MEDICARE’S TEACHING PHYSICIAN BILLING RULES
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Agenda
Section 1
• Key TP Terms/Concepts
• Approved Programs
• Organizational Supervision Guidelines vs. Medicare TP Billing Rules
• Medicare TP Billing
• Overarching TP Participation/Documentation Rules

Agenda
Section 2
• Level of TP Participation/Documentation Necessary for:
  • E/Ms (normal/time-based/Critical Care/PCE)
  • Surgeries (“minor,” “major,” endoscopic)
  • Radiological Procedures
  • OB Services
  • Psych Services
  • ESRD Services
  • Certain Complex/High Risk Services
SECTION 1
General TP Billing Concepts

Key TP Section Definitions

- Teaching Physician (TP): any physician who involves residents in patient care
- Resident: individual who participates in an “approved” graduate medical education (GME) program
  - Encompasses residents, interns, and fellows
  - Can also apply to physicians who are not in an approved GME program but who are authorized to practice only in a hospital setting

Key TP Section Definitions

- Immediately Available:
The TP is:
  - Not involved in scheduled patient care
  - Not involved in unscheduled patient care from which they could not easily return to assist the resident at a moment’s notice
  - In close physical proximity to the resident so as to be able to assist them within 5 minutes
“Approved” Programs

- Programs accredited by one of the following:
  - Accreditation Council for Graduate Medical Education (ACGME)
  - American Osteopathic Association (AOA)
  - Commission on Dental Accreditation (CODA)
  - Council on Podiatric Medical Education (CPME)

“Approved” Programs

- Programs that count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
  - The American Medical Association’s Directory of Graduate Medical Education Programs; or
  - The American Board of Medical Specialties (ABMS) Directory published by the American Board of Medical Specialties

“Approved” Programs

- A program approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine
- A program that would be accredited except for the accrediting agency’s reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.
Sample Organizational Resident Supervision Guidelines

Residents:
- May only exercise privileges set out in training protocols approved by the service
- Must adhere to specific supervision rule(s) set forth in GME resident supervision guidelines
- Must be supervised by an attending holding a medical staff appointment at hospital

Sample Organizational Resident Supervision Guidelines

These standards ensure that supervision is consistent with:
- Provision of safe/effective patient care;
- Educational needs of residents;
- Progressive responsibility appropriate to residents’ level of education, competence, and experience; and,
- Other applicable common and specialty/subspecialty-specific program requirements

Government Payer TP Billing Rules

- Payer TP rules identify the level of TP participation/involvement necessary to support TP billing for a service
- Separate from organizational resident supervision standards meant to ensure high-quality patient care, patient safety, and progressive training of residents
### Medicare TP Billing
- Medicare pays for TP services in two ways:
  - “Part A” payments
  - “Part B” payments
- Part A payments made to hospitals
- Part B payments made to teaching physicians

### Medicare Part A Payments
- **Facility services billed by the hospital**
- Reimburse hospitals for costs associated with GME programs
- Cover a portion of resident salaries
- Cover a portion of TPs’ salaries relating to teaching residents
- Cover TP administrative support
- Cover GENERAL supervision by TPs

### Medicare Part B Payments
- **Professional services billed to Medicare by the attending/teaching physician**
- Payable to TP, though services may have been primarily performed by a resident, when TP has documented personal interaction with the patient
- Actual required level of TP interaction/supervision/documentation will vary based on the nature of the service
<table>
<thead>
<tr>
<th>Overarching TP Documentation and Billing Rules</th>
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<tbody>
<tr>
<td>1) All services billed by a TP must have a TP note</td>
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<td>2) TP notes should be entered contemporaneously with resident service, but no more than 24 hours later</td>
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<td>3) All TP notes must be signed/dated (and timed in hospital setting)</td>
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<td>4) All TP charges must be billed with a TP modifier</td>
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<td>5) Where the policy does not require in-person presence by the TP for the entire resident service, the TP must at least be “in the building” during all parts of the resident service for FL Medicaid patients</td>
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<th>Teaching Physician Modifiers</th>
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<tr>
<td>• Resident participation in service identified on claim form using one of two modifiers:</td>
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<tr>
<td>• GC—Service performed in part by a resident under direction of a TP</td>
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<tr>
<td>• GE—Service performed by a resident without the presence of a TP under the primary care exception</td>
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<td>• Modifiers created by Medicare, but to be used with all other payers</td>
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Attestation Associated With TP Modifiers

