform is performed by a qualified individual, 4) monitor the course of anesthesia administration at frequent intervals, 5) remain physically present and available for immediate diagnosis and treatment of emergencies, and 6) provide indicated post-anesthesia care.
- If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and an anesthetist, payment will be for medical direction rather than as an anesthesiologist's services.
- The teaching physician must direct no more than four (4) anesthesia procedures concurrently and can not perform any other service while he or she is directing the concurrent procedures.
- If the teaching physician is involved in furnishing more than four (4) 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 the Medicare carrier.

GUIDELINES FOR WORKING WITH MEDICAL STUDENTS

- Medical students may chart in the medical record however the teaching physician regulations concerning furnishing and documenting of services by residents does not apply to medical students.
- While a medical student can train by performing and recording an evaluation on the chart, the only portions to which a physician can refer in his or her own note are the past medical history, family history, social history and review of systems.
- A resident or teaching physician is responsible for all components of the E/M service.
- The physician must independently perform and document the service.
- In his or her own note, a physician can use a student's review of systems (ROS) and past, family and social history (PFSH) by initialing it or referring to it in a narrative statement.

RESIDENCY PRIMARY CARE CLINICS EXCEPTION

Medicare has an exception to the teaching physician regulations that applies solely to primary care residency ambulatory care sites. Under the exception, residents can bill for the lower and mid-level outpatient new and established patient E/M services without a teaching physician actually having to see the patient. However, the teaching physician must review the patient with the resident and document the review and management of the patient.

The primary care exception rules apply only in the Family Medicine Spokane Clinic, the Internal Medicine Residency Spokane Clinic and the family practice centers of the Family Medicine Rural Training Track in Colville and Goldendale. In no other location, neither a physician's office nor the hospital, do these regulations apply.

A center requesting a primary care exception must request that in writing from its Medicare intermediary. The patients seen in this facility must be an identifiable group of individuals who consider the center to be their primary location for healthcare 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 letter has to attest that the facility meets these requirements as well as those in the following guidelines.

GUIDELINES FOR THE PRIMARY CARE EXCEPTION SITES

- A claim for a service performed by a resident with appropriate teaching physician documentation in a facility that bills under the teaching facility ambulatory care exception must include the GE-modifier. Services provided by non-residents, and/or documented completely by teaching physicians do not require the use of the GE-modifier.
- Under this exception, residents can bill for the lower and mid-level outpatient new and established patient E/M services only, CPT codes 99201-99203 and 99211-99213, respectively.
- A teaching physician can not bill for preventive medicine services under the primary care exception. The primary care exception only applies to the six specific CPT codes for low and midlevel E/M services.
- Any resident furnishing a service without a teaching physician present must have completed more than six months of an approved residency program.
- A teaching physician may supervise up to four residents at any one time and must be immediately available to assume management responsibility for patients seen by the residents in the ambulatory care facility. (Medical students who accompany the residents for instruction and observation are not counted in the up-to-four category.)
- The teaching physician must not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident.
- The teaching physician does not have to actually see each patient.
- The teaching physician must review the patient with each resident during or immediately after each visit.
- When the medical chart notes become available, the teaching physician must personally document that he or she has reviewed the patient's care with the resident, agrees or disagrees with the resident's assessment and plan of care, and clarifies additions or differences.

Example of Documentation for Primary Care Exception E/M Services

"During today's clinic session, I discussed the patient with Dr. [Name of resident] and agree with [his/her] findings and plan as documented in [his/her] note except [name the differences, if any, to include additional items or clarifications]."