

UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE/JACKSONVILLE
TEACHING PHYSICIAN BILLING POLICY

Revised December 2008¹

1.0 Introduction

1.1 Applicable Regulations. On December 8, 1995, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with administering the Medicare program, published a final rule with respect to Medicare billing by teaching physicians. The effective date of this rule was July 1, 1996. In adopting this final rule, HCFA sought to end years of ambiguity and inconsistent enforcement among carriers nationwide with respect to Medicare billing by teaching physicians. Certain state payers like Georgia Medicaid have adopted these rules as well.

1.2 University Compliance Plan. In 1996, the University developed a Compliance Plan to help ensure compliance with HCFA's teaching physician rules. As part of that plan, the University prepared this Teaching Physician Billing Policy to describe the standards that the University expects all faculty and employees to follow in connection with the Medicare teaching physician rules.

This policy was revised in October 2003, and is based primarily on instructions that CMS has issued to its carriers. In addition, the University, based on legal advice that it has received, has added guidelines to clarify CMS's requirements or to address issues that are not covered by CMS's instructions. Furthermore, the Office of Physician Billing Compliance collaborates with the University of Florida Jacksonville Physicians, Inc. Education Department to provide education and training programs for all faculty, residents, fellows, and billing personnel regarding the Medicare teaching physician rules. In keeping with the mission of this teaching institution, all faculty members must comply with these requirements and attend all mandatory education and training programs.

1.3 Questions. Through its Compliance Plan, the University will make all best efforts to respond to questions faculty may have with respect to specific implementation of this Teaching Physician Billing Policy. If you have a question about some aspect of the Compliance Plan, this Teaching Physician Billing Policy, or CMS's rules, you should contact the Office of Physician Billing Compliance at 904-244-2158.

1.4 Review of this Policy. This Teaching Physician Billing Policy shall be reviewed periodically by the University and revised as appropriate to reflect current federal requirements. Faculty and staff will be informed promptly of any changes.

2.0 General Rule

In general, with very few extremely limited exceptions described below, if a resident participates in a service provided in a teaching setting, the Teaching Physician may not bill Medicare Part B for services unless **the Teaching Physician is present during, or personally performs, the key portion of any service for which payment is sought.**

3.0 Definitions

3.1 “Approved Graduate Medical Education (GME) Program” means a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association or the equivalent entity for osteopathy, dentistry, or podiatry or a program that may count towards certification of the participant in a specialty or subspecialty listed in the Annual Report by the American Board of Medical Specialties (ABMS). (Note that the ABMS listing is not mentioned in the Medicare teaching physician rules except by incorporating existing language in another longstanding regulation concerning cost reporting by hospitals).

3.2 “Direct Supervision” means the Teaching Physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the Teaching Physician must be present in the room when the service is performed.

3.3 “Key Portion” means that part (or parts) of a service that the Teaching Physician determines is (are) a key portion(s).

3.4 “Immediately Available” has not been defined by CMS, however, as a matter of University policy, the Teaching Physician should, at a minimum, remain In the Building and not become involved in other scheduled patient care. The Teaching Physician may perform rounds, check on patients in recovery, review charts in his or her office, and even begin another procedure. The Teaching Physician may not see previously scheduled patients in a clinic unless such patients are seen on an urgent or emergent basis of short duration, or for a pre-operative visit.

3.5 “In the Building” means the Pavilion and the Towers are not considered the same “building” as the Faculty Clinic or the Clinical Center. However, the Faculty Clinic is considered the same “building” as the Clinical Center. For example, a surgeon is not “immediately available” in the Pavilion operating room while he/she is in the Clinical Center operating room and vice versa.

3.6 “Medical student” means an individual who participates in an accredited educational program, such as medical school, that is not an Approved GME Program.

3.7 “Non-provider Setting” means a setting other than a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility in which residents furnish services. This could include, but is not limited to, family practice or multi-specialty clinics or physician offices.

3.8 “Physically Present” means that 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.

