

## **MEDICARE TEACHING PHYSICIAN QUESTIONS & ANSWERS December 2003**

In November 2002 CMS issued revisions to the Carrier Manual Instructions, section 15016, Supervising Physicians in Teaching Settings. To help members understand the changes, the AAMC hosted two teleconference calls with CMS staff, one in December 2002 and the second in January 2003. The AAMC asked CMS to confirm in writing the information that was conveyed on the calls. We believe that these FAQs are a helpful document and answer some of the most pressing questions that have been posed.

### **Definitions**

Q1. The definition of a resident includes, "...a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting." Who, specifically, does this include?

A1. Examples include individuals with temporary or restricted licenses or unlicensed graduates of foreign medical schools. The definition is included in the regulations at 42 CFR §415.152 and in the Medicare Carriers Manual (MCM) section 15016 A.1. (Transmittal 1780, dated November 22, 2002).

Q2. MCM section 15106 E.2. defines an assistant at surgery as a physician, but adds that a nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS), authorized by State law, can also serve as an assistant at surgery. Please explain.

A2. Medicare will pay separately for an assistant at surgery when the assistant is a physician (other than a resident), NP, PA, or CNS. However, Medicare does not pay separately for an assistant at surgery when a resident is available.

Q3. Does "primary medical responsibility" mean the same as "assume management responsibility"? Is "reasonable and necessary" equivalent to "ensured care provided was appropriate"?

A3. "Primary medical responsibility" equates to the term "assume management responsibility" used previously in the MCM. Likewise, the basic requirement for Medicare payment is that services are "reasonable and necessary". This phrase more accurately describes the criterion than "ensured care provided was appropriate".

Q4. What is the difference between the terms: “providing,” “performing,” “participating in,” and “involved in” as used in MCM section 15016?

A4. The terms are used interchangeably.

Q5. Does the definition of “entire surgery” include opening/closing?

A5. Yes, however, a teaching physician’s presence is not required during opening/closing.

### **Physician Responsibility**

Q6. What is the teaching physician’s responsibility when he leaves the operating room after the critical portions of the surgery?

A6. When the teaching physician is involved in a single surgery, he must be immediately available to furnish services during the entire procedure. When the teaching physician is involved in overlapping surgeries, he must be present for the critical or key portions of both surgeries. When he is not present during the non-critical portions of either surgery, he must arrange for another qualified surgeon to be immediately available to assist the resident in the other case, as needed. A resident does not qualify as another physician for this purpose.

Q7. Would the requirement that a surgeon be “immediately available”, be met via pager access and assured surgeon presence in the operating room within 5 minutes?

A7. There is no specific definition of “immediately available”. The above example appears reasonable, however, you should check with your carrier to ensure compliance with local policy.

Q8. Does the teaching physician or the resident determine the appropriate level of an E/M service?

A8. 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.

### **Documentation**

Q9. A teaching physician is responsible for determining which portion(s) of a service are critical or key. If he determines that only the medical decision-making is the key portion, is that all he has to document?

A9. Where a teaching physician determines that only the medical decision-making is the key portion of a service, he must document his physical presence during the medical decision-making. The combined documentation of the teaching physician and resident must support the level of service billed.

Q10. When a teaching physician is involved in overlapping surgeries, Medicare requires the availability of another qualified surgeon. What documentation is required that a second surgeon was available to satisfy compliance audits?

A10. 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.

Q11. What is the significance of the three E/M scenarios in Transmittal 1780?

A11. The scenarios acknowledge the three basic ways that teaching physicians and residents interact and provide examples of the minimal documentation requirements.

For each scenario, the teaching physician must perform, or be physically present, for the key portion(s) of the service. The combined notes of the teaching physician and resident must support the medical necessity and level of service billed.

Q12. Must the teaching physician's documentation include the patient's name or is the sample language provided in the scenarios in MCM section 15016 sufficient?

A12. The sample language is sufficient.

Q13. Transmittal 1780's scenario #3 presents an example where the teaching physician's diagnostic assessment differs from that of the resident. In such cases, do the resident's notes serve as primary documentation of a patient encounter?

A13. The level of service is supported by the combined documentation of the teaching physician and the resident.

Q14. Can more than one teaching physician utilize a single resident's documentation?

A 14. No.

Q15. 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?

A15. 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.

Q16. Under the primary care exception, the teaching physician's presence is not required when residents furnish services to patients. How does the teaching physician document his participation in the direction and review of services furnished in cases where the resident's notes in the medical records are not immediately available?