• “Claims for services meeting these [TP Billing] requirements must show either the GC or GE modifier as appropriate…”

• “Claims for teaching physician services in compliance with the requirements outlined in sections 100.1 -100.1.6 of this chapter must include a GC modifier for each service, unless the service is furnished under the primary care center exception…”

• “When a physician (or other appropriate billing provider) places the GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in sections 100.1 through 100.1.6.”

Medicare Policy Regarding Services Performed by Students

“Any contribution and participation of a student to the performance of a billable [E/M] 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.”

SECTION 2

TP Billing Participation and Documentation Rules for Specific Services
Evaluation and Management Services—Possible Scenarios

1) TPs may perform the entire visit service alone (prior resident service possible)
2) TPs may see patients along with a resident for some or all of the visit
3) TPs may see patients after a resident and just repeat the important parts
4) TPs may see patients WAAAAYYY after a resident and repeat the important parts

Evaluation and Management Services

• For a TP to bill an E/M performed by or with a resident, the TP must:
  • Personally perform, or supervise/witness the resident's performance of, the key portion(s) of the visit, and
  • Participate in the management of the patient
  • Personally document each of the above in a separate TP note

Documenting TP Interaction During Key Components

• TP note should include clear wording such as "I saw the patient and..." or "I examined the patient with the resident and...."
• Portion of encounter TP felt was key and decided to supervise or personally perform should be identified in the TP's note, as in "I performed the physical exam with the resident..."
**Documenting TP Interaction During Key Components**

- In cases where a TP feels a key portion of the encounter cannot be identified, they should be present during the entire encounter, in which case their note may include non-specific wording such as "I saw and evaluated the patient with the resident...."
Determining the Level of Service

• Question:
  • Does the teaching physician or the resident determine the appropriate level of an E/M service?
• Medicare Answer:
  • The teaching physician is responsible for ensuring that the appropriate level of an E/M service is assigned based on medical necessity and supported by medical record documentation.

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Determining the Level of Service

• Question:
  • Can more than one teaching physician utilize a single resident's documentation?
• Medicare Answer:
  • No.

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Determining the Level of Service

• Question:
  • When multiple residents document the medical chart on the same day, is it necessary to clarify which resident the attending physician is referring to in his note?
• Medicare Answer:
  • If multiple residents saw the patient, the attending must refer to resident by name, or specialty, e.g., cardiology resident, if that serves to identify the individual.
Scenario 4—Late-Night Admissions

- TP may see patient next morning and combine documentation with resident note from night before
- All other TP E/M billing rules apply
- TP must take special care to ensure that any changes to patient’s condition since resident admission from the night before are documented
- TP will bill combined service using DOS he/she as TP saw patient

Examples of Minimally Acceptable TP E/M Notes

- "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."
- "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."
- "I performed the physical exam of the patient with the resident. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Examples of UNacceptable TP E/M Notes

- "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 signature or identity
- "Patient seen and evaluated.", followed by legible signature or identity
- [A legible signature or identity alone]
The Primary Care Exception

- When a GME program operates a clinic using the primary care exception, TPs may bill certain E/M services provided by residents when the TP did NOT see the patient face-to-face
- Billable codes:
  - 99201–99203 (New Pt. Office Visit)
  - 99211–99213 (Established Pt. Office Visit)
  - G0402 (IPPE)
  - G0438–G0439 (AWV, Initial and Subsequent)

Common Specialties

- Residency programs most likely qualifying for this exception include:
  - Family Practice
  - General Internal Medicine
  - Geriatric Medicine
  - Pediatrics
  - Obstetrics/Gynecology
  - Psychiatry

Location Requirements

- Center where the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital
  - Outpatient department of a hospital
  - Other ambulatory care entity
- Requirement is not met when the resident is assigned to a physician’s office away from the center or makes home visits
**Center Documentation Necessary**