3.9 “Resident” means an individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry. For the purpose of federal rules includes interns and fellows, as well as residents

“Resident” also includes a physician who is not in an approved GME program, but who is authorized to practice only in a hospital setting, i.e., physicians with temporary or restricted licenses or unlicensed graduates of foreign medical schools.

3.10 “Teaching Physician” means a physician (other than another resident) who involves resident in the care of his or her patients.

3.11 “Teaching Setting” means any provider, hospital-based provider, or non-provider setting in which Medicare payment for resident services is made under the Part A direct GME payment.

4.0 Evaluation and Management (E/M) Services

On November 22, 2002, the Centers for Medicare and Medicaid Services (CMS) revised the documentation requirements for Evaluation & Management Services (E/M) billed to Medicare by Teaching Physicians. These revisions still require that Teaching Physicians personally document their participation in the service, however, for E/M services, Teaching Physicians need not repeat documentation already provided by a resident.

4.1 Participation and Presence. In general, Teaching Physicians may bill and be reimbursed for services involving residents when:

- the Teaching Physician personally furnishes the services; or
- the Teaching Physician was physically present during the critical or key portion(s) of the services that a resident performs.

4.2 Documentation. For purposes of payment, E/M services billed by the Teaching Physician require that they personally document at least the following:

- they performed the service or were physically present during the critical or key portion(s) of the service when performed by the resident; and
- the participation of the Teaching Physician in the management of the patient.

This rule change now makes it permissible to append the Teaching Physician documentation when reviewing the resident's note, upon condition that the time lapse between the date of service, and appending the note is reasonable.

As a result, what the resident did and documented may be combined with what the Teaching Physician did and documented to support a service. The Teaching Physician must only perform the key elements of the exam. However, the resident's note must be available to review. For example, if the resident's note supports a 99203 and the Teaching Physician is billing a 99205, then the Teaching Physician's note must include additional documentation required to support the service.

NOTE: 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.

If the resident provides the service without the Teaching Physician's direct participation, the resident must dictate the clinic note, but the service cannot be billed.

4.2.1 Acceptable Documentation. The following are examples of minimally acceptable documentation of three scenarios for E/M encounters in teaching settings.

Scenario 1

The Teaching Physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- *Admitting Note:* "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."
- *Follow-up Visit:* "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."
- *Follow-up Visit:* "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

NOTE: In this scenario if there are no resident notes, the Teaching Physician must document as he or she would document an E/M service in a non-teaching setting.

Scenario 2

The resident performs the elements required for an E/M service in the presence of, or jointly with, the Teaching Physician and the resident documents the service. In this case, the Teaching Physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The Teaching Physician's note should reference the resident's note. For payment, the composite of the Teaching Physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the Teaching Physician.

- *Initial or Follow-up Visit:* "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."
- *Follow-up Visit:* "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3

The resident performs some or all of the required elements of the service in the absence of the Teaching Physician and documents his or her service. The Teaching Physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the Teaching Physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The Teaching Physician's note should reference the resident's note. For payment, the composite of the Teaching Physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the Teaching Physician. *Initial Visit:* "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

- *Initial or Follow-up Visit:* "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."
- *Follow-up Visit:* "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."
- *Follow-up Visit:* "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

4.2.2 Unacceptable Documentation. The following are examples of unacceptable documentation:

- “Agree with above.”, followed by legible countersignature or identity;
- “Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;
- “Discussed with resident. Agree.”, followed by legible countersignature or identity;
- “Seen and agree.”, followed by legible countersignature or identity;
- “Patient seen and evaluated.”, followed by legible countersignature or identity; and
- A legible countersignature or identity alone.

4.2.3 Medical Student Documentation. Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by a Teaching Physician is limited to documentation related to the review of systems and/or past family/social history. These items are not separately billable, but are taken as part of an E/M service, and need not be performed in the physical presence of a Teaching Physician or physical presence of a resident in a service meeting the requirements set forth in the teaching physician rules.

Additionally, the Teaching Physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the Teaching Physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

NOTE: The only Medical Student documentation that supports a portion of the bill is the Review of Systems and the Past, Family/Social History portion of the history. The Teaching Physician must both perform and document the rest of the service. The Teaching Physician must repeat the exam, even if the medical student performed the exam in the Teaching Physician’s presence, except for those elements that the Teaching Physician can assess by observing the medical student’s performance of the element (for example: gait).

