

What Internists Need To Know About Documentation For Services Provided By Teaching Physicians

A FACT SHEET

Compiled by ACP-ASIM's Division of Governmental Affairs and Public Policy
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The patient's medical record must include the documentation to substantiate the claim submitted. The

teaching physician does not need to submit these records with the claim.

Modifiers

Teaching physicians must use the **GC-** modifier with a claim code to indicate that a resident was involved in the service provided. Without this code modifier, the Centers for Medicare and Medicaid Services (CMS), assumes that the service was performed by the teaching physician exclusively— i.e., a resident was not involved.

A claim for a service performed in a facility that bills under the teaching facility ambulatory care exception must include the **GE-** modifier with the code.

Evaluation and Management Services

For Medicare payment purposes, the teaching physician must personally document, at a minimum, that he or she performed the evaluation and management (E/M) service or was physically present during the critical or key portion(s) of the service. CMS defines the “critical ” or “key portion(s)” of the services as the portion of the service that determines the level of E/M service billed. The teaching physician must also personally document his or her participation in the management of the patient. The combined documentation by the resident and the teaching physician in the patient’s medical record substantiates the level of service billed. Medicare auditors must consider the combined documentation when conducting medical review of teaching physician E/M service claims.

CMS revised the Medicare regulations to clarify the documentation requirements pertaining to teaching physician evaluation and management (E/M) services that involve a resident. The revised regulations now make it clear that teaching physicians need not repeat documentation already provided by a resident for E/M services. Medicare auditors must consider the combined medical record entry of the teaching physician and resident when determining whether the documentation justifies the level of service the teaching physician billed for the E/M service.

The revised regulations include documentation instructions pertaining to common scenarios that illustrate how teaching physicians involve residents in furnishing E/M services and provide examples of acceptable and unacceptable medical record notations.

Scenario 1

Documentation Instructions

The teaching physician personally performs all the required elements of an E/M service

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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 the non-teaching setting.
- When a resident has written notes, the teaching physician's note 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. For payment, the composite 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 service billed by the teaching physician.

Minimally Acceptable Medical Record Notations

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: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

Scenario 2

Documentation Instructions

The resident performs the elements required for an E/M 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 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. For payment, the composite 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 service billed by the teaching physician.

Minimally Acceptable Medical Record Notations

Initial or Follow-up Visit: "I was present with 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."

Scenario 3

Documentation Instructions

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his or 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. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed the critical or key portion(s) of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite 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 service billed by the teaching physician.

Minimally Accepted Medical Record Notations

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

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."

Generally Unacceptable Medical Record Notations

- "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; and
- A legible countersignature or identity alone.

The above documentation examples are unacceptable because the documentation 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.

The revised regulations also clarify the teaching physician documentation requirements when a medical student participates in the provision of an E/M service.

E/M Service Documentation Provided by Medical Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the 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. The teaching physician may not refer to a student's documentation of physical 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 medical decision making activities of the service.

Teaching Facility Ambulatory Care Exception

CMS created an exception to the teaching physician regulation, for ambulatory care entities that receive intermediary payments based in part on time spent by residents in patient care activities. These facilities also must provide acute care for undifferentiated problems or chronic care for ongoing problems, coordination of care, and comprehensive care not limited by organ system or diagnosis. Residency programs most likely qualifying for the exception are family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Under the exception, residents can bill for low-level outpatient new and established patient E/M services only, Current Procedural Terminology (CPT) 99201-99203 and 99211-99213, respectively. Any resident furnishing a service without a teaching physician present must have completed more than six months of an approved residency program. A teaching physician may supervise up to four residents at any one time and must be immediately available to assume management responsibility for patients seen by the residents in the ambulatory care facility. (Medical students who accompany the residents for instruction and observation are not counted in the up-to-four category.) The teaching physician must ensure that the care provided was medically necessary, review the care provided during or immediately after each visit, and document the extent of his or her participation in the review and direction of the resident service.

Procedures

The record for a claim for a minor procedure must document that the attending physician was physically present for the entire procedure. CMS defines a "minor procedure" as one that takes less than five minutes, e.g. a simple suture, and involves relatively little decision making once the need for the procedure is determined. The record for a claim for other procedures must document that the attending physician was physically present for the key portion of the procedure.

Endoscopy

The record for a claim must document the physical presence of the teaching physician during the scope insertion, diagnostic viewing, and scope withdrawal--in other words, during the entire procedure.

Critical Care Services

The record for a claim must document the physical presence of the teaching physician for the entire time period indicated by the critical care code.

Electronic Medical Record Systems

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Electronic medical record systems are acceptable for documentation; however, the use of macros is not acceptable in place of patient-specific documentation for services that require a record of both the teaching physician's physical presence and the level of service.

Generic-Attestations

Generic documentation attestations are not acceptable, except for radiology reports, diagnostic test reports, and routine anesthesia reports.

Signature and Proxy Stamps

Signature stamps and electronic signatures are acceptable for noting who provided the service. Proxy stamps by covering physicians are also acceptable when necessary.

Additional Information

For additional information and clarification, contact your local Medicare carrier. Carrier medical directors are available for on-site training.