SIU School of Medicine
SIU Health Care
POLICY
Teaching Physician Policy

It is the policy of SIU, SIU School of Medicine (SOM) and SIU HealthCare (SIUHC) to consistently and fully comply with all laws and regulations pertaining to the training of medical residents which apply to SIU, SIU SOM, and SIUHC.

I. Background

The purpose of this policy is to set forth the policy that will be used by SIU, SIU SOM, and SIUHC to supervise, document, and bill for services when a medical resident or fellow in an approved Graduate Medical Education (GME) program is involved in the care of patients to ensure compliance with Medicare Teaching Physician Guidelines.

NOTE: The guidelines contained in this policy should be applied regardless of payer source

For purposes of this section, the following definitions apply:

1. **Critical or key portion** means that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
2. **Direct medical and surgical services** means services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician.
3. **Documentation** means notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in specific situations (see Section III. E) regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated, and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.
4. **Indirect Medical Education Adjustment (IME) -** An additional payment a prospective payment a hospital receives for a Medicare discharge when it has residents in an approved GME Program.
5. **Macro** means a command in an electronic medical record or dictation application that automatically generates predetermined text that is not edited by the user.

   When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.
6. **Physically present** means that the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple

patients) as the patient and/or performs a face-to-face service.

7. **Primary Care Center**
   An area located in the outpatient department of a hospital or another ambulatory care entity where the time spent by residents in patient care activities is included in determining DGME payments to a teaching hospital.

8. **Primary Care Exception**

   An exception within an approved GME Program that applies to limited situations when the resident is the primary caregiver and the faculty physician sees the patient only in a consultative role (that is, those residency programs with requirements that are incompatible with a physical presence requirement). In such programs, it is beneficial for the resident to see patients without supervision to learn medical decision making.

9. **Resident** means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting (for example, has a temporary or restricted license or is an unlicensed graduate of a foreign medical school). For DGME and IME payment purposes, a resident means an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.

10. **Student** means an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A medical student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

11. **Teaching physician** means a physician (other than another resident) who involves residents in the care of his or her patients. Generally, for the service to be payable under the Medicare PFS, he or she must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service.

12. **Teaching hospital** means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

13. **Teaching setting** means any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding skilled nursing facility (SNF) or home health agency (HHA) in which such payments are made on a reasonable cost basis.

II. Policy

Medicare Teaching Physician Requirements - General Teaching Guideline[1]

CMS has instructed carriers to pay for physician services furnished in teaching settings under the physician fee schedule only if:

- 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.

If a resident participates in a service furnished in a teaching setting, payment may be made for the services of a teaching physician under the physician fee schedule only if the teaching physician is physically present during the key or critical portions of the service for which payment is sought, unless an exception waiver for specific services has been granted by the carrier.

SIU SOM and SIU HC Policy

Teaching Physician Guidelines and supervision should be applied regardless of payer.

A. Teaching Physician Services

Medicare Part B covers services that attending physicians (other than interns and residents) render in the teaching setting to individual patients. These include such services as reviewing the patient's history and physical exams, personally examining the patient within a reasonable time after admission, confirming or revising diagnoses, determining the course of treatment to be followed, assuring that any supervision needed by interns or residents is furnished, and making frequent review of the patient's progress. The medical record must contain signed or countersigned notes by the physician which show that the physician personally reviewed the patient's diagnoses, visited the patient at more critical times of the illness, and discharged the patient. For other services, such as surgical procedures, notes in the record by interns, residents, or nurses, which indicate that the physician was physically present when the service was rendered, are sufficient.

Note that, in order to pay a teaching physician under Medicare Part B, the teaching physician must at least be present during the key portion of a service rendered by a resident or intern.

When a resident does a visit without teaching physician presence, the teaching physician must repeat the key portions of the visit and have his own documentation in order bill.

B. Interns and Residents

For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is

designated, for example, a “fellow,” it does not change the resident’s status for the purposes of Medicare coverage and payment. As a general rule, the intermediary pays for services of interns and residents as provider services.

a. Services Furnished by Interns and Residents Within the Scope of an Approved Training Program

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. Effective with services furnished on or after July 1, 1987, provider services includes medical and surgical services furnished in a setting that is not part of the provider, where the hospital has agreed to incur all or substantially all of the costs of training in the non-provider facility.