5.0 Consultations (Inpatient and Outpatient)

5.1 Requirements. Consultations require a request from another physician for evaluation of a patient’s condition **AND** that a written report on the consultation be sent back or otherwise be communicated (such as by inclusion in a hospital chart for an inpatient) to the physician who requested the consultation. The identity of the physician requesting

the consultation, the actual request for the consultation, and a copy of the written report that was communicated back to the requesting physician must be documented in the record.

A consultation is meant to provide *advice* to another physician who has primary care of the patient and should not be billed as a consultation if the expectation is that the “consulting” physician is simply accepting a transfer of primary responsibility for treating the patient. Nonetheless, a consulting physician may prescribe and begin treatment of the patient. If the consulting physician will then continue to follow the patient’s course of treatment, all subsequent services are office or inpatient visits, not follow-up consultations.

5.2 Participation and Documentation. Guidelines for Consultations and Teaching Physician participation and documentation are as outlined in Section 4.0.

6.0 Primary Care Exception

6.1 General Rule. In 1996, the College requested the Primary Care Exception for the selected residency programs. Under the Primary Care Exception, for certain new and established patient office visit services (CPT codes 99201-203; 99211-213), the Teaching Physician only needs to be immediately available when a resident performs these services and the Teaching Physician may bill Medicare Part B for his or her services.

All faculty and residents are trained in the requirements for Teaching Physician participation and required documentation in the course of their billing compliance training activities described in the orientation and continuing education sections above.

Effective January 1, 2005, the following code is included under the primary care exception: G0344 - Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 6 months of Medicare enrollment.

6.2 Attestation. For this exception to apply, a primary care center must apply to a carrier and *attest in writing* that all of the following conditions are met for a particular residency program:

- The services must be furnished in a center 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. This requirement is not met when the resident is assigned to a physician’s office away from the center or makes home visits. In the case of a non-hospital entity, the carrier should verify with the fiscal intermediary that the entity meets the requirements of a written affiliation agreement between the hospital and the entity.

- Any resident furnishing the service without the presence of a Teaching Physician must have completed more than 6 months of an approved residency program.
- The Teaching Physician in whose name the payment is sought must not supervise more than 4 residents at any given time and must direct the care from such proximity as to constitute immediate availability.
- The Teaching Physician must:
 - Have no other responsibilities at the time of the service for which payment is sought;
 - Assume management responsibility for those beneficiaries seen by the residents;
 - Ensure that the services furnished are appropriate;
 - Review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and
 - Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.
- The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of Teaching Physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that the Teaching Physicians remain the same over any period of time.
- The range of services furnished by residents includes all of the following:
 - Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
 - Coordination of care furnished by other physicians and providers; and
 - Comprehensive care not limited by organ system or diagnosis.

6.3 Programs Likely to Qualify.

The types of residency programs most likely to qualify for the primary care exception include: Family Practice, General Internal Medicine, Geriatric Medicine, Pediatrics and Obstetrics/Gynecology. A very limited number of GME programs in Psychiatry may qualify 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.

NOTE: If a service other than those listed above is furnished, the general Teaching Physician Policy set for in Section 8.0 applies. Additionally, the Primary Care Exception for low-level E&M services does not apply to in-patient services.

7.0 Time-Based Codes other than Critical Care Services (CPT codes 99291-99292)

7.1 Presence. For procedures determined on the basis of time, the Teaching Physician must be present for the period of time for which the claim is made. Do not add the time spent by the resident with the patient in the absence of the Teaching Physician to time spent by the resident and the Teaching Physician with the patient, or time spent by the Teaching Physician alone with the patient. For example, a code that specifically describes a service of 20-30 minutes applies only if the Teaching Physician is present for 20-30 minutes.

