MEDICARE CLAIMS PROCESSING MANUAL

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100.1 - Payment for Physician Services in Teaching Settings Under the MPFS

(Rev. 1, 10-01-03)

Payment is made for physician services furnished in teaching settings under the physician fee schedule only if the teaching physician is present during the key portion of the service for which payment is sought, and either:

- The services are personally furnished by a physician who is not a resident; or
- The services are furnished jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions as provided below.

In both situations, the services of the resident are payable to the hospital through the FI.

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 1, 10-01-03)

For a given encounter, the selection of the appropriate level of E/M service should be based on "Documentation Guidelines for Evaluation and Management Services" developed by the American Medical Association (AMA) and CMS and published by the AMA. Carriers publish guidelines based on the combination of this document and the CPT book. If a teaching physician documents his or her presence and participation in the E/M service, the level of service may be selected based on the extent of history and/or examination and/or the complexity of the medical decision making required by the patient and documented in his or her personal entry in the medical record which may include references to notes entered by the resident.

Except as indicated in subsection C, the teaching physician must be physically present during the portion of the service that determines the level of service billed. In all cases, the teaching physician must personally document his/her presence and participation in the services in the medical records. This documentation by the teaching physician may be either in writing or via a dictated note and expressed in the following ways for these major categories of E/M service.

A - Initial Hospital Care, Emergency Department Visits, Office Visits for New Patients, Office Consultations, and Hospital Consultations

A personal notation must be entered by the teaching physician documenting his or her participation in the three key components of these services (i.e., history, examination, and medical decision making) as required by CPT and demonstrating the appropriate level of

service required by the patient. If the teaching physician is repeating key elements of the service components obtained previously and documented by the resident, e.g., the patient's complete history and physical examination, the teaching physician need not repeat the documentation of these components in detail. Rather, the documentation of the teaching physician may be brief, summary comments that relate to the resident's entry and which confirm or revise the key elements defined for the purpose of this section as:

- Relevant history of present illness and prior diagnostic tests;
- Major finding(s) of the physical examination;
- Assessment, clinical impression, or diagnosis; and
- Plan of care.

Therefore, the documentation of the key elements above may be satisfied by combining entries into the medical record made by the resident and the teaching physician. The documentation requirements for some common clinical situations for teaching physicians are illustrated below.

Illustration 1

All required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service. If no resident has seen the patient, the physician should document on the same basis he or she would document an E/M service in a nonteaching setting. If a teaching physician's service follows a resident's service, then the teaching physician's documentation should refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family social history in the case of an initial hospital service. However, the teaching physician would have to examine and question the beneficiary to verify the key findings of the resident's notes since he or she was not present during the resident's interaction with the beneficiary.

Illustration 2

All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the resident's note may document the teaching physician's direct observation, performance, and personal input into the key elements. The teaching physician's personal documentation may be limited. At a minimum, it must include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. The combination of entries must be adequate to substantiate the level of service required by the patient.

Illustration 3

Selected required elements of the service, for example, history and physical examination are obtained by the resident independently. The teaching physician repeats the key elements of the examination. These elements are discussed with the resident either prior to or after the teaching physician's personal service. In this situation, the resident's note

may document the teaching physician's input into the history and medical decision making. The teaching physician's note must include summary comments that revise or confirm the findings of the resident's physical examination and discussion of the history and medical decision making. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

B - Subsequent Hospital Care and Office Visits for Established Patient

A personal notation by the teaching physician must be entered highlighting two of the three key components of these services (i.e., history, physical examination, and medical decision making). The same guidelines set forth in subsection a are required for follow-up visits for established patients.

For E/M codes that are selected on the basis of time, see §100.1.4.

C - Exception for E/M Services Furnished in Certain Primary Care Centers

For the E/M codes listed below, carriers pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a GME program is granted the primary care exception, it applies to the following lower and mid-level E/M services:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. A center does not have to be approved in advance. Maintain a file of such attestations for later use in the case of questionable future claims for payment.

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 FI. 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 nonhospital entity, verify with the FI that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(1)(iii).

Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program. If it becomes necessary to verify this information, teaching hospitals are required to maintain such information under the provisions of 42 CFR 413.86(f)(2).

The teaching physician in whose name the payment is sought must not supervise more than 4 residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Have no other responsibilities (including the supervision of other personnel) at the time of the service for which payment is sought;
- Assume management responsibility for those beneficiaries seen by the residents;
- Ensure that the services furnished are appropriate;
- 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
- Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

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, but there is no requirement that the teaching physicians remain the same over any period of time.

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.

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.

Certain 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 being prescribed as well as psychotropic drugs.

