

# FACULTY PRACTICE PLAN

## TEACHING PHYSICIAN BILLING POLICY

(Based on Medicare Carriers Manual Transmittal 1780, Section 15016, Supervising Physicians in Teaching Settings, Effective 11/22/2002)

### PURPOSE

The purpose of this document is to provide a unified Faculty Practice Plan policy regarding submission of bills to third party carriers for teaching physician services where residents and fellows are involved with the provision of these services. This policy is intended to comply with the HCFA Teaching Physician Billing Requirements. Each department is responsible for ensuring compliance with these policy requirements.

### GENERAL POLICY – RESIDENTS AND FELLOWS

The teaching physician must be physically present for the “critical or key portion” of the service rendered by a resident or fellow in order to submit bills to third party payers. The documentation in the medical record must support the specific level of service billed as well as support the teaching physician’s physical presence during the critical or key portion. The terms critical or key portion are interchangeable. The teaching physician can determine the critical or key portion of a service. The documentation must be in sufficient detail to help the teaching physician recall the visit or service. Documentation may be dictated and typed, hand-written or computer-generated. Documentation must be dated and include a legible signature or identity. If there is insufficient documentation to support the service, a bill should not be submitted.

### PHYSICAL PRESENCE REQUIREMENTS and DOCUMENTATION REQUIREMENTS (see Attachment I Acceptable Documentation Templates)

**Major Procedures (5 minutes or greater duration):** (Major procedures and other high risk/complex procedures.)

Physical Presence: The teaching physician must be present during all key (critical) portions of the procedure. The teaching physician may define the key portion of each procedure. The teaching physician should not be involved in more than two overlapping procedures. The key portions of the procedures cannot overlap. The teaching physician must be immediately available during all non-key portions of a surgical procedure. Immediately available is defined as being able to immediately return to the patient if necessary (i.e., he/she cannot be performing another procedure). If the teaching physician leaves the operating room, before or after the key portions of the procedure to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original procedure.

For major procedures that are a part of global payment packages, the teaching physician must personally perform or observe the resident perform the post-operative visit(s) considered by the teaching physician to be key visits during the post-operative period. If the post-operative period extends beyond the patient’s discharge and the teaching physician (and/or a member of the teaching physician’s specialty) is not providing the patient’s follow-up care, then the teaching physician should not bill the full global package.

In the case of three concurrent surgical procedures, the role of the teaching surgeon in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not billable.

Documentation: Documentation should indicate what the teaching physician views as the key portion and should indicate that the teaching physician was present for the key portion of the procedure. It should also indicate that the physician was immediately available for the non-key portions of the surgical procedure. If the teaching physician was not immediately available for the non-key portions of the procedure, the medical record or other supporting documentation (i.e. back-up schedule) should clearly identify which teaching physician was immediately available.

For **single surgical episodes** (non overlapping) the teaching physician, resident or other staff can document the teaching physician’s presence.

In the case of **overlapping/concurrent procedures**, the teaching physician must document presence in his/her own note. The teaching physician must personally document the key portion of each of the overlapping procedures performed using patient-specific terms to describe the personal services

provided or observed and that he/she or another physician was immediately available to return to either procedure in the event of complication.

**Minor Procedure (Procedures with less than 5 minutes duration):**

Physical Presence: The teaching physician must be present during the entire procedure.

Documentation: The documentation must state that the teaching physician - was present during the entire procedure. The documentation may be provided by either the resident, the nurse, or personally by the teaching physician.

**Endoscopies: (Excluding endoscopic surgery. Refer to the requirements for major procedures for endoscopic surgery.)**

Physical Presence: The teaching physician must be present during the entire "viewing" portion of the procedure. The viewing portion is defined as insertion, viewing and withdrawal of the scope. Viewing via a monitor from a remote location or at a later time is not acceptable.

Documentation: The documentation must state that the teaching physician was present during the entire process. The TP may document his/her presence personally. The documentation may be made by a resident, nurses, or an attestation statement and must be countersigned by the teaching physician.

**Interpretation of Diagnostic Radiology and Other Diagnostic Tests:**

Physical Presence: The teaching physician must personally interpret or review the interpretation of the test results.

Documentation: The interpretation report may be dictated by either the teaching physician or the resident/fellow. If a resident or fellow prepares and signs the interpretation, the teaching physician must indicate that he/she has reviewed the film/study and the resident's interpretation and either agrees with it or edits the findings. A countersignature of the resident's interpretation by the teaching physician is insufficient documentation, unless there is accompanying attestation of the above. For pathology consultative services, documentation must include the name of the requesting physician, and the nature of the request.