7.2 Documentation. If a Teaching Physician chooses to bill based on time, the following items must be documented in the medical record:

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

Acceptable documentation of the Teaching Physician's participation would 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 patient's condition)].**

7.3 Examples of Time-Based Codes. Examples of codes falling into this category include:

- hospital discharge day management (CPT codes 99238-99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50%) the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- individual medical psychotherapy (CPT codes 90804-90829);
- prolonged services (CPT codes 99358-99359); and
- care plan oversight (HCPCS codes G0181-G0182)

Refer to Section 8.0 for guidance related to critical care services (CPT codes 99291-99292).

8.0 Critical Care Services (CPT codes 99291-99292)

8.1 Presence. In order for the teaching physician to bill for critical care services the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes.

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

8.3 Acceptable Documentation. A combination of the teaching physician's documentation and the resident's documentation may be used to support critical care services. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

The teaching physician medical record documentation must provide substantive information including:

- time the teaching physician spent providing critical care;
- that the patient was critically ill during the time the teaching physician saw the patient;
- what made the patient critically ill; and
- the nature of the treatment and management provided by the teaching physician.

NOTE: 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.

If the resident provides the service without the Teaching Physician's direct participation, the resident must dictate the clinic note, but the service cannot be billed.

8.3.1 Example of Acceptable Documentation. The following is an example of acceptable documentation:

- *"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."*

8.3.2 Unacceptable Documentation. The following is an example of unacceptable documentation:

- “I came and saw (the patient) and agree with (the resident).”

9.0 Physician Assistant (PA) or Advanced Registered Nurse Practitioner (ARNP) Services

These requirements are relevant to Medicare Part B billing. For Georgia Medicaid or Florida Medicaid requirements, refer to respective payer Handbooks.

9.1 General. On October 25, 2002, CMS provided revisions to address payment for E/M services provided by a physician and non-physician practitioner (NPP). This revision clarifies the billing criteria for combined E/M services between a physician and an NPP in the same practice group.

9.2 Hospital-Based Inpatient / Hospital-Based Outpatient / Emergency Department Setting. When a hospital inpatient / hospital outpatient / emergency department E/M encounter is shared or split between a physician and a PA/ARNP from the same group practice the E/M encounter may be billed under the physician's name and provider number **if and only if:**

- The physician provides any face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and
- The physician personally and contemporaneously documents in the patient's record the physician's face-to-face portion of the E/M encounter with the patient.

NOTE: Under Medicare, if the physician does not personally perform and personally and contemporaneously document a face-to-face portion of the E/M encounter with the patient, then the E/M encounter *cannot* be billed under the physician's name and provider number and may be billed only under the PA/ARNP's name and provider number.

9.3 Non-Hospital-Based Outpatient Clinic / Office Setting. When a non-hospital outpatient clinic / office E/M encounter is shared or split between a physician and a PA/ARNP the E/M encounter may be billed under the physician's name and provider number **if and only if:**

- The patient is an established patient; and
- The "incident to" rules are met. (**Medicare has clarified that "incident to" billing is not allowed for new patients/first visits.**)

NOTE: If the patient is not an established patient and the "incident to" rules are not met, then the E/M encounter *cannot* be billed under the physician's provider number and may be billed only under the PA/ARNP's provider number.

This means, under *Medicare*, that a physician *cannot* combine the E/M services of a PA/ARNP and a physician for a NEW patient on a FIRST visit E/M encounter and bill under the physician's name and provider number. Additional guidelines on incident-to billing are provided in Section 9.

There is no incident-to billing for inpatient or hospital-based clinics.

10.0 Incident-to Billing

These requirements are relevant to Medicare Part B billing. For Georgia Medicaid or Florida Medicaid requirements, refer to respective payer Handbooks.

10.1 Requirements. Medicare Part B covers services and supplies furnished as an incident to the services of a physician, if the following requirements are met:

- The services and supplies are of the type that are commonly furnished in a physician's office and are either furnished without charge or are included in the Teaching Physician's bill.
- The services are an integral, although incidental, part of the professional services performed by the Teaching Physician.
- The services are performed under the direct supervision of the Teaching Physician.

NOTE: There is no incident-to billing for inpatient services or hospital-based clinics.

