

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

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¹Replaces June 1996, February 1997, December 1998, August 2001, October 2003, December 2005, July 2007, December 2008, August 2011, November 2018, and March 2020 Policies.

Chapter 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 payors 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 several times, 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. In 2018 and 2019, several changes were made to Medicare policy surrounding medical student documentation contributing to a billable service. This latest revision incorporates those changes. 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. Changes will be incorporated into mandatory education materials.

Chapter 2

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.**

Chapter 3

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 “Concurrent Surgeries” are those in which two or more operations occur when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring at the same time.

3.3 “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.

3.4 “Key Portion” means that part (or parts) of a service that the Teaching Physician determines is (are) a key portion(s). Although referred to as “critical portion(s).

3.5 “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.

3.6 “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.

3.7 “Student” means an individual who participates in an accredited educational program, such as a medical school, that is not an Approved GME Program. Effective January 1, 2020, the definition of “Student” is no longer restricted to medical students but may also apply to the following student types:

- physician assistant;
- advanced practice registered nurse;

- clinical nurse specialist;
- certified nurse midwife; and
- certified registered nurse anesthetist.

Prior to January 1, 2020, the definition of “Student” only applies to medical students.

3.8 “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.

3.9 “Overlapping Surgeries” means surgical procedures where the primary surgeon is initiating and participating in another operation when he or she has completed the critical portions of the first procedure and is no longer an essential participant in the final phase of the first operation.

3.10 “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.

3.11 “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.

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

3.13 “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.

Chapter 4

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 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.

Alternatively, effective January 1, 2019, a resident or nurse may document on behalf of the Teaching Physician the Teaching Physician's presence and participation in the E/M service. The Teaching Physician must cosign the resident's or nurse's note. The resident or nurse may document on behalf of the Teaching Physician only if both the resident or nurse and the Teaching Physician evaluate the patient concurrently.

4.2.1 Acceptable Documentation. The following are examples of minimally acceptable documentation of four (4) E/M scenarios 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.

Acceptable Teaching Physician Attestations:

- *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.”

Effective for dates of service January 1, 2019 and after, a resident or nurse may document the Teaching Physician’s presence and participation in the E/M service. The Teaching Physician does not have to attest personally to his or her presence and participation; however, the Teaching Physician must review the resident or nurse’s note for accuracy and cosign the resident or nurse’s note.

Acceptable Resident Attestation:

- *Initial or Follow-up Visit:* “Dr. [Teaching Physician] was present with me during the history and exam. The case was discussed with Dr. [Teaching Physician] who agreed with my findings and plan as documented in my note.

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.

Acceptable Teaching Physician Attestations:

- *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.”

Scenario 4:

When a medical resident admits a patient to a hospital late at night and the Teaching Physician does not see the patient until later, including the next calendar day:

- The Teaching Physician must document that he/she personally saw the patient and participated in the management of the patient. The Teaching Physician may reference the resident's note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided the patient's condition has not changed, and the Teaching Physician agrees with the resident's note.

- The Teaching Physician's note must reflect changes in the patient's condition and clinical course that require the resident's note be amended with further information to address the patient's condition and course at the time the patient is seen personally by the Teaching Physician.
- The Teaching Physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the Teaching Physician's and resident's documentation satisfies criteria for a higher level of service. 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.

Acceptable Teaching Physician Attestations:

- *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. Effective 01/01/19, the following TP notes would be unacceptable without a resident or a nurse attesting to the TP's presence and participation in the service and participation in patient management.

- "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 (prior to January 1, 2019).

4.3 Student Documentation.

4.3.1 Student. Effective January 1, 2020. The definition of “Student” is no longer restricted to medical students but may also apply to the following student types:

- physician assistant;
- advanced practice registered nurse;
- clinical nurse specialist;
- certified nurse midwife; and
- certified registered nurse anesthetist.

4.3.2 Prior to January 1, 2018. Medical students were permitted to document services in the medical record. However, the documentation of an E/M service by a medical student that the Teaching Physician could refer to was limited to documentation related to the Review of Systems (ROS) and/or Past Family/Social History (PFSH). 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 was not permitted to refer to a medical student’s documentation of exam findings or medical decision making in his or her personal note. If the medical student documented the E/M service, the Teaching Physician was required to verify and re-document the history of present illness as well as perform and re-document the exam and medical decision-making activities of the service.

