

## MEDICARE RULE FOR TEACHING PHYSICIANS

Effective July 1, 1996.

**1.0 GENERAL RULE:** If a resident participates in a service provided in a teaching setting, the teaching physician may not bill Medicare for such services unless the teaching physician is present during or personally performs the key portion(s) of any services for which payment is sought.

### **2.0 DEFINITIONS:**

**2.1 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.

**2.2 “Teaching Setting”** is any provider, in which Medicare payment for services of residents is made by Medicare Part A under the direct Graduate Medical Education (GME) payment methodology.

**2.3 “Teaching Hospital”** is a hospital engaged in an approved GME residency program in Medicine, Osteopathy, Dentistry, or Podiatry.

**2.4 “Teaching Physician”** is a physician who involves residents in the care of his or her patients.

**2.5 “Resident”** The federal government includes as a “resident” any individual who participates in an approved GME program. “Resident” may also include 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.

**2.6 “Medical Student”** is never considered to be an intern or a resident. A medical student is an individual who participates in an Accredited Educational Program (e.g. a medical school) that is not an approved GME program. Medicare does not pay for any service provided by a medical student.

### **3.0 SERVICES PROVIDED BY RESIDENTS AND FELLOWS**

**3.1 General Rule:** Medicare Rules on billing by Teaching Physicians when services involve residents apply equally to services involving fellows. Except for the limited situations described below, a resident or fellow may not bill in his/her own name, regardless of whether the teaching hospital included the resident/fellow in its count of full-time in its cost report.

If residents/fellows are not in an approved GME program, the resident/fellow may bill for services in his/her own name in any provider setting, provided that the resident/fellow is a fully licensed physician in the State of Florida and has a provider number.

**3.2 Moonlighting arrangements:** If the resident/fellow is in an approved program, the resident/fellow may bill for his/her services under moonlighting arrangement either in his/her home institution or another institution. The services can be separately identified from those services that are required as part of the training program and are provided in an outpatient department or emergency room of the hospital where he/she has the training program. Inpatient services are not included in moonlighting arrangements.

**A separate contract, with a separate salary, for moonlighting services to be provided outside of the scope of the training program is required.**

## **4.0 EVALUATION AND MANAGEMENT (E&M) SERVICES**

**4.1 General Rule:** The Teaching Physician must be physically present during, or personally perform, the key portions of the E&M service which determine the level of service billed. The key portions are History, Examination, and Medical Decision Making.

**4.2 Initial Hospital Visit, Emergency Department Visit, New Patients, Office and Hospital Consultation:** The Teaching Physician must personally document in writing or by dictated note his/her participation in the three key components of these services – History, Physical Examination, and Medical Decision Making.

The Teaching Physician does not need to repeat, in detail, the key elements of the service personally obtained by the resident. Rather, the documentation of the Teaching Physician may be brief, summary components that tie into the resident's entry and which confirm, add or revise the key elements defined as:

- History of Present Illness (HPI);
- Findings of the physical examination;
- Assessment, clinical impression, prior diagnostic tests, diagnosis and Plan of Care

**4.3 Billing for Initial Hospital Visit the next morning after a resident admitted the patient the night before:** The Teaching Physician may bill for an initial hospital visit the next morning or within 24 hours after a resident has admitted a patient provided that the Teaching Physician personally performs the level of service the next day that meets the requirements of an initial hospital visit.

#### **4.4 EVALUATION AND MANAGEMENT (E&M) SERVICES PERFORMED BY TEACHING PHYSICIANS WITH RESIDENTS:**

Evaluation and Management (E&M) Services billed by Teaching Physicians require that they personally document at least the following:

- 1. THAT THEY PERFORMED THE SERVICE OR WERE PHYSICALLY PRESENT DURING THE KEY OR CRITICAL PORTIONS OF THE SERVICE WHEN PERFORMED BY THE RESIDENT; AND**
- 2. THE PARTICIPATION OF THE TEACHING PHYSICIAN IN THE MANAGEMENT OF THE PATIENT.**

#### **Documentation by the Teaching Physician must be patient specific**

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

*The resident should mention the teaching physician's name in his note and the Teaching Physician should mention the resident's name in his note in order to create a clear link between their notes.*

The combined notes into the medical record by the teaching physician and resident will determine the level of service provided.