Where the provider does not incur all or substantially all of the training costs and the services are performed by a licensed physician, the services are payable under Part B by the carrier.

b. Services Furnished by Interns and Residents Outside the Scope of an Approved Training Program – Moonlighting

Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physician services where the requirements in the first two bullets below are met. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians’ services where all three of the following criteria are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient’s condition;
- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and
- The services performed can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents.

C. Teaching Physician Billing Modifiers

Services furnished by teaching physicians involving a resident in the care of their patients must be identified as such on the claim. To be payable, claims for services furnished by teaching physicians involving a resident must comply with the requirements in Section III. E of this policy. Claims for services meeting these requirements must show either the GC or GE modifier as appropriate.

GC Modifier

Claims for teaching physician services in compliance with the requirements outlined in this policy must include a GC modifier for each service, unless the service is furnished under the primary care exception described in Section V of this policy (refer to the paragraph below for GE modifier). When a physician (or other appropriate billing provider) places the GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in Section III of this policy.

GE Modifier

Teaching physicians who meet the requirements in Section V of this policy must provide their contractor with an attestation that they meet the requirements. Claims for services furnished by teaching physicians under the primary care exception must include the GE modifier on the claim for each service furnished under the primary care exception.

III. MEDICARE TEACHING PHYSICIAN SERVICES

A. Payment for Teaching Physicians

CMS will pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident;
- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or
- Certain E/M services furnished by a resident under the conditions contained in the "Primary Care Exception Rule".

Specific information regarding the "Primary Care Exception Rule" is outlined in Section V, "Primary Care Exception Rule: E/M Services Performed in Certain Primary Care Centers."

B. SIU School of Medicine Policy on Inpatient Resident Supervision[6]

The Southern Illinois University (SIU) and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for Graduate Medical Education (GME) Trainees and Attending Physicians, Section VI, establishes the minimum requirements for trainee supervision in clinical sites in which SIU School of Medicine residents and fellows train. An affiliated hospital or clinical site may have additional requirements for supervision as they pertain to that specific hospital. Individual training programs may also have additional requirements for their faculty/attendings and trainees. This policy can be found on the SIU Residency Affair's policies webpage http://www.siumed.edu/resaffairs/policies.html.

This policy requires the following:

- The attending physician on the *primary s*ervice will personally see all hospitalized patients **at least once daily**.

- The attending physician on *consultative services* will personally see patients for initial consultation within the specified time frame (usually 24 hours) and thereafter frequently enough to ensure safe and appropriate patient care, until the time of sign-off. When patients are acutely unwell, and/or the trainees are junior or off-service learners, this may necessitate daily attending visits.

The attending physician will, at a minimum:

1) Examine the patient within 24 hours of admission, when there is a significant change in patient condition or as required by good patient care.
2) Review the patient's history, the record of examinations and tests, and make appropriate reviews of the patient's progress.
3) Confirm or revise the diagnosis made by the trainee and determine major changes in the course of treatment to be followed.
4) Either perform personally the physician services required by the patient or supervise the treatment so as to assure the appropriate services are provided by trainees and that the care meets the proper quality level.

5) For surgical or other complex, high risk medical procedures, the attending physician must be immediately available to assist the trainee who is under the attending physician's direction.
6) Make decisions to authorize or deny any admissions, discharges or transfers.
7) Sign all DNR orders, or document appropriate involvement in the decision.
8) Assure that a properly completed, signed and witnessed consent form is obtained and placed in the patient's record prior to the performance of any operative or invasive procedure.
9) Assure that supervision of care for inpatients is documented in the patient record. It is the attending physician's responsibility to see that all documentation must be in accordance with appropriate regulations and the standards of good patient care and must provide evidence in writing of supervisor concurrence with the admission, history, physical examination, assessment, treatment plan and orders.
10) Document appropriate attestation and/or sign all residents' notes in EHR.

Teaching physicians should review the policy in its entirety for all supervision requirements.

C. SIU School of Medicine Policy on Outpatient Resident Supervision[6]

Per the Southern Illinois University and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for Graduate Medical Education Trainees and Attending Physicians, Section VII, all outpatient visits provided by trainees will be conducted under the supervision of a staff provider who has full responsibility for the care provided. The extent and duration of the attending's physical presence will be variable, depending on the nature of the clinical situation and the level of training and capabilities of the trainee. The responsibility or independence given to trainees depends on their knowledge, skills and experience as judged by the responsible attending physician. The attending physician supervisor must be designated and be available in accordance with all ACGME and AOA (if applicable) institutional and program requirements, CMS standards and specific departmental policies.