4.3.3 Effective January 1, 2018. Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must 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 this section for Teaching Physician billing. The performance of the E/M service in the presence of a resident does not absolve the Teaching Physician from personally performing or re-performing the exam and medical decision making portions of the service.

Students may document services in the medical record. However, the Teaching Physician *must verify in the medical record all student documentation or findings, including history, exam and/or medical decision making. The Teaching Physician must personally perform (or re-perform) the exam and medical decision making activities* of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-document this work.

Services involving students require:

- **PHYSICAL PRESENCE** of a Teaching Physician or resident with the student while activities occur;

- **PERFORMANCE** (or re-performance) personally by the Teaching Physician_of ALL elements of the physical exam and medical decision-making activities of the E/M service.
- **VERIFICATION** personally by the Teaching Physician_of all student documentation; AND

If the Teaching Physician chooses to rely on the student documentation and chooses not to re-document the E/M service, the Teaching Physician will add an attestation statement to the student’s note, sign, and date the student’s note. The Teaching Physician must review and/or edit the student’s note and then select the “Make Me the Author” button in EPIC. If this button is not selected, the student’s note will not be visible in chart review.

Resident Attestation: “I was/was not present (pick one) with the student during the history and exam. I discussed the case with the student and agree with the findings and plan as documented in the student’s note.”

The presence of a resident attestation statement does not relieve the Teaching Physician of the responsibility for performing the physical exam and the medical decision making and attesting as such.

Teaching Physician Attestation when Present with Medical Student: “I was present with the medical student for the service. I personally verified the history of present illness and performed the physical examination and medical decision making. I have verified all of the medical student’s documentation for this encounter.”

Teaching Physician Attestation when NOT Present with Medical Student: “I attest that I have reviewed the medical student note and verified the documentation and performed (or re-performed) the exam and medical decision making. I have made corrections and additions as appropriate.”

Chapter 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 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 Medicare Guidelines for Consultations.

Medicare will no longer pay for consultation codes 99241-99245 and 99251-99255 for dates of service 01/01/2010 and after. For specific instructions on billing for consultative services and replacement codes, refer to the following Compliance Policies:

- Selecting a Consultation Replacement Code When Medicare is the Primary Payor - Compliance Policy # 2009-12-001
- Consultation Payment Policy - Skilled Nursing Facility or Nursing Facility Location When Medicare is the Primary Payor - Compliance Policy # 2010-01-002
- Billing Medicare as the Secondary Payor for Consultation Services - Compliance Policy # 2010-02-001.

5.3 Participation and Documentation. Teaching Physician participation and documentation for consultation replacement E/M codes are as outlined in [Chapter 4.0](#).

Chapter 6

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 or other outpatient visit services (CPT codes 99201-99203; 99211-99213), 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. **Effective January 1, 2022, teaching physicians may use only medical decision making (MDM) for purposes of E/M visit level selection when billing the Medicare program under the physician fee schedule for office/outpatient E/M visits under this primary care exception.**

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:

G0402 - Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment.²

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

G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit

G0439 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

HCPCs Level II code G0344 was approved for use under the Primary Care Exception effective 01/01/05. This procedure code was deleted in 2009.

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 four (4) residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching Physicians may include one or more residents with less than 6 months in a GME approved residency program in the mix of four residents under the Teaching Physician's supervision. However, the Teaching Physician must be physically present for the critical or key portions of services furnished by the resident(s) with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of the resident with less than 6 months in a GME approved residency program.

Teaching Physicians submitting claims under this exception must:

- not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the residents;
- have the primary medical responsibility for patients cared for by the residents;
- ensure that the care provided was reasonable and necessary;
- review the care provided by the residents during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and
- patients under this exception should consider the center to be their primary location for health care services. The residents generally must be expected to provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:
 - 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.
- 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 prescribed as well as psychotropic drugs.