**Interventional Radiology and/or Other Complex, High-Risk Procedures:**

High-Risk procedures for which national Medicare policy or the CPT description indicates that the procedure requires personal supervision of its performance by a physician. Examples: interventional radiological and cardiology supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

Physical Presence: The teaching physician must be present with the patient during all critical and key portions and remain immediately available to furnish services for the duration of the entire procedure. Key portions of two procedures being performed may not overlap. Observation via a monitor from another location is not acceptable to satisfy the presence requirement. Immediately available means that the teaching physician must be in the area and not engaged in the key portion of an overlapping or concurrent procedure. The same rules for major procedures for single and overlapping cases apply to interventional procedures.

When the descriptor of the CPT billing code states "supervision and interpretation" (S&I), the teaching physician must be present during the entire radiologic portion of the interventional procedure, that portion of the procedure that is reflected in the wording of the procedure code or in accordance with the "supervision and interpretation" requirements as specified in the CPT code description.

Documentation: If the teaching physician performs both the surgical and radiologic portions of the procedure, the documentation must indicate that the teaching physician was present during the key/critical portions of the procedure. If the teaching physician is billing an S&I code, the documentation must indicate that the teaching physician was present during the surgical and radiologic portion of the procedure before moving on to another procedure. A co-signature to a report prepared by the resident is insufficient documentation by the teaching physician. For single procedures, a resident, nurse or teaching physician may document the teaching physician's presence. For overlapping procedures, the teaching physician must document personally his/her presence and key portions. In addition, there must be documentation by the

teaching physician or a signed attestation that the teaching physician reviewed the films and confirm (or revised) the interpretation.

### **Anesthesia:**

**Physical Presence:** If the teaching physician is present during the key portion of the procedure, including induction, emergence, and any other critical parts of the procedure and immediately available to furnish services during the entire procedure, a bill can be submitted based on the unreduced fee schedule. The teaching physician's physical presence during only the preoperative or postoperative visits with the patient is not sufficient to bill for the service.

If the teaching physician is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, payment will be for his/her services as medical direction. The teaching physician's presence is not required during pre-operative or post-operative visits with the patient.

**Documentation:** If the service is performed with one resident, the teaching physician must personally document his/her presence with the patient during the key portions of the procedure, including induction and emergence, or regional anesthesia and any other key portion of the procedure. The teaching physician must also document his/her immediate availability during the entire procedure. When a medical student or other student is involved, the teaching physician must also document the pre- and post-anesthesia evaluation and care.

### **Psychiatry:**

**Physical Presence:** For time based counseling codes, the physical presence requirement can be met by remote, simultaneous observation and immediate consultation with the resident or fellow. Audio-only equipment does not satisfy the physical presence requirement. The teaching physician should only bill on the basis of the time he/she spent observing the session.

Evaluation and Management services and procedures provided in Psychiatry need to comply with the same physical presence requirements of other Evaluation and Management services and procedures.

The teaching physician supervising the resident must be a physician. The Teaching Physician Billing Policy does not apply to psychologists who supervise psychiatry residents.

**Documentation:** The teaching physician must document his/her time spent and a description of the involvement in observing the service. He/She should only bill for the time directly observing the service. Documentation of Evaluation and Management services must comply with Evaluation and Management requirements listed in the Evaluation and Management section of this policy. Procedures must comply with procedure documentation requirements.

**Time-Based Codes** (Individual Medical Psychotherapy, Critical Care Services, Evaluation and Management: Counseling and/or Coordination of Care, Prolonged Services, Hospital Discharge Day Management, Care Plan Oversight)

**Physical Presence:** The teaching physician must be present for the period of time for which the claim is made. Time for resident services in the absence of the teaching physician can not be billed.

**Documentation:** Teaching physician documentation must indicate the length of time he/she was directly involved with the service to the beneficiary and a brief description of the service provided.

**Evaluation and Management Services** (Outpatient visits, hospital daily care, consultations, nursing home, home visits etc.)