D. SIU School of Medicine Policy on Resident Supervision in the Emergency Department[6]

All trainees within the Emergency Department must be under the supervision of qualified emergency medicine attendings. When residents from other services provide care to patients in the emergency department, they must be supervised by emergency medicine attendings or by faculty from their service.

E. General Documentation Instructions and Common Scenarios

Evaluation and Management (E/M Service) - For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

a. The teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and

b. The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician. **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 teaching physician must document their own presence and participation for E/M services.**

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. The teaching physician should reference the resident by name in his/her personal note.

Following are four 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 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 the service billed by the teaching

physician.

Example 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** -- "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."

NOTE: In these scenarios, if there were no resident notes, the TP must document as he/she would document an EM service in a non-teaching setting.

SIGN and DATE

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. In this case, 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. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity and the level of the service billed by the teaching physician.

Example Scenario 2:

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."

SIGN and DATE

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. In this instance, the teaching physician must document that he or 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. 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 the service billed by the teaching physician.

Scenario 4

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, 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 the service billed by the teaching physician. Note: **It must be emphasized that the TP note be directly tied to the resident's note, especially when the resident's note is written at the time of service and the TP note is dictated and placed in the chart later.**

Example Scenarios 3 and 4:

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."

SIGN and DATE

Following are examples of unacceptable documentation:

- "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.

Such documentation is not acceptable 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.

IV. EVALUATION AND MANAGEMENT (E/M) SERVICE DOCUMENTATION PROVIDED BY MEDICAL STUDENTS

E/M Documentation Provided by 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. If the medical student documents E/M services, the teaching physician must verify in the medical record all student documentation or findings, including the history, physical exam and or medical decision making. The teaching physician must personally perform or re-perform the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work. This rule does not apply to other types of students (e.g., physician assistants and nurse practitioners in training).

This rule only applies to Evaluation and Management services (Office visits, inpatient visits, etc.…) Medical students cannot document billable procedures.

V. PRIMARY CARE EXCEPTION

Exception for E/M Services Furnished in Certain Primary Care Centers – Teaching physicians providing E/M services in a GME program setting granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient	Initial Preventative Physical Exam (IPPE)	Annual Wellness Visit (AWV)
99201	99211	G0402	G0438
99202	99212		G0439
99203	99213		

The exception rule does not apply to procedures or any other services, only to these very limited number of E/M service codes. If a service, other than those listed above, needs to be furnished (i.e., require a more comprehensive service (level 4 or 5)), then the general teaching physician policy set forth in Section III above applies, meaning the teaching physician may see the patient, but must revert to the standard Teaching Physician Guidelines outlined in Section III.

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least six (6) months of a GME approved

residency program. Centers must maintain this information under the provisions of 42 CFR 413.79(a) (6).

Teaching physicians submitting claims under this exception may not supervise more than four (4) residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than six (6) months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than six (6) months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than six (6) months in a GME approved residency program.

NOTE: For Medicaid this requirement is 12 months. For residents beyond their first year, the department will recognize the medical school's or sponsoring hospital's protocols in the department's audit process if the protocol of each residency program meets all of the following: 1) identifies the level of supervision for each year of residency; 2) describes specific situations where residents may and may not function independently; and 3) specifies the manner in which documentation will be maintained to verify that the teaching physician has personally supervised the resident to the degree required in the protocol and has participated in the patient's care to the degree specified in the protocol. The department will accept the medical school's or sponsoring hospital's residency program supervision protocol and other medical record documentation in the determination of whether the teaching physician has provided appropriate supervision and assumed appropriate responsibility for the services provided by the resident. If the protocol and residency records are not readily available in the event of a department audit, the medical school or sponsoring hospital will be held to the requirements specified in Section III.

The teaching physician submitting claims under this exception 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 cared for 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 (i.e., record of tests and therapies); and
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Documentation Requirements

The TP must still write a personal note (or attestation) that indicates he/she:

1) Reviewed and discussed with the resident the patient-specific information from the resident's history, exam and plan of care as well as any labs/tests/records, etc.; and that
2) The TP and resident discussed the visit 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.
3) The TP must provide a brief summary of the discussion highlights with the resident with "patient-specific" references of the service (i.e. key exam findings, diagnosis and treatment plan).