11.0 Surgical Procedures (Including Endoscopic Procedures)

11.1 General. The Teaching Physician is responsible for the pre-operative, 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 critical or key portion(s) of the procedure.

NOTE: When a Teaching Physician is not present during the non-critical or non-key portion(s) of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified physician to immediately assist the resident in the other case should the need arise.

11.2 Scrubbed-In Determination. The Teaching Physician determines whether he or she needs to be scrubbed-in (even during the key portions of a procedure).

11.3 Minor Procedures. For procedures that take only a few minutes (5 minutes or less) to complete, for example, 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 procedure.

11.3.1 Sample Documentation. "I was present for (or performed) the entire procedure" along with the signature of Teaching Physician.

11.3.2 Teaching Physician not Present. Minor procedures during which the Teaching Physician is not present for the entire procedure will not be billed. Additionally, emergency and/or elective major procedures (i.e. burr holes, craniotomy for trauma, etc.) performed on patients without the attendance of the Teaching Physician for the key portion (regardless of telephone consultation or availability within the medical center) will not be billed.

11.4 Diagnostic Endoscopic Procedures. In order to bill Medicare for endoscopic procedures, 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.

11.4.1 Documentation. The medical record must explicitly state that the Teaching Physician was present through the entire viewing.

NOTE: Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

11.5 General Documentation Requirements for Surgical Procedures. The Teaching Physician *must* document his or her participation in surgical cases by completing the designated section at the bottom of the Operative Record. The key portion(s) of the procedure must be designated, as well as any immediately available Teaching Physician who covered non-key portion(s) of the case, and what portion specifically they covered (e.g. opening or skin closure). The signature of the Teaching Physician is required on the Operative Record.

11.5.1 Sample Documentation. *"I was present during (or personally performed) the key portions of the procedure, which included [list key portions], as well as other portions. I was immediately available for the entire procedure between opening and closing. Signature "Dr. Teaching Physician." This may be entered in the chart as either a written or typed note*

11.6 Single Surgery. When the Teaching Physician is present for the entire procedure, his or her presence may be demonstrated by notes in the medical record made by the physician, resident, or O.R. nurse. However, the Teaching Physician *must* document his or her participation in surgical cases by completing the designated section at the bottom of the Operative Record.

11.6.1 Single Surgery Documentation. When the Teaching Physician is present for the entire period between opening and closing of the surgical field, his or her presence may be demonstrated by notes in the medical record made by the physician, resident or O.R. nurse. However, the Teaching Physician *must* document his or her participation in surgical cases by completing the designated section at the bottom of the Operative Record.

11.7 Two Overlapping Surgeries. Teaching Physicians may bill Medicare for two, but no more than two, overlapping procedures, provided that the Teaching Physician is physically present for the key portion(s) of both operations and all the key portions of the initial procedure have been completed before the Teaching Physician begins to become involved in a second procedure. It is critical that the Teaching Physician personally document the key portion(s) of each procedure in their respective medical record, as well as document his or her “immediate availability” or the identity of the “covering” Teaching Physician. The following requirements apply:

- The cases must be scheduled so that the key portions do not take place simultaneously.
- The billing surgeon must complete the key portion of case #1 before moving to case #2.
- There must be a surgeon who is immediately available to provide assistance in case #1. If the billing surgeon cannot return to case #1 because he or she has become involved in the key portion of case #2, then arrangements must be made for another surgeon to cover case #1.
- The billing surgeon must document his or her participation in the key portion of each case, including in that documentation a description of the key portion.
- In those instances when it is necessary for another surgeon to provide coverage for case #1 on an immediately available basis, the identity of the covering surgeon should be noted in the operative record.

NOTE: There is no limit on the number of times the Teaching Physician may overlap cases during the day as long as there are no more than two cases running at the same time, the Teaching Physician is present for the key portion of each case and he or she is immediately available for the entire case.

11.8 Other Complex or High-Risk Procedures. In the case of complex or high-risk procedures for which national Medicare policy, a local carrier 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 with the resident in order to bill Part B. The presence of the resident alone would not establish a basis for Part B payment for such services.