6.4 Acceptable Documentation. The patient medical record must document the extent of the Teaching Physician’s participation in the review and direction of the services furnished to each beneficiary. **Effective 01/01/2019, the extent of the Teaching Physician’s participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.**

NOTE: If a service other than those listed above is furnished, the general Teaching Physician Policy set forth in [Chapter 4.0](#) applies. Additionally, the Primary Care Exception for low-level E&M services does not apply to inpatient services.

Acceptable documentation of the Teaching Physician’s participation for an Initial or Follow-Up Visit would read:

“I reviewed with the resident the patient’s medical history, exam, diagnosis, and results of tests and treatments and agree with the patient's care documented.”

Chapter 7

7.0 Time-Based Codes Other than Critical Care

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

- hospital discharge day management (CPT codes 99238-99239);
- psychiatry services (CPT codes 90832-90838; 90839-90840; 90846-90847; 90875-90876);
- prolonged services (CPT codes 99354-99359); and
- care plan oversight (HCPCS codes G0181-G0182)
- interprofessional telephone/Internet consultations (CPT codes 99446-99449; and 99451-99452)
- advance care planning (CPT codes 99497-99498)

Note: Refer to Chapter 8 for guidelines specific to critical care services.

7.3 Office/outpatient E/M visit codes for which total time is used for the visit level selection. For purposes of selecting visit level, only count time spent by the teaching physician performing qualifying activities listed by CPT (with or without direct patient contact on the date of the encounter), including the time the teaching physician is present when the resident is performing such activities.

7.4 Documentation. The Teaching Physician must document his or her presence and participation in the service for the time being claimed. Depending on the service, the time spent by the Teaching Physician may be face-to-face time with the patient in an office/other outpatient visit setting or floor/unit time in an observation, inpatient, or nursing facility setting. If the Teaching Physician chooses to bill an E/M service based on counseling or coordination of care time, the following items must be documented in the medical record:

- the total Teaching Physician time spent with the patient;
- the time the Teaching Physician spent engaged in patient care; and

- the nature of the treatment and management provided by the Teaching Physician.

An example of acceptable Teaching Physician documentation for hospital discharge day management code 99239 (more than 30 minutes) would read:

“I saw the patient and spent 40 minutes discussing the hospital stay with the patient as well as writing discharge orders, prescriptions, and referral forms.”

7.5 E/M Services other than Office/Outpatient Visits Based on Counseling/Coordination of Care Time. For E/M codes in which counseling and/or coordination of care dominates (more than 50%) the encounter, time may be considered the key or controlling factor in determining a particular level of E/M service.

7.5.1 Documentation. If a Teaching Physician chooses to bill an E/M service based on counseling or coordination of care time, the following items must be documented in the medical record:

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

Acceptable documentation of the Teaching Physician’s participation would read:

“I spent 30 minutes with [patient name], 25 minutes of which was spent counseling on [list counseling topics (e.g. surgical and non-surgical options for treatment of patient’s condition or specific care coordination performed)].”

Chapter 8

8.0 Critical Care Services (CPT codes 99291-99292)

8.1 General. Medicare regulations for critical care services vary based on whether a resident is involved, an APP, or two physicians of same or different specialties. For a detailed policy on critical care, including split/shared billing between a physician and an APP and activities that count toward critical care time, refer to UFJPI Policy # 2022-02-001 (Billing Medicare Part B for Critical Care Services).

8.1 Presence. In order for the teaching physician to bill for critical care services the teaching physician must personally perform or be present with the resident 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 personally renders 35 minutes of critical care time or is present with the resident 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 time. 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. The teaching physician does not have to remain at the patient's bedside to count the critical care time; however, the teaching physician must at least be on the floor or in the unit to be considered immediately available and to count appropriate activities 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. The allowance for resident documentation of a Teaching Physician's presence and participation in an E/M service as detailed in section 4.0 is not applicable to critical care services.

If the resident provides the service without the Teaching Physician's direct participation, the resident must compose the 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 personally 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 Split/Shared Billing between Physicians and Advanced Practice Professionals (APP)

These requirements are relevant to Medicare Part B billing. For Medicaid and TriCare requirements, refer to respective payor Handbooks.