TouchWorks Attestation:
While the patient was in clinic or immediately following the patient leaving the clinic, I reviewed the patient's medical history, the resident's findings on physician examination, and the patient's diagnosis and treatment plan with the resident and agree with the information documented unless otherwise noted below.
SIGN and DATE

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency program. The types of services furnished by residents under this exception include:

- 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.

Residency programs that most likely qualify for this 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.

VI. SURGICAL PROCEDURES

Surgical Procedures – 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.

To bill for a procedure, the SIU SOM and SIU HC requires the teaching physician presence and/or participation be documented in the patient's medical record for any surgical, high-risk, or other complex procedure.

SIU and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for GME Trainees and Attending Physicians, Section IX[6] - The attending physician must be present in the operating room for the key or critical portion of all cases and must remain in immediate proximity and available to return to the procedure immediately if needed. ("Immediate proximity" is generally defined as within the OR Suite and immediately available to return to the operating room if needed). If the attending physician leaves the OR Suite after the completion of the key portion of the procedure or another case would prohibit him/her from returning to the original case, the attending physician must make arrangements with another physician to be immediately available for the original case.

It is the attending surgeon's responsibility to obtain written informed consent that is in compliance with all CMS, the Joint Commission and hospital regulations, including the role of the resident/fellow in the surgery or procedure.

a. **Surgery (Including Endoscopic Operations)** – The teaching surgeon is responsible for the pre-operative, operative, and post-operative 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 determines which post-operative visits are considered key or critical and require his/her presence. If the post-operative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in Medicare Claims Processing Manual, 100-04, Chapter 12, Section 40, apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he/she must be immediately available to return to the procedure (i.e., he/she cannot be performing another procedure). If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

1. **Single Surgery** – When the teaching surgeon is present for the entire surgery, 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.

Documentation Requirements for Surgical, High Risk, Complex
• Typically 90 day global period • TP **must** be present during all critical and key portions of the procedure • TP **must** be immediately available to return to the procedure (i.e., cannot be performing another procedure) • Documentation must include a statement regarding the TP's presence. The statement can be made personally by the TP, or by the resident or nurse. • TP and resident **must** sign and date the report. • GC Modifier required for each procedure code billed for Medicare or Medicaid patients. ***Acceptable Single Surgery Attestation*** • **Teaching physician is present for entire surgery:** "I was present for the entire surgery." "The attending physician, Dr. (full name of TP) was present for the entire procedure." • **Teaching physician is present for critical and key portions of surgery:** "I was present during the critical and key portions of the surgery and I was immediately available to provide assistance." "The attending physician, Dr. (full name of TP) was present for all critical and key portions of this case and was immediately available during the remainder of the case."

2. **Two Overlapping Surgeries** – In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or 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 in the medical record that he/she was physically present during the critical or key portions of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. 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 patient and is not payable under the physician fee schedule.

Documentation Requirements for Overlapping Surgeries
• Typical 90 day global period • The teaching physician must be present during the critical or key portions of both operations. • The critical or key portions may not take place at the same time. • When all the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. • The TP **must personally document** presence for both procedures. • When a teaching physician is not present during non-critical or non-key portions of the procedure, the TP must arrange for another qualified surgeon to immediately assist the resident. • TP and resident must sign and date the report. • GC Modifier required for each procedure code billed for Medicare or Medicaid patients. ***Acceptable Overlapping Surgery Attestation*** • **Teaching physician is present for the critical/key portion of two overlapping surgeries:** "I was present during the key and critical portions of the surgery and another attending surgeon was immediately available throughout the procedure."

Minor Procedures – For procedures that take only a few minutes (5 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.

Documentation Requirements for Minor (five minutes or less)
• Typically 0-10 day global period • For a minor procedure, the TP **must** be present in same room as the resident and patient for the entire time the procedure is being performed in order to bill for the service. • Documentation must state the TP's presence. The statement can be made personally by the TP, or by the resident or nurse. Whoever makes the statement, they must *explicitly state that the TP was present for the entire procedure.* • TP and resident must sign and date the report. • GC Modifier required for each procedure code billed for Medicare or Medicaid patients. • Avoid using the word "supervised" or phrases "directly supervised" or "personally supervised" as these statements do not necessarily convey that the TP was present for the entire procedure. ***Acceptable Minor Procedure Attestation*** • **Procedure only with resident:** "I was present for the entire procedure." "The attending physician, Dr. (full name of TP) was present for the entire procedure." • **Minor procedure and E/M with the resident (Available in TouchWorks):** "I saw and examined the patient and discussed with resident, agree with the resident's note and was present for the entire procedure."