In the absence of a note by the resident, the Teaching Physician must personally document all the required elements of an E/M service.

#### **Medicare Rule for Teaching Physicians Update - June 24, 2011**

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 that 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 that 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, both 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.

### EXAMPLE #1

When there is a resident's note, the Teaching Physician may reference the resident'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.

The following are examples of **minimally acceptable documentation** by the Teaching Physician:

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

**The documentation of the Teaching Physician must be patient specific.**

## EXAMPLE #2

When the resident performs the elements required for an E/M service in the presence of, or jointly with, the Teaching Physician, 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 following are examples of minimally acceptable documentation by the Teaching Physician:

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

The documentation of the Teaching Physician must be patient specific.

### EXAMPLE #3

If resident performs some or all of the required elements of the E/M service in the absence of the Teaching Physician and documents his/her service, the Teaching Physician independently performs the critical and key portion(s) of the service and discusses the case with the resident. In this case, the Teaching Physician must document that he/she personally saw the patient, personally performed the critical or key portion(s) of the service, and participated in the management of the patient.

OR

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 following are examples of minimally acceptable documentation by the teaching physician:

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

The documentation of the Teaching Physician must be patient specific.

#### **4.5 EVALUATION AND MANAGEMENT (E&M) SERVICES DOCUMENTATION BY STUDENTS**

The documentation of E/M services by students that may be referred to by the Teaching Physician is limited only to the Review of Systems (ROS) and Past/Family/Social History (PFSHx) and must be performed in the presence of the Teaching Physician and/or resident.

The teaching physician may not refer to the student's documentation of the physical exam findings or medical decision making in his or her personal note.

If the medical student documents E/M services, the Teaching Physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and the medical decision making of the service.

#### **4.6 EXAMPLES OF UNACCEPTABLE DOCUMENTATION BY TEACHING PHYSICIANS**

- **“Agree with the above”, followed by a Teaching Physician signature;**
- **“Rounded, Reviewed, Agree.”, followed by a Teaching Physician signature;**
- **“Discussed with resident, and Agree.”, followed by a Teaching Physician signature;**
- **“Seen and Agree.”, followed by a Teaching Physician signature;**
- **“Patient seen and evaluated.”, followed by a Teaching Physician signature;**
- **A Teaching Physician signature alone.**

#### **GC MODIFIER**

**The GC Modifier must be used to bill Medicare for any service involving a resident/fellow regardless of the Teaching Physician's presence during the entire service or just the key portions of a service.**

#### **5.0 EXCEPTION FOR EVALUATION AND MANAGEMENT (E&M) SERVICES FURNISHED IN CERTAIN PRIMARY CARE CENTERS**

**5.1 Exception for low level E&M services furnished in certain primary care centers:**

For certain new and established patient office visit services (CPT codes 99201-99203, 99211-99213), the teaching physician is not required to see the patient, but rather need only to be immediately available when a resident performs these services in order for the Teaching Physician to bill Medicare Part B for his/her services.

Effective January 1, 2005, code G0334 (Initial preventive physical examination; face-to-face visit) is included under the primary care exception. This is limited to new patients during the first six (6) months of Medicare enrollment.

Effective January 1, 2011, HCPCS codes G0438 and G0439 annual wellness visits are included under the primary care exception.

The only programs that may qualify for this exception are: Family Practice, General/Internal Medicine, Geriatric Medicine, Pediatrics, and Obstetrics and Gynecology.

The only Medicare approved programs at University of Miami are, Family Medicine at Jefferson Reeves Clinic and Internal Medicine at JMH ACC West clinics.