A16. The regulations at 42 CFR 415.174(a)(3) and the guidelines at MCM section 15016 C.2 require the teaching physician to review with each resident, during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies, and to document the extent of the teaching physician's participation in the review and direction of the services.

The teaching physician must document that he has reviewed the patient's care with the resident and agrees or disagrees with the resident's assessment and plan of care. The teaching physician must still document his review of the resident's notes when they become available.

Q17. Can a teaching physician utilize the documentation of a nurse practitioner (NP)? What if the physician does not employ the NP?

A17. The teaching physician rules do not apply to NPs. CMS has a separate policy on shared visits by physicians, including NPs, relating to physicians in the same group practice.

Q18. Do pre-printed forms, questionnaires, medical record macros, or checklists serve as adequate documentation?

A18. No. A teaching physician must note that he personally furnished a service. Such documentation must be dated and include the legible signature or identity of the teaching physician. However, pre-printed forms, questionnaires medical record macros or check lists can be used to supplement written notes.

Q19. MCM section 15016 A.8. requires a "legible signature or identity" of the teaching physician. Can identity be satisfied by comparing the physician's signature in the patient's medical records to the physician's signature either on file in the medical records department, or as found on other documents?

A19. CMS has not defined "identity". Check with your carrier to determine what alternatives to a legible signature it deems appropriate.

Q20. Is a physician's time spent teaching included in critical care time, i.e., for time-based codes? What documentation requirements apply to critical care?

A20. A physician's time spent teaching is not counted toward critical care time. Only the time spent by the teaching physician alone with the patient, and the time spent by the teaching physician and resident together with the patient, is counted toward critical care time. For time-based codes with code descriptors of greater than 30 minutes (e.g., CPT 99239), the teaching physician must document the actual amount of time spent with the patient. Such documentation is not required for codes (e.g., CPT 99238) with code descriptors of 30 minutes or less.

Q21. What are the documentation requirements for endoscopic procedures?

A21. The teaching physician's presence may be documented by notes written by a resident or nurse.

### **Applicability of Instructions**

Q22. Transmittal 1780 has an effective date of November 22, 2002. Does the effective date apply to services furnished beginning November 22, 2002, or is the policy applied retroactively for carrier claims review purposes?

A22. The effective date applies to the services furnished on or after November 22, 2002, the effective date of the transmittal. Unless otherwise noted, transmittals are not effective retroactively.

Q23. Some carriers have not acknowledged or commented on the revised guidelines. In such cases, does a carrier's earlier policy guidelines remain in effect, or are they superseded by Transmittal 1780?

A23. Transmittal 1780 represents national policy and supersedes previous guidelines issued by carriers, regardless of whether a carrier has updated its local medical review policy (LMRP). (In the absence of national policy, carriers may develop LMRPs). If you have a concern, you should contact your carrier.

Q24. Do the rules that apply to residents also apply to medical students?

A24. No. The teaching physician policy, concerning furnishing and documenting of services by residents, does not apply to students. A student's contribution and participation in the performance of a billable service must be furnished in the presence of either a physician or resident. A student's services must be independently documented by the physician, i.e., the physician cannot simply refer to the student's notes. Documentation of an E/M service by a student that may be referred to by a teaching physician is limited to documentation related to the review of systems and/or past family/social history.

Q25. Do the teaching physician rules apply to pre-operative visits?

A25. Yes. A teaching physician's presence is required for the critical or key portions of a service. Where pre-operative services are included in the global surgery period, and the teaching physician determines the pre-operative services are not key or critical, his presence is not required. Where pre-operative services are not included in the global surgery period, the teaching physician's presence is required during the key or critical portions of those services.

Q26. Can a teaching physician bill for preventive medicine services under the primary care exception in MCM section 15016?

A26. No, the primary care exception only applies to the six specific CPT codes for low and midlevel E/M services.

Q27. Is the policy in the letter from Dr. Robert Berenson dated October 15, 1998, concerning the primary care exception and the supervision of residents, still applicable?

A27. Yes. The primary focus of the revisions to MCM section 15016 was to clarify documentation requirements for E/M services billed by a teaching physician. Policies concerning supervision of residents and the primary care exception were not revised.

Q28. Do the E/M guidelines apply to ophthalmologic services and non time-based psychiatric services?

A28. Yes. The E/M guidelines apply to ophthalmologic services and to non time-based psychiatric services, such as pharmacologic management and diagnostic services. In these instances, the teaching physician psychiatrist/ophthalmologist must personally document his participation.

Q29. Is the reference in MCM section 15016 C.6. correct?

A29. No. The correct reference is subsection C.7. (Time-Based Codes).