**Physical Presence:** The TP must personally perform or observe the resident perform the key portion of every E&M service billed. The teaching physician must perform enough personal work (either independently, or by the resident in the presence of the teaching physician) that satisfies the requirements for the level of service billed. History, exam and medical decision-making are considered the key components that must be performed when selecting a visit code. Perform all 3 components for new outpt. visits, initial consults (inpt. or outpt.), initial hospital care, and E.D. Perform 2 components for follow-up consults, established outpt. visits, and subsequent hospital care. The teaching physician must participate in the management of the patient.

**Documentation:** The teaching physician must personally document:

1. That he/she performed the service or was physically present during the key or critical portions of the service when performed by the resident/fellow, and

2. The participation of the teaching physician in the management of the patient.
3. Any additional documentation that is needed to support the level of service billed.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

The combined entries by the teaching physician and the resident/fellow should support medical necessity and the level of care billed.

Following are three common scenarios for teaching physicians providing E&M services:

**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.

- In the absence of a note by a resident, the teaching physician must document as he or she would document an E&M service in a non-teaching setting.
- Where a resident/fellow has written notes, the teaching physician's note may reference the resident's/fellow's note. The teaching physician must document that he or she **performed the critical or key portion(s) of the service** and that he or she was **directly involved in the management of the patient**.

**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. 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.**

**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/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. The teaching physician must document that he/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.**

**EXCEPTION: E/M SERVICES FURNISHED IN CERTAIN PRIMARY CARE CENTERS (Approved Primary Care Exception clinics: FCC, General OB/GYN clinic, and certain GME programs in psychiatry that furnish comprehensive care for chronically mentally ill patients.)**

For certain office visit codes (99201, 99202, 99203, 99211, 99212, 99213) teaching physicians may submit claims for services furnished by residents without the presence of a teaching physician. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. The center must maintain records demonstrating that they qualify for the exception.

- a) Services are furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by the residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary.
- b) The teaching physician in whose name the payment is sought must not supervise more than four residents at any given time and must be immediately available when providing this supervision. The staff physician must:
  1. Have no other responsibilities (including the supervision of other personnel) during the time the residents are seeing patients under the PC Exception (for example: seeing patients independent of the resident).
  2. Assume primary medical responsibility for those patients cared for by the resident/fellow.
  3. Ensure that the services furnished are reasonable and necessary.
  4. Review with each resident during or immediately after each visit, the patient's medical history, the resident's/fellow's finding on physical examination, diagnosis, and record of tests and therapies, and treatment plan, and.
  5. Document the extent of his/her own participation in the review and direction of the services furnished to each patient. **Also document any addition information necessary to support the level of care billed.**

6. If a patient comes to the center and requires a more comprehensive visit service (level 4 or 5) that is unexpected and unscheduled by the center, the teaching physician may see the patient, but must revert to the physical presence rule. The teaching physician may continue to bill for other level 1, 2, and 3 E&M services furnished by up to 4 resident under his/her direct supervision under the exception during the same clinic session.
- c) Residents must have completed six months of a GME approved residency program.
  - d) The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program.
  - e) The range of services furnished by residents includes:
    1. Acute care for undifferentiated problems for chronic care for ongoing conditions.
    2. Coordination of care furnished by other physicians and providers,
    3. Comprehensive care not limited by organ system or diagnosis..

Documentation: The teaching physician must still write a personal note that indicates he/she:

1. Reviewed the resident's history, exam and plan of care as well as any labs/tests/records, etc., and that
2. The review occurred with the resident while the patient was in the clinic or immediately after the resident saw the patient. If the review does not occur within these parameters, the service is not billable.

**Conclusion:**

Each department is responsible for ensuring that they are in compliance with this policy prior to submitting claims for services provided by residents and fellows. Questions regarding this policy and requests for exceptions should be forwarded to the Faculty Practice Plan Management Office.

**Acceptable Documentation Templates  
for Compliance with  
Faculty Practice Plan Teaching Physician Billing Policy**

This document provides examples of acceptable medical record documentation templates for teaching physician documentation requirements when resident and/or fellow medical record documentation is also used to support billable services.

**E&M:** The teaching physician (TP) must personally document (dictated or hand-written) presence and participation in all services billed. **The TP should also document any additional information necessary to support the level of care billed.**

**Scenario 1:**

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: “I saw and evaluated the patient. I agree with the findings and plan of care as documented in the resident’s/fellow’s note. OR “I saw and examined the patient. I agree with the resident’s note except ....., so I will .....”

**Scenario 2:**

Initial or Follow-up Visit: “I was present with resident/fellow 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/fellow’s note.”