11.9 Three or More Overlapping Surgeries. In the case of three or more concurrent surgical procedures, the Teaching Physician’s role in each of the cases would be classified as supervisory and not payable under Medicare Part B.

NOTE: Under no circumstances may the Teaching Physician be involved in more than two separate procedures at one time and still bill for any of the procedures. In other words, if the Teaching Physician has three or more separate procedures going on at the same time he or she cannot bill for any Medicare procedures.

11.10 The Teaching Physician is Not Present for Part of the Key Portion or is Not Immediately Available. In this case, the Teaching Physician may arrange for another Teaching Physician to cover for him or her.

11.10.1 Designation of Another Physician to be Immediately Available. There may be cases when the Teaching Physician is involved in the key portions of a single surgery but he or she cannot be immediately available during the non-key portions of the procedure. For example, the Teaching Physician may need to begin the key portion of a second surgery, leave the building and/or perform other non-surgical patient care activities. In such cases, the Teaching Physician could arrange for another Teaching Physician to be immediately available to intervene in the original case should the need arise and the original Teaching Physician still could bill for the surgery. The medical record should note which physician is immediately available. The designee would be a physician who is not involved in or immediately available for any other surgical procedure.

NOTE: As described above, if the Teaching Physician has been involved in the key portions of one surgery and then leaves that operating room during the non-key portions to participate in the non-key portions of a second procedure, CMS considers the Teaching Physician immediately available for the first surgery. Therefore, the need to designate another physician as being immediately available only arises in the event the Teaching Physician leaves a single surgery to perform other non-surgical patient care activities or leaves to participate in the key portion of the second surgery which render the physician not immediately available.

11.10.2 Covering Physician. The covering physician must be present during the key portion of the procedure (if the Teaching Physician is not). The covering physician can be involved with one other procedure during the non-key portions of the procedure as long as he or she is notified that he or she is now responsible for being immediately available for the first procedure. The covering physician cannot be involved with patient care in the clinic.

11.10.3 Documentation for Primary Teaching Physician. The Teaching Physician will document (either written in the Operative Record or by personally dictating the operative report) which portion of the procedure he or she participated in and which portion the covering physician participated in and state the name of the covering physician. *"I was present during (or personally performed) the key portion of the procedure, which included [list key portions]. I was not immediately available during other aspects of the case which were covered by Dr. Coverage who was immediately available. Signature Dr. Teaching Physician."* The Teaching Physician will sign the operative report and the written statement and billing will be under the Teaching Physician's name.

11.10.4 Documentation for Covering Physician. *"I was present during (or personally performed) the key portion of the procedure not covered by Dr Teaching Physician which included [list key portions]. I was immediately available during the other aspects of the case. Signature Dr. Coverage."* The covering physician must sign this statement. If the Teaching Physician is unable to be present for a part of the key portion of the procedure or is unable to be immediately available for the entire procedure and another Teaching Physician is unable to cover the key portion of the case and/or is unable to be immediately available for the non-key portions of the case, then the Teaching Physician will not bill for the case.

11.11 Pre-Operative Evaluations. Routine pre-operative visits are included in the "global" surgical fee. The Teaching Physician will personally see patients upon whom they will be doing surgery within a reasonable period of time prior to surgery. The pre-operative visit in such cases can safely and effectively be performed by a resident to merely confirm that no significant change has occurred in the patient's condition since the prior visit which might change the considerations in going forward with the surgery. The Teaching Physician is responsible for determining whether the pre-operative visit is a key portion. If the pre-operative visit is a key portion, but the Teaching Physician does not participate in it, then a reduced fee for the surgical procedure must be billed.

11.11.1 Documentation of Pre-Operative Evaluation: *"I was present for the pre-operative evaluation. Signature Dr. Teaching Physician."* This documentation should be a part of the pre-operative evaluation in written or dictated form. This may be entered in the chart in the by either a written or typewritten note.

11.12 Post-Operative Visits. The Teaching Physician determines which post-operative visits are considered critical or key and require his or her presence. In appropriate cases, there may be no key post-operative visits. In this case, an unreduced fee may be billed as long appropriate care is provided by a resident or nurse.