- Prior approval for center to be GME exception location not necessary
- Center must attest in writing that all the conditions are met for a particular residency program
- Center must maintain records demonstrating that they qualify for the exception

**Resident Requirement**

- Residents must have completed at least 6 months of a GME approved residency program

**Supervision Restriction**

- TPs may not supervise more than four residents at any given time
  - Non-GME residents may be included in mix
  - Normal TP billing rules apply to the non-GME residents
TP Requirements
- TPs must:
  - Not have other responsibilities (including the supervision of other personnel) at the time of the resident service
  - Have the primary medical responsibility for the patients
  - Ensure that the care provided was reasonable and necessary
  - Direct the care from such proximity as to constitute immediate availability

TP Requirements
- TPs must:
  - Review the care provided by the resident during or immediately after each visit
  - Review of the patient’s medical history
  - Resident’s exam findings
  - Patient’s diagnosis
  - Treatment plan

TP Requirements
- TPs must:
  - Document the extent of his/her own participation in the review and direction of the services furnished to each patient
  - Review and co-sign the resident’s note to ensure no discrepancy exists between what was initially communicated to the TP and what appears in the resident’s note
Additional Guidelines for Admission/Discharge Services

- Residents may not place admission orders
  - If a resident determines a patient should be admitted, the resident must notify the supervising physician, and the supervising physician will enter the order
- Residents and fellows may place discharge orders unless specified otherwise in their program’s Scope of Practice

Maternity Care Services

- For a TP to bill for any OB service that involves a delivery, the TP must have been present for the delivery event itself
- To bill for a “global” OB code, the TP must have been present for at least 3 antepartum visits and 1 post-partum visit
- When billing for antepartum care only, the code selected should be based on the number of visits during which the TP was present

End Stage Renal Disease Services

- When a resident is involved in rendering ESRD-related visits furnished under the monthly capitation payment method (MCP),
  - TP required to perform, or witness resident’s performance of, key portions of each visit
  - Visits by residents may be counted toward the MCP visits if TP is physically present during visit
  - TP may utilize resident’s notes, but TP must document his/her presence during the resident visit(s) and that he/she reviewed resident’s notes
  - The TP could document these criteria as part of an extensive once/month MCP note
**Time-Based Services**

- TP must be present for the period of time for which the claim is made
  - concurrent observation of the service by use of a one-way mirror or video equipment is acceptable for psych services
- Examples of time-based codes:
  - Hospital discharge day management (99238-99239);
  - E/M codes when time is used to select the level;
  - Prolonged services (99358-99359);
  - Critical care services (99291-99292)

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**Critical Care—TP Time**

- Time-based service, so only TP’s CC time can be used to bill
- TP’s CC time may include both:
  - Time spent by the TP face-to-face with the critical patient, and
  - Time spent by the TP elsewhere on the floor/unit engaged in work directly related to the patient’s care

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**Critical Care—TP Documentation**

The TP must personally document:

1. The time spent by the TP providing CC
2. That the patient was actually critical during this time spent by the TP
3. What made the patient critically ill
4. The nature of the treatment/management provided by the TP
Critical Care—TP Documentation Examples

- UNacceptable: "30 minutes Critical Care."
- Acceptable: "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."

Surgical Services

- Required level of TP involvement/documentation depends on whether service is “minor” vs. “major”
- Minor = takes 5 minutes or less to complete and involves relatively little decision making once the need for the procedure is determined
- Major = takes longer than 5 minutes to complete

“Minor” Surgical Services

- TP must be present for entire service
- TP must document a note indicating presence for entire service

Example:

“I was present for the entire wound repair.”
“Major” Surgical Services

- TP must be present during the critical/key portions of the procedure
- TP defines the key/critical portion(s) of the procedure
- The TP must be “immediately available” to return to the procedure during non-critical portions of the surgery, or designate another surgeon that was available

Overlapping “Major” Surgeries

- TP must be present during the critical/key portions of each procedure (key portions cannot overlap)
- TP must finish supervising all key portions of Case 1 before participating in Case 2
- Once key portions of Case 2 begin, TP no longer immediately available to return to Case 1

Immediate Availability
Situation 1

TP leaves Case 1 before completion, but after all key portions. Case 1 will end before key portion of Case 2 begins.
Case 2

TP leaves Case 1 before completion, but after all key portions. Case 1 will NOT end before key portion of Case 2 begins.