Certain GME programs in Psychiatry may qualify in certain situations, such as when the program furnishes comprehensive care for chronically mentally ill patients. The range of services residents are trained to furnish, and actually furnish, at these centers include comprehensive medical as well as psychiatric care.

**5.2** 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.

**5.3 Patients** seen must be patients who consider the center to be the continuing source of their health care in which services are provided by residents under the medical direction of Teaching Physicians.

**5.4 Residents:** Any resident furnishing the service without the presence of the Teaching Physician must have completed more than 6 months of an approved residency program.

The residents must generally follow the same group of patients throughout the course of their residency program.

The range of services provided by residents includes:

- Acute care for undifferentiated problems

- Chronic care for ongoing conditions including mental illness
- Coordination of care provided by other physicians
- Comprehensive care not limited by organ systems or diagnosis

**5.5 Teaching Physicians** in whose name the services are billed must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.

The Teaching Physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident.
- Have the primary medical responsibility for patients care by the residents.
- Ensure that the care provided was reasonable and necessary.
- Review the care provided by the resident 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 (e.g., record of tests and therapies).

Personally document the extent of his/her own participation in the review and direction of the services furnished to each patient.

**5.6 EXAMPLES OF TEACHING PHYSICIANS DOCUMENTATION UNDER THE PRIMARY CARE EXCEPTION:**

*Case discussed with Dr. Resident at the time of the visit. Patient presents a diagnosis of .....and treatment with.....Agree or (revise) with diagnosis of.....and plan of care  
.....*

*Or:*

*Patient case reviewed and discussed with resident at the time of visit. Given a history of ..... Exam and assessment show.....(state test findings of significance). I agree (revise) plan of care as.....*

Phrases such as, "Discussed and agree with resident's assessment and plan" are NOT adequate, since this language does not show when the review occurred and what patient specific information was reviewed with resident.

**GE MODIFIER**

**The GE Modifier must be used to bill Medicare for any service involving residents under the Teaching Physician Primary Care Exception Rule.**

## 6.0 TIME-BASED CODES

**6.1 General Rule:** For procedure codes determined on the basis of time, **THE TEACHING PHYSICIAN MUST BE PHYSICALLY PRESENT FOR THE TIME PERIOD FOR WHICH THE CLAIM IS MADE.**

The time spent by the resident in the absence of the Teaching Physician should not be included in determining the time-based codes.

Codes falling into this category (TIME-BASED CODES) include:

- Medical Psychotherapy (CPT codes 90804-90829)
- Critical Care Services (CPT codes 99291-92)
- E/M Codes in which counseling and/or coordination of care dominates (more than 50%) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service.
- Prolonged Services (CPT codes 99358-99359)
- Care Plan Oversight (HCPCS G0181-G0182)
- Anesthesia Services
- Hospital Discharge Day Management
  - Less than 30 minutes (99238)
  - More than 30 minutes (99239)

## **7.0 MAJOR SURGERIES, INCLUDING SURGICAL ENDOSCOPIES**

**7.1 General Rule:** The Teaching Physician must be present in the Operating Room with the resident during the entire procedure or all key portions of the surgical procedure and immediately available during the non-key portions.

**7.2 Scrubbed determination:** It is up to the Teaching Physician.

**7.3 “Critical or Key Portion”** refers to the parts of a service that the Teaching Physician determines are critical or key portions. It is up to the Teaching Physician to define the key portions of each procedure. The key portion (s) varies by procedure and by patient.

**7.4 “Immediate availability for the non-key portions”:** The Teaching Physician should, at a minimum, remain in the building or close proximity to the Operating Room suites and not become involved in other scheduled patient care outside the Operating Room suite. For example, the Teaching Physician may not see patients in clinic.

