



POLICY SUBJECT:

EFFECTIVE DATE: 08/12/2011

*Teaching Physician Presence
And Documentation*

*To be reviewed every three years by
Compliance and Ethics Committee*

Teaching Physician Presence and Documentation

POLICY: In general, if a resident participates in a service provided in a teaching setting, the Teaching Physician may not bill Medicare Part B for that services unless the Teaching Physician is present during, or personally performs, the critical or key portion of that service and the Teaching Physician personally documents his/her services consistent with this Policy. The Teaching Physician is deemed to be responsible for that service for billing purposes, including those portions of the service that were provided outside the presence of the Teaching Physician.

This policy does not apply to non-physician providers. Non-physician providers are never Teaching Physicians. Teaching Physicians cannot bill under these Teaching Physician rules for his/her participation in services provided by non-physician trainees or non-physician providers.

Sound Physicians' documentation standards include the Medicare requirements. Sound Physicians applies a uniform documentation standard for all services, but bills according to specific payor requirements.

PURPOSE: The purpose of this Policy is to set forth the standards for participation and documentation of Teaching Physicians in settings in which residents also provide care to patients.

PROCEDURE:

I. Definitions

A. CMS: The U.S. Health and Human Services Centers for Medicare and Medicaid Services.

B. Critical or Key Portion: That part (or parts) of a service that the Teaching Physician determines is (are) a critical or key portion(s). For purposes of this policy, these terms are interchangeable. For E/M services, the Critical or Key

Portion is that portion(s) of the service that determines the level of service billed.

C. Documentation:

1. Notes recorded in the patient's medical record by a resident and/or Teaching Physician or others, as provided below for the specific service furnished. Documentation may be dictated, hand-written, computer-generated, or typed. Documentation must be dated and include a legible signature or include an accepted secure electronic signature. Documentation must identify, at a minimum, the service furnished and the participation of the Teaching Physician in providing the service, and, if a resident is present during the patient encounter, whether the Teaching Physician was physically present.

2. In the context of an electronic medical record, the term “macro” means a command in a computer or dictation application invoked by the provider during the generation of the note that automatically inserts predetermined text. 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.

3. 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 only use macros without adding to or customizing the content of the note.

4. For written documentation of E/M services, use of a checkbox alone to document Teaching Physician participation or presence is not sufficient documentation. The Teaching Physician must have sufficient documentation in the note of their participation in addition to the use of any checkbox statement(s) documenting their presence.

D. Documentation Linkage or Link to a Resident’s Note: Explicit reference by the Teaching Physician to the identified resident’s note.

E. Physically Present: The Teaching Physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

F. Student: An individual who participates in an accredited educational program (e.g. a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

G. Teaching Hospital: A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry or podiatry.

H. Teaching Physician: A physician (other than another resident) who involves residents in the care of his/her patients.

I. Teaching Setting: Any facility, hospital-based facility, or non-provider facility in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or a freestanding skilled nursing facility or home health agency in which such payments are made on a reasonable cost basis.

II. Residents

- A. A resident is an individual who participates in an approved 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, residents, and fellows in GME programs recognized as approved for purposes of direct GME payments made by the CMS fiscal intermediary.
- B. Receiving a staff or faculty appointment, participating in a fellowship, or whether the individual is included in the hospital's GME count does not by itself define whether the individual is a resident under this policy.
- C. Individuals who are not in an approved GME program and who are licensed to practice in multiple settings are **not** residents. The Teaching Physician cannot supervise these individuals or link to the notes of these individuals as if they were residents.

III. General Presence Standard

- A. Sound Physicians submits payment for physician services in the teaching setting only under the following circumstances:
 - 1. The services are personally furnished by a physician who is not a resident;
 - 2. A Teaching Physician was physically present during the critical or key portions of the service that a resident performs, subject to the exceptions provided below; or
 - 3. A Teaching Physician provides care in a Primary Care Center, in accordance with the conditions required by CMS and this Policy.

IV. Evaluation and Management ("E/M") Services

- A. The selection of the appropriate level of E/M service should be determined according to the American Medical Association's Current Procedural Terminology ("CPT") and any applicable documentation guidelines.
- B. To bill E/M services, the Teaching Physician must personally document at least the following:
 - 1. That he or she performed the service or was physically present during the critical or key portions of the service (those portions that determine the level of service billed) while a resident performed the services; and

2. That he or she participated in the management of the patient. (NOTE: In this scenario if there are no resident notes, the Teaching Physician must document as they would document an E/M service in a non-teaching setting.)