3. **Procedures performed in Treatment Room or on Unit/Floor by Resident Alone** – When a resident sees a patient and the Teaching Physician does not, these services are not billable.

Procedures Performed in Treatment Room or on Unit/Floor by Resident Alone
• When a resident sees a patient and the TP DOES NOT, these encounters are not billable. • Residents and fellows are under the direction and supervision of an SIU faculty member. Residents are only permitted to perform those procedures approved by their overseeing faculty member and those listed on the SIU SOM training program protocols as acceptable to be performed absent the direct personal supervision of a faculty member. • The TP must place an attestation on the documentation stating they discussed the case with the resident and agree with the plan and content as written. • The TP and resident must sign and date the documentation. ***Acceptable Attestations for procedures performed in Treatment Room or on Unit/Floor by Resident Alone*** • **Resident sees patient alone and the case was discussed with the resident**. "I reviewed the progress note and agree with the resident's findings and plans as written. Case discussed with the resident."

- **Resident sees patient and performs an approved training program protocol procedure alone (i.e., chest tubes, arterial lines, etc.) and the case was discussed with resident.**

  "I discussed the case with the resident and we determined the performed procedure was medically necessary. I reviewed the progress note and procedure details and agree with the resident's findings and plans as written. Case discussed with resident."

b. **<u>Anesthesia</u>** – Medicare pays at the regular fee schedule level if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he/she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment.

In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident. The teaching anesthesiologist can bill base units if he/she is present with the resident throughout pre and post anesthesia care. The teaching anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For anesthesia services, payment may be made under the Medicare physician fee schedule at the regular fee schedule level if the teaching anesthesiologist is involved in the training of a resident in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. To qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary. If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form.

The teaching anesthesiologist should use the "AA" modifier and the "GC" certification modifier to report such cases. See Medicare Claims Processing Manual, 100-04, Chapter 12, Section 50 B and 50 K.

c. Endoscopy Procedures – To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection a. above), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

Documentation Requirements for Endoscopic Procedures
• Typically 0-10 day global period • For an endoscopic procedure, the TP **must** be present with the resident and patient for the entire viewing portion of an endoscopy including the insertion and removal of the scope. • Documentation must state the TP's presence. The statement can be made personally by the TP, or by the resident or nurse. • TP and resident must sign and date the report. • GC Modifier required for each procedure code billed for Medicare patients. ***Acceptable Endoscopy Attestation*** • Teaching Physician must be physically present for the entire viewing from the insertion of the endoscope through the removal of the endoscope "I was present for the entire procedure from insertion of the scope until removal of scope." "The attending physician, Dr. (full name of TP) was present for the entire procedure from insertion of the scope until removal of scope."

VII. DIAGNOSTIC TESTS AND DIAGNOSTIC RADIOLOGY

Interpretation of Diagnostic Radiology and Other Diagnostic Tests – Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician. If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. **Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.**

Acceptable Attestations:
"I attest to having personally viewed the images/test and approve the above interpretation." *"I reviewed and agree with the resident's findings or interpretation unless noted below."* **SIGN and DATE**

VIII. PSYCHIATRY

Psychiatry – The general teaching physician policy set forth in Section II above applies to psychiatric services. For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service through the use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the physical presence requirement. In the case of time-based services, such as individual medical psychotherapy, see subsection IX 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.

TouchWorks Attestations

I was present for and/or observed via video monitoring the resident physician's evaluation of this patient. I provided the resident physician with appropriate supervision and assume full responsibility for the care that was provided. I have reviewed the resident physician's note and agree with the services provided and treatment plan as written, unless otherwise noted below.

OR

I was present for and/or observed via video monitoring the resident physician's evaluation of this patient for the time frame billed, ___minutes. I provided the resident with the appropriate supervision and assume full responsibility for the care that was provided. I have reviewed the resident physician's note and agree with the services provided and treatment plan as written, unless otherwise noted below.

SIGN and DATE

IX. TIME-BASED CODES

Time-Based Codes – 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 20 to 30 minutes may be paid only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (CPT codes 90832-90838);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);
- Smoking and Tobacco Use Cessation (CPT codes 99406, 99407);
- Prolonged services (CPT codes 99358-99359); and
- Care plan oversight (HCPCS codes G0181-G0182).
- 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.