Follow-up Visit: “I saw the patient with the resident/fellow and agree with the resident’s/fellow’s findings and plan.”

**Scenario 3:**

Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s/fellow’s note and agree, except that.....”

Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident/fellow and agree with resident’s/fellow’s findings and plans as written.”

Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s/fellow’s findings and plans as written.”

Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s/fellow’s note except for.....”

**Unacceptable Documentation:** The following documentation is not acceptable because it does not make it possible to determine whether the teaching physician was present, evaluated the patient and/or had any involvement with the plan of care.

- “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
- A legible countersignature or identity alone.

**E&M Primary Care Exception:** The TP must personally document (dictated or handwritten) his/her review of and direction of the services provided by the resident either during or immediately after the patient's visit.

“I discussed the care of this patient with the resident providing the service, during or immediately after the patient’s visit, and was directly responsible for the patient’s management. I have assured that the services provided are appropriate, and I was immediately available to the patient should the need have arisen.”

**Major Procedures (5 minute or greater duration) - Single:** The resident, nurse, or TP can document the TP's presence for the key portion in the case of single (non-overlapping and non-concurrent procedures). If the TP is not present for the entire procedure, the key portion must be defined.

Staff note or resident note or Nsg note: "Dr. XYZ (or I) was present for the key portion of the procedure \_\_\_\_\_(define key portion) and was immediately available for the remainder of the procedure.

OR

"Dr. XYZ (or I) was present for the entire procedure."

**Major Procedures (5 minute or greater duration) - Concurrent:** The TP must document his/her presence for the key portion, define the key portion, and state his/her immediate availability (or the immediate availability of another TP) for the remainder of the procedure. The note or other supporting documentation should clearly delineate which TP was immediately available.

TP must document: I was present for the key portion of the procedure \_\_\_\_\_ (define key portion) and was immediately available for the remainder of the procedure.

OR

I was present for the key portion of the procedure \_\_\_\_\_ (define key portion) and another TP was immediately available for the remainder of the procedure. Back-up TP was \_\_\_\_\_

**Minor Procedures (lasting less than 5 minutes):** The TP must attest to being present for the entire procedure. This can be a generic attestation that is signed by the TP.

TP must state "I was present for the entire procedure."

The resident, nurse, or TP can document the TP's presence

**Endoscopies:** The TP must attest to being present for the entire viewing portion of the procedure (including scope insertion and withdrawal). This can be a generic attestation that is signed by the TP.

TP must state "I was present for the entire viewing portion of the procedure (including scope insertion and withdrawal) and agree with interpretation.

**Radiology and Other Diagnostic Testing:** The TP must attest to viewing the film/test, reviewing and agreeing with or editing the interpretation/results. This can be a generic attestation that is signed by the TP.

TP must document "I attest to having personally viewed the images/test and approve the above interpretation."

**Interventional Radiology and Similar High Risk Procedures - Single Cases:** The resident, nurse, or TP can document the TP's present for the key portion in the case of single (non-overlapping and non-concurrent procedures).

Staff note or resident note or Nsg note "Dr. XYZ (or I) was present for the key portion of the procedure \_\_\_\_\_(define key portion) and was immediately available for the remainder of the procedure.

OR

"Dr. XYZ (or I) was present for the entire procedure."

**Interventional Radiology and High Risk Procedures - Concurrent Cases:** The TP must document his/her presence for the key portion, define the key portion, and state his/her immediate availability (or the immediate availability of another TP) for the remainder of the procedure.

TP must document: I was present for the key portion of the procedure\_\_\_\_\_ (define key portion) and was immediately available for the remainder of the procedure.

OR

I was present for the key portion of the procedure\_\_\_\_\_ (define key portion) and another TP was immediately available for the remainder of the procedure. Back-up TP was \_\_\_\_\_

**Time-Based Codes (therapy, critical care, etc):** The TP must document the amount of time he/she spent and a brief description of the service provided. (TP cannot count time he/she spent teaching the resident.)

TP must document “spent X minutes \_\_\_\_\_ (brief description of service provided) \_\_\_\_\_”

**Anesthesia Time-Based Services (unreduced service).** The TP must document his/her presence during the key portion of each case. In anesthesia, induction and emergence are key portions of the service. (If the anesthesiologist supervises CRNAs in addition to one resident, then the special rules for medical direction provided by anesthesiologists will apply rather than the teaching physician rules.)

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