9.1 General. On October 25, 2002, CMS provided revisions to address payment for E/M services provided by a physician and Advanced Practice Professionals (APP). This revision clarified the billing criteria for combined E/M services between a physician and an APP in the same practice group (i.e., Split/Shared billing). The Medicare Physician Fee Schedule Final Rule for Calendar Year 2022 established new regulations for split/shared billing between a physician and an APP and critical care. Regulations specific to billing of critical care services may be found in UFJPI Policy # 2022-02-001 (Billing Medicare Part B for Critical Care Services).

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 APP, follow the procedure detailed in UFJPI Policy # 2020-07-001 (Split/Shared Billing between Advanced Practice Professionals and Physicians).

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 APP, the E/M encounter may be billed under the physician's name and provider number if and only if the incident-to billing requirements are met.

Additional guidance on incident-to billing is provided in [Chapter 10.0](#) of this policy and in Compliance Policy # 2011-05-001 (Medicare and Tricare Incident-to Billing in Physician-Based Settings).

9.4 Co-Signature Requirements. The University of Florida College of Medicine – Jacksonville will continue to require supervising physician co-signatures on all APP medical notes – regardless of the payor class of the patient in accordance with established UFJPI Policy # TB-09-07-001.

Chapter 10

10.0 Incident-to Billing.

10.1 General. Services and supplies furnished incident-to a physician or incident-to an Advanced Practice Professional (APP) may be billed under the physician's or APP's provider number, respectively. Refer to Compliance Policy # 2011-05-001 – Medicare and TriCare Incident to Billing in Physician-Based Settings. This policy is available on the Compliance website.

NOTE: There is no incident-to billing for services rendered in a hospital-based setting (whether emergency room, inpatient, or outpatient).

10.2 Co-Signature Requirements. The University of Florida College of Medicine – Jacksonville will continue to require supervising physician co-signatures on all APP medical notes – regardless of the payor class of the patient in accordance with established UFJPI Policy # TB-09-07-001.

Chapter 11

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 second surgical procedure, the Teaching Physician must arrange for another qualified physician to immediately assist the resident in the first 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.

11.4.1.1 Sample Teaching Physician Attestations.

"I was present for the entire procedure."

"I was present for the entire viewing."

11.4.1.2 Sample Resident/Nurse Note.

“Dr. John Smith was present for the entire procedure.”

“Dr. John Smith was present for 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 macro in the immediate post-operative note in EPIC OpTime or via a procedure note when the service is rendered outside of the operating room (e.g., at patient’s bedside, in clinic).

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 which specific portion(s) they covered (e.g. opening or skin closure). The signature of the Teaching Physician is required.

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.”

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 a nurse.

11.6.1 Single Surgery Documentation. Absent documentation by a resident or nurse of the Teaching Physician’s presence and participation, the Teaching Physician must document his or her participation in surgical cases by completing the designated macro in the immediate post-operative note in EPIC OpTime or via a procedure note when the service is rendered outside of the operating room (e.g., at patient’s bedside, in clinic).

11.6.1.1 Sample Single Surgery Documentation by Teaching Physician.

“I was present for the entire procedure. Signature Dr. Teaching Physician.”

“I personally performed the entire procedure. Signature Dr. Teaching Physician.”

11.6.1.2 Sample Single Surgery Documentation by Resident or Nurse.

“Dr. [list Teaching Physician’s name] was present for the entire procedure. Signature Resident.”

“Dr. [list Teaching Physician’s name] personally performed the procedure. Signature Nurse.”

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 (i.e., non-concurrent procedures). 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” during the entire case 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(s).
- 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 overlapping procedures going on, 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(s) of the second surgery, which render the physician not immediately available for the first surgery.

11.10.2 Covering Physician. The Covering Physician must be present during the key portion of the procedure (if the Primary 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 Primary Teaching Physician will document (via the immediate post-op note) 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. Covering Physician who was immediately available. Signature Dr. Primary Teaching Physician."* The Primary Teaching Physician will sign the note and billing will be under the Primary 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. Primary Teaching Physician which included [list key portions]. I was immediately available during the other aspects of the case. Signature Dr. Covering Physician."* The Covering Physician must sign this statement. If the Primary 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 Primary 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 of the global surgical package. 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 note. Alternatively, a resident or nurse may document the Teaching Physician's presence and participation in the pre-operative evaluation as detailed in [Chapter 4.0](#).