TouchWorks Attestation for E/M Based on Time:

"I have spent greater than 50% of this ___ minute encounter in counseling and/or coordination of care with the patient. See the Assessment and Plan for items discussed with the patient."

SIGN and DATE

X. OTHER COMPLEX OR HIGH-RISK PROCEDURES

Other Complex or High-Risk Procedures – In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicates that the procedure requires personal (in person) supervision of its performance by a physician, the physician services associated with the procedure are billable 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.

XI. MATERNITY SERVICES

Maternity Services – 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 you would for surgery. In order to bill Medicare 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 (pre-partum, 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.

SIU and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for GME Trainees and Attending Physicians, Section X[6] - Supervision of labor and delivery must be immediately available. When risk factors are present there must be on-site supervision. If this supervision is provided by anyone other than an attending physician, there must be documentation of the skill of the non-attending physician supervisor to function competently in this capacity and backup plans or emergency consultative arrangements when the supervising provider encounters a clinical situation or emergency outside of the scope of his or her practice.

XII. MISCELLANEOUS

Miscellaneous – In the case of end stage renal related visits furnished under the monthly capitation payment method (MCP), the physician presence policy, as discussed in Medicare Claims Processing Manual, 100-04 Chapter 12, Section 100.1- Payment for Physician Services in Teaching Settings, applies. Patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visit. The teaching physician may utilize the resident's notes, however, the teaching physician must document his or her physical presence during the visit(s) furnished by the resident and that he or she reviewed the resident's notes. The teaching physician could document these criteria as part of an extensive once a month MCP note.

XIII. ASSISTANTS AT SURGERY

Services of Assistants at Surgery Furnished in Teaching Hospitals

1. **General** – Services provided by 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 are not a reimbursable service unless the requirements of subsections 3, 4, or 5 are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed.

   Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which the carrier 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. 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 (noted below) is for use only when the basis for payment is the unavailability of qualified residents.

   > "I understand that section 1842(b)(7)(D) of the Social Security 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 not qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the limitation on liability provisions.

2. **Definition** – An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under state law can also serve as an assistant at surgery.) 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.

3. **Exceptional Circumstances** – Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in Medicare Claims Processing Manual, 100-04, Chapter 12, Section 40 – Surgeons and Global Surgery, notwithstanding 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 your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

4. **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 special limitation in Medicare Claims Processing Manual, 100-04, Chapter 12, Section 40 – Surgeons and Global Surgery, if the primary surgeon has an across-the-board policy of never involving residents in the pre-operative, operative, or post-operative 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 non-teaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment will be made unless either of the criteria of subsection V is met.

5. **Multiple Physician Specialties Involved in Surgery** – Complex medical procedures, including multi-stage 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 Medicare Claims Processing Manual, 100-04, Chapter 12, Section 40 – Surgeons and Global Surgery, 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 your 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 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.

XIV. SUPERVISION OF TRAINEES VIA TELEHEALTH

Resident supervision via Telehealth must meet all of the parameters outlined in this document. Instances of Telehealth supervision in which the resident and supervising physician are at physically distant sites must be approved by the Executive Director of SIU Telehealth and the Associate Dean for GME.

Approvals and References:

Adopted: 4/24/2018	**Contact: Compliance Officer**
Revisions: Approved by OCP: 4/11/18 Approved by Quality and Safety: 4/24/18	**Applicable Laws, Regulations & Standards:** 1. Medicare Claims Processing Manual, 100-04, Chapter 12, §100 – Teaching Physician Services. 2. Medicare Benefit Policy Manual, 100-02, Chapter 15, §30.2 – Teaching Physician Services and 30.3 – Interns and Residents. 3. UT Health Science Center San Antonio, Guidelines for Physicians in Teaching Settings. Retrieved May 27, 2015, from http://facultycompliance.uthscsa.edu/manual.asp 4. United States General Accounting Office (GAO). Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives. Medicare Concerns with Physicians at Teaching Hospitals (PATH) Audits. GAO/HEHS-98-174. July 1998. http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-98-174/pdf/GAOREPORTS-HEHS-98-174.pdf 5. Illinois Healthcare and Family Services. Handbook for Practitioners Rendering Medical Services, Chapter A-200 Policy and Procedures for Medical Services, Section 202.14, Services Provided by Interns and Residents. Issued August 2016. 6. Southern Illinois University and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for Graduate Medical Education Trainees and Attending Physicians