**7.5 Designation of another physician to be immediately available:** In the event that the Teaching Physician is involved in the key portions of a single surgery but he/she cannot be immediately available during the non-key portions of the procedure (i.e. the Teaching Physician must leave the building and/or perform other scheduled patient care activities), the Teaching Physician must arrange for another Teaching Physician to be immediately available.

**7.6 Single Surgery:** When the Teaching Surgeon is present for the entire period between opening and closing of the surgical procedure, his/her presence must be personally documented.

**7.7 Two overlapping Surgeries:** Teaching Surgeons may bill Medicare for two, but not more than two, overlapping procedures provided that the Teaching Surgeon is physically present for the key portions of both procedures.

When all key portions of the initial procedure have been completed, the Teaching Surgeon may begin to become involved in a second procedure. It is critical that the teaching surgeon personally document the key portions of both procedures.

The Teaching Physician must document the name of the physician (not a resident) who will be immediately available for the non-key portions of the first procedure. The designee must be a physician who is not personally involved in, or immediately available for, any other surgical procedure.

**7.8 Three or more overlapping Surgeries:** In the case of three or more overlapping surgical procedures, the Teaching Surgeon's role in each of the cases would be classified as supervisory and therefore, not reimbursable under Medicare Part B.

**7.9 Post-operative visits:** The Teaching Surgeon may determine which post-operative visits are "key" and require his/her presence. If the Teaching Surgeon does not participate in the post-operative care, the procedure should be billed with modifier 54 (Surgical Care Only) for a reduced payment. In cases where the Teaching Surgeon was not present for the key portions of the surgical procedure, and therefore the procedure was never billed, the teaching surgeon may bill for post-operative visits personally performed by him/her. Post-operative visits should be billed with modifier 55 (Post-Operative Management Only).

**Teaching Physician Documentation Requirements:**

"I personally performed the procedure"

OR

"I was present for the entire procedure"

OR

"I was present for the "Key Portions", which consist of  
.....", and remained immediately  
available for the non-key portions.

OR

"I was present for the "Key Portions", which consist of  
....., and Dr. .... was  
assigned to be immediately available for the non-key  
portions.

OR

"I was present and participated during the entire procedure except for opening and/or closing, which overlapped with the opening and/or closing of another case. The overlapping portions were  
non-key portions and I remained immediately available."

## 8.0 **ASSISTANT AT SURGERY**

**8.1 General Rule:** No payment is allowed for services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and a qualified resident is available, with very limited exceptions, described below.

**8.2 Exceptional circumstances:** Even if a qualified resident was available to furnish the services, exceptional medical circumstances, such as emergency, life threatening situations such as multiple traumatic injuries which require immediate treatment, would justify billing for an assistant at surgery.

**8.3 Availability of a qualified resident:** If a resident is not available to provide the services or has not had adequate training yet or becomes busy with other patient care activities, then the services of assistant at surgery are reimbursable.

Modifier 82 must be used to bill Medicare for Surgical Assistant when a qualified resident is not available.

- The Teaching Surgeon must personally document that no qualified resident is available to perform the services. This includes the following certification:

“I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services”.

## 9.0 **MINOR PROCEDURES**

9.1 **General Rule:** For procedures that take less than five minutes to perform and involve relatively little decision making, once the need for the procedure is determined, the Teaching Surgeon must be present for the entire procedure.

If the minor procedure takes more than five minutes to perform, the Teaching Physician does not need to be present for the entire procedure. He/she must only be present for the key portions of the procedure.

### **Teaching Physician Documentation Requirements:**

“I personally performed the procedure”

OR

“I was present for the entire procedure”

OR

“I was present for the “Key Portions”, which consist of  
.....”, and remained immediately  
available for the non-key portions.

OR

“I was present for the “Key Portions”, which consist of .....,  
and Dr.....was assigned to be immediately available for the  
non-key portions.

## 10.0 **DIAGNOSTIC ENDOSCOPIES**

**10.1 General Rule:** For procedures performed through an endoscope, the Teaching Physician must either personally perform or be present during the entire viewing.