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 as appropriate care is provided by a resident.

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. This is applicable only if a formal transfer of care has been arranged between the Teaching Physician performing the surgery and another physician performing the post-operative care.

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 pre-operative and post-operative visits he or she personally performs and documents or those which the resident performs if the Teaching Physician documents in accordance with [Chapter 4.0](#).

Chapter 12

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 Qualified Resident not Available. In circumstances where there is no qualified resident available, claims may be submitted either 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.

Based on the procedure being performed, the patient, and the resident's experience, the attending surgeon may determine that an available resident is not qualified to assist.

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

12.4 Documentation. The immediate post-operative note has boxes for the primary surgeon to complete which indicate whether or not a resident was involved and whether or not the resident was qualified to assist if a resident was present in the case.

12.5 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.

12.6 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.

Chapter 13

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.

13.2 Documentation.

13.2.1 Teaching Physician prepares interpretation. Use the standard language for interpretation, and sign the report.

*"I personally reviewed the images and the resident's findings and agree with the above.
Signature Dr. Teaching Physician."*

*"I personally reviewed the images and the resident's findings except for
_____ [list edited findings]. Signature Dr. Teaching Physician."*

13.2.2 Resident prepares interpretation. Documentation of the review is included in the printed verified report that is part of the official medical record. Include a notation in the medical record that states: "I have personally reviewed the film and the resident's findings and [agree or disagree and make the appropriate changes]." No report is final unless verified and electronically signed by the Teaching Physician. A resident physician may approve his or her dictation, but verification may only be indicated after review of the report by the Teaching Physician. Approval of the dictated report and verification of the final report may be done with an electronic signature through the Radiology Information System, which has a security system to prevent unauthorized approval and verification.

13.3 Interventional Radiology. The three levels of physician supervision assigned to the technical component of a diagnostic test payable under the Medicare Part B physician fee schedule (i.e., general, direct, personal) have nothing to do with the Teaching Physician regulations. Those levels of physician supervision were designed to ensure that technicians performing the technical component of a diagnostic test (in a location where Medicare Part B reimburses the technical component of a diagnostic test) were properly supervised.

When it comes to interventional cases or "surgical" cases performed under imaging guidance, there are actually two parts of the case: the interventional or procedural aspect

of the case and the imaging interpretation aspect of the case. Sometimes a single procedure code includes both the procedural aspect and the imaging interpretation aspect (e.g., 49083 – abdominal paracentesis (diagnostic or therapeutic); with imaging guidance) while some procedure codes only include the procedural aspect of the case and the imaging interpretation aspect is billed with a separate procedure code(s) (e.g., 36569: Power injectable PICC placement; 76937: Ultrasound guidance used in vascular access; and 77001: Fluoroscopic guidance used in catheter positioning).

NOTE: Documentation by the resident such as “the Teaching Physician supervised the service” or documentation by the Teaching Physician indicating his or her “supervision” of the case is not sufficient to support billing for the procedural aspect of an interventional. There are numerous levels of supervision and they differ depending on the entity defining them. As such, it is unclear in this example what level of supervision was provided by the Teaching Physician.

13.3.1 Procedural Aspect of Case. Most CPT® codes in the range of 10000 through 69990 are categorized as “surgical procedures” and as such, the Teaching Physician documentation guidelines detailed in [Chapter 10.0](#) must be followed when a resident or ACGME approved fellow is involved in the procedural aspect of the interventional case. The location where the service is performed (e.g., patient bedside, special procedures room, operating room, imaging center) has no bearing on the Teaching Physician presence and documentation required to support professional billing. In addition, these guidelines are applicable regardless of the division who performs the service.

13.3.2 Imaging Interpretation Piece. The imaging interpretation piece of the case (e.g., fluoroscopic guidance, ultrasonic guidance) is billed with modifier “-26” appended to the procedure code(s) to indicate professional component only. The majority of these procedure codes fall within the 70000 CPT® code range. For these codes, the Teaching Physician must satisfy the requirements as detailed in Section 12.1 above.