Immediate Availability Situation 2

Overlapping “Major” Surgeries

Immediate Availability Situation 2

Case 1

Case 2

Once key portion(s) of Case 2 begin, TP is no longer considered to be “immediately available” to return to Case 1

Overlapping “Major” Surgeries

Immediate Availability Situation 2

Case 1

Case 2

Sample “Major” Procedures—TP Documentation

I was present during the ________________________________

__________________________________________________
Sample “Major” Procedures—TP Documentation

I performed the following key portions of the case:

__________________________________________________________________________

I was present during the resident’s performance of the following key portions:

__________________________________________________________________________

I was immediately available during the remainder of the procedure.

“Major” Procedures—TP Documentation Example

• Question:
  • What documentation is required that a second surgeon was available to satisfy compliance audits?

• Medicare Answer:
  • While the guidelines contain no specific documentation requirements, the name of the second surgeon should be indicated either in the operative dictation notes or the medical record.

Sample “Major” Procedures—TP Documentation

I performed the following key portions of the case:

__________________________________________________________________________

I was present during the resident’s performance of the following key portions:

__________________________________________________________________________

I was immediately available during the remainder of the procedure.

☐ except for: ______________________
during which time Dr. ______________ was available."
### Single Surgery Documentation Allowance

- Per Medicare: “When the teaching surgeon is present for the **entire surgery**, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.”

### Definition of “Entire Surgery”

- **Question:**
  - Does the definition of “entire surgery” include opening/closing?
- **Medicare Answer:**
  - Yes. However, a teaching physician’s presence is not required during opening/closing.

### Pre- and Post-op Visits

- Visits that are bundled components of the global surgical package → the TP must only be present for visits deemed to be “key portions” of the overall surgical package
- Visits that are separately billable → the TP must follow the guidelines for normal E/M services
Assistant-at-Surgery Services

- Normally reimbursable at teaching institutions only when no qualified resident is available
  - Surgeon must document unavailability of qualified resident
  - Use Modifier 82

Assistant-at-Surgery Services

- Exceptions:
  - No residency program exists in department
  - Program exists within department, but exceptional medical circumstances occur that prompt use of non-resident assistant
    - Surgeon must document circumstances
  - Surgeon has no involvement in hospitals’ GME programs and never uses residents
    - Use Modifier 80 for all above exceptions

Endoscopies

- If surgical, follow established TP billing rules for surgeries
- If diagnostic, TP must be present during “entire viewing”
  - Entire viewing = insertion to removal
  - TP must document note similar to that for minor procedures
Other Complex/High Risk Procedures

• When a service is specifically mandated to be personally provided by a “physician”, the TP must satisfy this in-person requirement
• Requirement may come from:
  • Medicare at the national level
  • Local Medicare contractor policy
  • CPT code description

Radiological and Other Diagnostic Tests

• A separate written report must be documented for all dx tests
• When a resident has interpreted a test, the TP must:
  • Personally review the image/tracing
  • Confirm or revise the resident’s findings
  • Document the above components in a separate TP note, as in “I reviewed the chest films and agree with the resident’s interpretation as written.”

Radiological and Other Diagnostic Tests

• Diagnostic exam orders placed by the resident or fellow do not require the co-signature of the teaching physician
Medication Orders

- Residents may place orders for medications, including narcotics, unless specified otherwise in their program’s Scope of Practice
- Orders for narcotics placed by a resident or fellow to be filled:
  - within the hospital will utilize hospital’s DEA #: unless resident or fellow has own #
  - outside hospital must include TP’s name and DEA #: unless resident/fellow has own #

FL Medicaid 6/11/13 Policy Change

- Teaching physicians who seek reimbursement for oversight of patient care by a resident must personally supervise all services performed by the resident.
- Personal supervision pursuant to Rule 59G-1.010(276), F.A.C., means that the services are furnished while the supervising practitioner is in the building and that the supervising practitioner signs and dates the medical records (chart) within 24 hours of the provision of the service.