11.12.1 Reduced Global Surgical Fee. If the post-operative period extends beyond the patient's discharge and the Teaching Physician is not providing the patient's follow up care, then the surgical procedure should be billed using the -54 modifier for a reduced payment.

11.12.2 Teaching Physician not Present for Key Portions. In cases where the Teaching Physician was not present for the key portions of a surgical procedure, and the procedure was not billed, the Teaching Physician may bill for any post-operative visits he or she personally performs, provided that the payment for these post-operative visits does not exceed the post-operative component of the global surgical fee.

12.0 Assistants at Surgery

12.1 General Rule. No payment is allowed for services of assistants at surgery when furnished in a teaching hospital that has a training program related to the medical specialty required for the surgical procedure and a qualified resident is available

12.2 Resident not Available. In circumstances where there is no qualified resident available, claims may either be submitted with an – 82 modifier, indicating a qualified resident was not available, or by attaching the following certification:

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.

12.3 Exceptional Circumstances. Payment may be made, even if there is a qualified resident available, under exceptional circumstances such as emergencies, life-threatening situations such as multiple traumatic injuries that require immediate treatment.

12.4 Community Physicians. Payment may be made if the physician has an across-the-board policy of never involving residents in the surgical care of his or her patients, for example, community physicians who have no involvement in the hospital's GME program.

12.5 Multiple Specialties Involved in Surgery. Certain complex medical procedures, such as multi-stage transplant surgery and coronary bypass surgery, may require a team of physicians. In these cases, each physician is engaged in a level of activity different from assisting the surgeon in charge. Payment might be made on the basis of a single team fee. Team surgery is paid on a "By Report" basis.

In other situations, the services of physicians of different specialties may be necessary during surgery because of the existence of more than one medical condition. For example, a patient's cardiac condition may require a cardiologist's presence to monitor the patient's condition during abdominal surgery. In this case, the physician furnishing the concurrent care is functioning at a different level than an assistant at surgery, and payment would be based on the fee schedule value for these concurrent procedures.

13.0 Diagnostic Radiology and Other Diagnostic Tests

13.1 Interpretation of Diagnostic Radiology and Other 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. If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he/she is indicating that he/she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

14.0 Psychiatry

14.1 General Rule. The Teaching Physician presence and documentation requirements outlined in Sections 4.0 through 5.2 are applicable to E/M services rendered by teaching psychiatrists. For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy to the physical presence requirement.

14.2 Time-based services. In the case of time-based services such as individual medical psychotherapy (CPT codes 90804-90829), refer to Section 7.3 above.

14.3 Credentials of the Teaching Physician. The teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

15.0 Maternity Services

15.1 Deliveries and global packages. In the case of maternity services furnished to women who are eligible for Medicare, the Teaching Physician must be present in the delivery room at the time of the delivery in order to be reimbursed for the delivery service. There are separate codes for global obstetrical care (antepartum, delivery, and postpartum) and for deliveries only. In order to bill for the global package, the Teaching Physician must be present and participate in a minimum number of visits. The Teaching Physician who performs the delivery may be different than the Teaching Physician(s) who provide the antepartum or postpartum visits as long as these Teaching Physicians are in the same specialty group.

16.0 Anesthesia, Ophthalmology, and Pathology

The Departments of Anesthesia, Ophthalmology, and Pathology have billing rules unique to their specialties. These billing rules are provided in detail in their respective Departmental Compliance Plans.

17.0 End Stage Renal Disease Related Visits furnished under the Monthly Capitation Payment Method (MCP)

17.1 General. In the *Federal Register* published November 7, 2003 (68 FR 63216), CMS established new procedure codes (G0308-G0319) for management of patients on dialysis with payments varying based on the age of the patient and the number of face-to-face patient visits provided within each calendar month. A single procedure code is reported once per month for services performed in an outpatient setting that are related to the patients' ESRD. The frequency of these visits varies depending upon the patient's medical status, complicating conditions, and other determinants. At a minimum, one of the monthly patient visits must be a complete face-to-face assessment of the patient that

establishes the patient's plan of care (the "Complete Assessment"). Documentation of Subsequent Visits must also support face to face physician interaction between the Teaching Physician and the patient.