The entire viewing includes insertion and removal of the device. The medical record must explicitly state that the Teaching Physician was present for the entire viewing.

**Viewing the entire procedure through a monitor in another room DOES NOT meet the Teaching Physician presence requirement.**

### **Teaching Physician Documentation Requirements:**

“I personally performed the procedure”

OR

“I was present for the entire viewing”

**NOTE:** Surgical Endoscopic Procedures must follow the Major Surgery rules (Section **7.0**).

## **11.0 INTERVENTIONAL RADIOLOGIC AND CARDIOLOGIC OR OTHER COMPLEX OR HIGH-RISK PROCEDURES**

**11.1 In the case of complex and high-risk procedures,** the Teaching Physician must be present with the resident in order to bill Medicare.

The presence of the resident alone would not establish a basis for Medicare Part B payment for such services.

These procedures include, but are not limited to:

- Interventional Radiology and Cardiology
- Cardiac Catheterization
- Cardiovascular Stress Tests
- Transesophageal Echocardiography

These procedures have two components: the Surgical Component and the Radiologic Component

**Interventional Procedures follow the Minor surgery (Section 9.0) or the Major surgery (Section 7.0) policies.**

**Teaching Physician Documentation of the Surgical Component of the Procedure:**

“I personally performed the procedure”

OR

“I was present for the entire procedure”

“I was present for the “Key Portions”, which consist of  
.....”, and remained immediately  
available for the non-key portions.

OR

“I was present for the “Key Portions”, which consist of .....,  
and Dr.....was assigned to be immediately available for the  
non-key portions.

OR

“I was present and participated during the entire procedure except for opening and/or closing,  
which overlapped with the opening and/or closing of another case. The overlapping portions  
were  
non-key portions and I remained immediately available.”

**Teaching Physician Documentation for the Radiologic Component of the Procedure:**

Teaching Physician prepares and documents/dictates the interpretation report.

OR

Resident prepares and documents the interpretation report.

The Teaching Physician must document: “I personally reviewed the film/recording and/or images and  
the resident’s findings and agree with the final report”.

A countersignature by the Teaching Physician to the resident’s interpretation **is not** sufficient  
documentation.

## 12.0 **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

**12.1 General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician.

### **Teaching Physician Documentation Requirements:**

Teaching Physician prepares and documents the interpretation report.

OR

Resident prepares and documents the interpretation report

The Teaching Physician must document/dictate: "I personally reviewed the film/recording/specimen/images and the resident's findings and agree with the final report".

A countersignature by the Teaching Physician to the resident's interpretation **is not** sufficient documentation.

## **13.0 ANESTHESIA**

**13.1 General Rule:** The anesthesiology Teaching Physician is responsible to be present in the operating room for the critical or key portions of the procedure (including induction and emergence) and immediately available for the entire procedure. The Teaching Anesthesiologist must document in the medical records the key portions of the service for which he/she is present.

**13.2 Concurrent procedures:** If the Teaching Anesthesiologist is involved in concurrent procedures (up to four) with more than one resident or with a resident and a non-physician anesthetist, this constitute medical direction and may be reimbursed at a reduced fee.

## 14.0 **PSYCHIATRY**

**14.1 General Rule:** For psychiatric programs, the requirements 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 MEET THIS EXCEPTION.**

The Teaching Physician supervising the resident must be a physician. (The Medicare Teaching Physician policy does not apply to Psychologists).

## **15.0 MATERNITY SERVICES**

**15.1 General Rule:** Some pregnant women are eligible for Medicare through disability benefits.

In order to bill for deliveries, a Teaching Physician must be present in the delivery room and document his/her presence. The global obstetrical care includes prepartum, delivery, and postpartum.

If the Teaching Physician was involved in the delivery only, he/she should bill the delivery only.

In order to bill for the global obstetrical care, the Teaching Physician must be present in the delivery room and the minimum indicated number of antepartum care.