13.3.3 Supervision and Interpretation (S&I) Codes. These procedures often fall within the 70000 or the 90000 CPT® code range and include “supervision and interpretation” in the description. The Teaching Physician’s physical presence throughout the procedure is required to support billing and it must be documented.

Radiologic supervision and interpretation (S&I) codes are used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more physicians and the interpretation of the findings. In order to bill for the supervision aspect of the procedure, the Teaching Physician or Supervising Physician (Teaching Physician in a department other than Radiology) must be physically present for the entire radiological service. The interpretation of the procedure may be performed at the same time or later by the same or another Teaching Physician or Supervising Physician.

When a single Teaching Physician is performing both the supervision and interpretation, both Teaching Physician notes (i.e., supervision piece note and interpretation piece note) are needed to support billing.

Note: S&I codes require Teaching Physician presence throughout the entire procedure, regardless of whether the radiologic portion of the procedure is performed by a resident/fellow or technician. Documentation by the resident such as “the Teaching Physician supervised the service” or documentation by the Teaching Physician indicating his or her “supervision” of the case is not sufficient to support billing for an S&I code. There are numerous levels of supervision and they differ depending on the entity defining them. As such, in this example, it is unclear what level of supervision was provided by the Teaching Physician.

13.3.3.1 Sample Documentation for the Supervision Piece of an S&I Procedure.

The Teaching Physician/Supervising Physician performing the supervision piece must personally document one of the following in order to bill for the service:

“I was present for the entire procedure. Signed Teaching Physician.”

“I personally performed the entire procedure. Signed Teaching Physician.”

Alternatively, the resident could document the Teaching Physician’s presence during the supervision piece as follows:

“Dr. [Teaching Physician’s name] was present was the entire procedure. Signed Resident”

“Dr. [Teaching Physician’s name] personally performed the entire procedure. Signed Resident”

13.3.3.2 Sample Documentation for Interpretation Piece of an S&I Procedure.

The Teaching Physician performing the interpretation piece must personally document one of the following in order to bill for the service:

“I personally reviewed the images and the resident’s findings and agree with the above. Signed Teaching Physician”

“I personally reviewed the images and the resident’s findings except for _____ [list edited findings]. Signed Teaching Physician”

13.3.3.3 Fragmented S&I Service. In situations in which a Supervising Physician (e.g. cardiologist) bills for the supervision (the ‘S’) of the S&I code, and a radiologist bills for the interpretation (the ‘I’) of the code, both physicians should append modifier “-52” (reduced service) to the procedure code(s). Payment for the fragmented S&I code is no more than if a single physician furnished both aspects of the case. When a single Teaching Physician is performing both the supervision and interpretation, both Teaching Physician notes (i.e., supervision piece note and interpretation piece note) are needed to support billing.

Chapter 14

14.0 Psychiatry

14.1 General Rule. The Teaching Physician presence and documentation requirements outlined in [Chapters 4.0](#) is 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 the physical presence requirement.

14.2 Time-based services. In the case of time-based services such as CPT® codes 90832-90834; 90836-90838; 90839-90840; 90846-90847; and 90875-90876, refer to [Chapter 7.0](#).

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.

Chapter 15

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 situations in which the Teaching Physician's only involvement was at the time of delivery, the Teaching Physician should bill the delivery only code. In order to bill for the global procedures, the Teaching Physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the Teaching Physician is not required to be present for a specified number of visits. The Teaching Physician who performs the delivery may be different than the Teaching Physician who provides the antepartum or postpartum visits as long as these Teaching Physicians are in the same specialty group.

Chapter 16

16.0 Anesthesia

The Department of Anesthesia has billing rules unique its specialty. These billing rules are provided in detail in a separate departmental compliance plan available on the Compliance website.

Chapter 17

17.0 Ophthalmology

17.1 General. 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.

17.2 Evaluation and Management Services. Follow the guidelines detailed in [Chapter 4.0](#).

17.3 Eye Examinations (CPT® codes 92002, 92012, 92004, 92014). Follow the guidelines detailed in [Chapter 4.0](#).

17.4 Ophthalmologic Examination and Evaluation under General Anesthesia (CPT® codes 92018-92019). Although not surgical in nature, follow the guidelines in [Chapter 10.0](#) for documentation of the Teaching Physician's presence and participation in the key portions of the procedure and immediate availability throughout the procedure.