100.1.2 - Surgical Procedures

(Rev. 1, 10-01-03)

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

A - Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be key

or critical portions of the procedure. The teaching surgeon may determine which postoperative visits are considered key and require his or her presence. However, if the postoperative period extends beyond the beneficiary's discharge and the teaching surgeon is not going to be involved in the beneficiary's follow-up care, the instructions on billing for less than the global package in §40 apply. During the period in which the teaching surgeon does not have to be physically present, he or she must remain immediately available to return to the procedure, i.e., he or she must not be involved in another procedure from which he or she cannot return. If the teaching physician is not immediately available, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. The designee is a physician who is not involved in or immediately available for any other surgical procedure. The CMS is not defining availability in terms of geographic location vis-à-vis the operating room.

1 - Single Surgery

When the teaching surgeon is present for the entire period between the opening and closing of the surgical field, 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.

2 - Two Overlapping Surgeries

In order to bill for two overlapping surgeries, the teaching surgeon must be present during the key portions of both operations. Therefore, the key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document the key portion of both procedures in his or her notes in order that a reviewer may clearly infer that the teaching physician was immediately available to return to either procedure in the event of complications. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical field to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. In the case of three concurrent surgical procedures, the role of the teaching **surgeon** (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual beneficiary and is not payable under the physician fee schedule.

3 - Minor Procedures

For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

4 - Anesthesia

An unreduced fee schedule payment is made if a teaching anesthesiologist is involved in a procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure including induction and emergence. The teaching physician's presence is not required during the preoperative or postoperative visits with the beneficiary. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist, pay for the anesthesiologist's services as medical direction.

5 - Endoscopy Procedures

In order to bill for procedures performed through an endoscope (other than endoscopic operations that follow the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

100.1.3 - Psychiatry

(Rev. 1, 10-01-03)

For psychiatric services furnished under an approved GME program, 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 to the physical presence requirement. In the case of time-based services such as individual medical psychotherapy, see §100.1.4, below. Further, 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.

100.1.4 - Time-Based Codes

(Rev. 1, 10-01-03)

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Even if the resident is with the teaching physician when the time is spent with the beneficiary or if time is spent by the teaching physician alone with the beneficiary a claim may be submitted. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90809 - 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) 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 99354-99359); and
- Care plan oversight (HCPCS codes G0181 - G0182).

100.1.5 - Other Complex or High-Risk Procedures

(Rev. 1, 10-01-03)

In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and trans-esophageal echocardiography.

100.1.6 - Miscellaneous

(Rev. 1, 10-01-03)

In the case of maternity services furnished to women who are eligible for Medicare, apply the physician presence requirement for both types of delivery as carriers would for surgery. In order to bill for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, 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.

Carriers do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

100.1.7 - Assistants at Surgery in Teaching Hospitals

(Rev. 1, 10-01-03)

B3-15016.D

A - General

Carriers do not pay for the 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 has a qualified resident available to perform the service unless the requirements of one of subsections C, D, or E are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed.

The FI should provide the carrier with a list of teaching physicians and hospitals. There may be some teaching hospitals in which carriers can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid

reasons. Carriers process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

> I understand that §1842(b)(7)(D) of the 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.

Carriers retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, carriers investigate situations in which it is always certified that there are no qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied based on these instructions do not qualify for payment under the limitation on liability provision.

B - Definition

An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

C - Exceptional Circumstances

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §20.4.3 not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

D - Physicians Who Do Not Involve Residents in Patient Care

Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the limitations in §20.4.3, above, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a nonteaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection E is met.

E - Multiple Physician Specialties Involved in Surgery

Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §20.4.3 is not applied. If payment is made on the basis of a single team fee, additional claims are denied. The carrier will determine which procedures performed in the service area require a team approach to surgery. Team surgery is paid for on a "By Report" basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require the a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

100.1.8 - Physician Billing in the Teaching Setting

(Rev. 1, 10-01-03)

B3-8204, B3-15016

A - Reimbursement to the Hospital

When a hospital is billing the carrier, as opposed to the physician billing the carrier, for covered services, it must bill the carrier on the Form CMS-1500 or equivalent electronic format. It no longer has the option to establish any other type of agreement with the carrier.

B - Carrier Claims

The method by which services performed in a teaching setting must be billed is determined by the manner in which reimbursement is made for such services. For carriers, the shared system suspends claims submitted by a teaching physician, for review.

100.2 - Interns and Residents

(Rev. 1, 10-01-03)

B3-2020.8, B3-8030

An attending physician's services to beneficiaries in a teaching setting are covered under the supplementary medical insurance program. Many physicians rendering such services are on the faculty of a medical school or have arrangements with providers to supervise and teach interns and residents. Payment may be made for professional services to a beneficiary by an "attending" physician where the attending physician provides personal identifiable direction to interns or residents who are participating in the care of this patient.

See the Medicare Benefit Policy Manual, Chapter 15, for services furnished by interns and residents within and outside the scope of an approved training program.