17.2 Participation and Presence. For purposes of payment, the Teaching Physician may bill and be reimbursed for services involving residents when:

- the Teaching Physician personally furnishes the services; or
- The Teaching Physician was physically present during the critical or key portion (s) of the services that a resident performs.

NOTE: More than one Teaching Physician may provide some of the visits during the month but the Teaching Physician who provides the Complete Assessment, must be the Teaching Physician who submits the bill for the monthly service.

17.3 Key Portions. With regard to the monthly management of dialysis patients, the ESRD-related visits are the key portion of the monthly capitation payment (MCP) service that determines the applicable payment amount. Patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visit.

17.4 Documentation. For purposes of payment, documentation for ESRD-related visits billed by the Teaching Physician may be a combination of both the resident's note and the Teaching Physician's note. However, **the Teaching Physician must document his or her physical presence and his or her review of the resident's note during each visit furnished** in order to count that visit toward the total number of monthly visits which determines the service billed.

NOTE: 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.

If the resident provides the service without the Teaching Physician's direct participation, the resident must dictate the note, but the service cannot be counted toward the total number of monthly visits which determines the service billed.

17.5 Acceptable Documentation. The complexity of the documentation for an encounter may vary depending upon whether the service rendered is a Complete Assessment or a Subsequent Visit . Consequently, the following are examples of minimally acceptable documentation for the Complete Assessment and for Subsequent Visits.

Complete Assessment: "I performed a history and physical examination of the patient and discussed the management of the patient with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Complete Assessment: “I was present with the 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.”

Complete Assessment: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

Subsequent Visit: “I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.”

Subsequent Visit: “I saw and examined the patient. I agree with the resident’s note except decrease dry weight to 102.0 kg.”

Subsequent Visit: “I saw the patient with the resident and agree with the resident’s findings and plan.”

Subsequent Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s findings and plan as written.”

17.6 Unacceptable Documentation. The following are examples of unacceptable documentation for either the Complete Assessment or the Comprehensive Visit:

- “Agree with above.” followed by countersignature or identity;
- “Rounded, Reviewed, Agree.” followed by countersignature or identity;
- “Discussed with resident. Agree.” followed by countersignature or identity;
- “Seen and agree.” followed by countersignature or identity;
- “Patient seen and evaluated.” followed by countersignature or identity; and
- A countersignature or identity alone.

18.0 Services Provided by Fellows

18.1 General Rule. The Medicare rules on billing by Teaching Physicians when services involve residents apply equally to services involving fellows. Except for the limited situations described in this section, a fellow may not bill in his or her own name, regardless of whether the teaching hospital included the fellow in its count of full-time equivalents for its cost report. **Note that the federal government’s teaching physician rules apply even to fellows in an approved training program who an individual hospital may choose not to include as an eligible individual in its full-time equivalency count of residents for its Part A cost report.**

18.2 Fellows Not in Approved Programs. If the fellow is not in an approved program, (as defined in Section 3.0 above), the fellow may bill for services in his or her own name in

any provider setting, provided that the fellow is a duly licensed physician in the state and has a provider number.

18.3 Moonlighting Arrangements. If the fellow is in an approved program, the fellow may bill for services under a moonlighting arrangement either in his or her home institution or another institution. A separate contract, with a separate salary, for moonlighting clearly stating that the services to be provided are outside the scope of the training program is required. If the moonlighting occurs at the home institution, services provided may be only in hospital outpatient departments and emergency departments.

18.4 Fellows in Non-Provider Settings. A fellow in an approved program who is duly licensed in the state may bill in his or her own name if: 1) the fellow is in a non-provider setting, such as an independent outpatient center, private physician's office, clinic, or HMO, and 2) the hospital does not count the fellow's time spent in the non-provider setting for direct GME payment purposes.

¹ Replaces June 1996, February 1997, December 1998, August 2001, October 2003, December 2005, and July, 2007 Policies.