- C. Documentation by the resident of the presence and participation of the Teaching Physician is not sufficient to establish the presence and participation of the Teaching Physician. 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. If the resident provides the service without the Teaching Physician's direct participation, the resident may document the clinical encounter, but the service cannot be billed.
- D. If the Teaching Physician documents his/her own note without an appropriate linking/presence statement to the resident's note, the service may only be billed on the basis of the Teaching Physician's note.
- E. If no resident has participated in the patient encounter, the physician documents on the same basis he or she would document an E/M service in a non-teaching setting.

VI. Unacceptable Documentation

The following are examples of unacceptable documentation:

- A. "Agree with above.", followed by legible countersignature or identity;
- B. "Rounded, Reviewed, Agree.", followed by legible countersignature or identity;
- C. "Discussed with resident. Agree.", followed by legible countersignature or identity;
- D. "Seen and agree.", followed by legible countersignature or identity;
- E. "Patient seen and evaluated.", followed by legible countersignature or identity; and
- F. 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.

VII. E/M Service Documentation Provided By Students and Mid Level Practitioners.

Teaching Physician rules do not apply to students or mid level practitioners (i.e., nurse practitioners, physician assistants) Students or mid level practitioners may perform and document a review of systems and/or past family/social history, and the Teaching Physician may refer to this documentation as part of his/her personal note. However, the Teaching Physician may not refer to a student's or the mid level practitioners documentation of the history of present illness, physical exam findings or medical decision-making.

VIII. Procedures

In order to bill for surgical, high-risk, or other complex procedures, the Teaching Physician must be present during all critical or key portions of the procedure and be immediately available to furnish services during the entire procedure. The Teaching Physician must personally document his or her presence and availability during the procedure.

Minor Procedures.

For procedures that take only a few minutes (5 minutes or less) or designated as minor procedures by CMS to complete and involve relatively little decision making once the need for the operation is determined, the Teaching Physician must be present for the entire procedure in order to bill for the procedure.

If the Teaching physician personally performs the entire procedure without a resident present and personally documents his/her own procedure note, a separate presence statement is not required and the Teaching Physician would document on the same basis as a service provided in a non-teaching setting.

When a resident is involved, the Teaching Physician must document his/her presence or participation in the procedure. If the Teaching Physician is not present for the entire procedure, the procedure will not be billed.

The documentation must state:

“I performed the entire procedure.”

OR

“I was present for the entire procedure, which was performed under my personal supervision”

XI. Time-Based Codes

For procedure codes determined on the basis of time, the Teaching Physician must be present for the period of time for which the claim is made. For example, Sound Physicians bills for a service of from 20 to 30 minutes only if the Teaching Physician is present for 20 to 30 minutes. Any time spent by the resident in the absence of the Teaching Physician is not counted. The Teaching Physician must document his/her presence or participation in the services for the period of time for which the claim is made. Examples of codes falling into this category include:

- A. Individual medical psychotherapy (CPT codes 90804-90829);
- B. Critical care services (CPT codes 99291-99292);
- C. Hospital discharge day management (CPT codes 99238-99239);
- D. E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- E. Prolonged services (CPT codes 99358-99359); and
- F. Care plan oversight (HCPCS codes G0181-G0182).

If a Teaching Physician chooses to bill based on time, the Teaching Physician must personally document the following in the medical record:

- A. The total Teaching Physician time spent with the patient;
- B. The time spent counseling the patient and/or coordinating patient care; and
- C. The subject matter of the counseling and/or coordination of care.

Acceptable documentation of the Teaching Physician's participation could read: "I spent 30 minutes with (patient name), 25 minutes of which was spent counseling (patient) on (list subject of counseling [e.g., surgical and non-surgical options for treatment of the patient's condition])."

XII. Other Complex or High-Risk Procedures

In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, the Teaching Physician must be present throughout the procedure that is billed. The presence of the resident alone is not sufficient. These procedures include interventional radiologic and cardiologic supervision and interpretation codes; cardiac catheterization; cardiovascular stress tests; and trans-esophageal echocardiography.

The Teaching Physician must document his/her presence or participation in the procedure. If the Teaching Physician personally performs the entire procedure without a resident present and personally documents his/her own procedure note, a separate presence statement is not required as part of the documentation.