17.5 Diagnostic Ophthalmological Services. Follow the guidelines in [Chapter 12.0](#) for the interpretation of diagnostic ophthalmological services that have a professional component whether billed globally (i.e. technical and professional components) or with the Modifier -26 for professional component only.

Chapter 18

18.0 Pathology

18.1 Within this Pathology chapter, the term “**Qualified Designee**” refers to a trained technical assistant employed by the University of Florida, with designated faculty or trained technical assistant status.

18.2 All pathology reports will be reviewed and issued by the Teaching Physician. When appropriate, issuance of the report shall include the Teaching Physician’s electronic signature.

18.3 Teaching Physicians are responsible for safeguarding the password to their electronic signature and ensuring that only the Teaching Physician may issue reports in his or her name.

18.4 All bills for pathology services will be generated as a consequence of the Teaching Physician performing the key portions of the pathology consultation.

18.5 Key portions of the procedure will be documented as follows:

18.5.1 Surgical pathology cases. Review of the gross description prepared by the resident, Qualified Designee or other faculty as well as all microscopic slides. All pathology reports should have one of the following affirmative statements:

A. All usual surgical pathology reports should have an affirmative statement: *“I, or a Qualified Designee, have performed the gross examination and description and I have personally reviewed the gross description and specimen preparations referenced herein, and have personally issued this report.”*

B. All pathology reports where the resident participated in grossing the specimen should have an affirmative statement such as: *“I, or a Qualified Designee, have supervised the resident in the gross examination and description and I have personally reviewed the gross description and specimen preparations referenced herein, and have personally issued this report.”*

C. For “consultation cases” for surgical pathology, and cytopathology where slides and accompanying reports are submitted for second opinion, transfer of patient or other reasons, the documentation of this review is by insertion of the following statement. *“I have personally reviewed the accompanying paperwork, gross description and specimen preparations referenced herein, and have personally issued this report.”*

18.5.2 Frozen sections. The Teaching Physician will be present at the time of all frozen section evaluations. He or she will review all slides and issue a signed report.

18.5.3 Gross only specimens. Examination of all “gross only” specimens by the Teaching Physician, or review of a description generated by the Pathologist’s Assistant, shall be documented by insertion of the following statement: *“I, or a Pathologist’s Assistant, have performed the gross examination and I have personally reviewed the gross description and have personally issued this report.”*

18.5.4 Performance of Fine Needle Aspiration (FNA).

A. The Teaching Physician may accompany the resident and be present for the performance of the FNA procedure, or perform the FNA with the resident observing. In such a case, one of the following applicable teaching physician statements will be added to the fine needle aspiration biopsy report:

“I have personally performed the fine needle aspiration biopsy, personally examined all microscopic slides and my diagnosis is as stated.”

“I was physically present during the performance of the fine needle aspiration biopsy, personally examined all microscopic slides and my diagnosis is as stated.”

B. In cases in which the patient’s attending physician supervises the pathology resident in FNA performance (and not the Pathology department Teaching Physician), the patient’s attending physician will be the physician of record.

18.6 Clinical Pathology/Laboratory Medicine. The same general principles described above apply to reports issued by the Clinical Pathologist, including, but not limited to, interpretations of peripheral blood smears, electrophoreses, body fluids and microscopic examination.

18.6.1 Any preliminary interpretations performed and released for patient care use by the resident will be reviewed and interpreted by the Pathologist who will document this by an appropriate note such as: *“The pathology resident initially prepared this consult. The consult was next reviewed by me and was edited and corrected by me as required to supply the correct interpretation of the laboratory data.”*

18.6.2 Hematology or coagulation or blood bank related consultations. An appropriate teaching physician note would be *“I have reviewed and interpreted the patient’s laboratory data.”*

18.6.3 Immune Panel consultations. An appropriate teaching physician note would be: *“I have personally reviewed the flow cytometry cell patterns referenced herein and issue this report.”*

Chapter 19

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

19.1 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. These HCPCS Level II codes were deleted in 2009 and replaced with CPT® codes 90951-90962. 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.

19.2 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.

19.3 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.

19.4 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.

19.4.1 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.”

19.4.2 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.

Chapter 20

20.0 Services Provided by Fellows

20.1 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 chapter, 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.**

20.2 Fellows Not in Approved Programs. If the fellow is not in an approved program, (as defined in [Chapter 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.

20.3 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. **Effective January 1, 2021, moonlighting residents’ services provided to inpatients (as well as services provided in outpatient or emergency departments) are billable as physician services under the physician fee schedule as long as the services are not related to the resident’s approved GME program. Prior to January 1, 2021, moonlighting occurring at the home institution was limited to those provided in hospital outpatient departments and emergency departments.**

20.4 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.

Chapter 21

21.0 Billing Modifiers

Effective January 1, 1997, services furnished by Teaching Physicians involving a resident in the care of their patients must be identified as such on the claim. Charges for services meeting these requirements must show either the GC or GE modifier as appropriate and described below.

21.1 Teaching Physician Services that Meet the Requirement for Presence During the Key/Critical Portion(s) of the Service. Charges for Teaching Physician services must include a GC modifier, unless the service is furnished under the primary care center exception described in [Chapter 6.0](#). When a Teaching Physician appends the GC modifier to the charge(s), the Teaching Physician is certifying his or her presence during the key/critical portion(s) of the service (as applicable to the type of service rendered).

21.2 Teaching Physician Services Under the Exception for E/M Services Furnished in Primary Care Centers. Charges for services furnished by Teaching Physicians under the primary care center exception must include the GE modifier on the charge(s).

Chapter 22 – COVID-19 Public Health Emergency (PHE) Flexibilities

22.0 General. This chapter has been added to track flexibilities and waivers that CMS added as a result of the COVID-19 PHE. When the PHE ends, these flexibilities and waivers may end altogether or may only be available in rural settings, and the teaching physician documentation requirements and code limitations will return to pre-PHE status as detailed Chapters 1 through 20. .

22.1 Presence in Primary Care Exception Clinics. The teaching physician may not only direct the care furnished by residents, but also review the services provided with the resident, during or immediately after the visit, remotely through virtual means via audio/video real time communications technology. Audio only is not sufficient except for CPT codes 99441-99443 described below.

22.1.1 Documentation. The note needs to stipulate that the teaching physician was present via audio/video real time communications technology as well as the portion or portions during which the teaching physician was virtually present.

22.2 Primary Care Exception Services. All levels of office/outpatient E/M services may be furnished in primary care centers under the primary care exception. In addition, The following codes may also be performed in primary care exception clinics:

- CPT code 99441 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/ M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion);
- CPT code 99442 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/ M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion);
- CPT code 99443 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/ M service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion);
- CPT code 99495 (Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or

caregiver within two business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge);

- CPT code 99496 (Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge);

- CPT code 99421 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes);

- CPT code 99422 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11– 20 minutes);

- CPT code 99423 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes);

- CPT code 99452 (Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes);

- HCPCS code G2012 (Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion); and

- HCPCS code G2010 (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/ M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment).

22.2 Presence in Locations other than Primary Care Exception Clinics. The teaching physician must provide supervision either with physical presence or be present through audio/video real time communications technology during the key portions of the service. Excluded from the presence via audio/video communications technology are: surgical, high risk, interventional, endoscopic, or other complex procedures, and anesthesia services.

22.2.1 Documentation. The note needs to stipulate that the teaching physician was present via audio/video real time communications technology as well as the portion or portions during which the teaching physician was virtually present.

22.3 Interpretation of Diagnostic Tests. CMS will reimburse residents' interpretation of diagnostic radiology and other diagnostic tests, if a teaching physician is virtually present via audio/video real time communications technology. CMS has made this change permanent for rural settings.

22.4 Psychiatric services. Traditionally, CMS will reimburse psychiatric services furnished by a resident when the teaching physician is present via observation of the service by use of a one-way mirror, video equipment or similar device. For the duration of the PHE, CMS will reimburse all settings for psychiatric services furnished by a resident if the teaching physician is virtually present via audio/video real time communications technology. CMS has made this change permanent for rural settings.