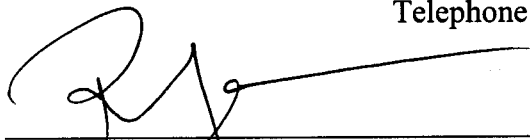


LSU – HEALTH CARE SERVICES DIVISION

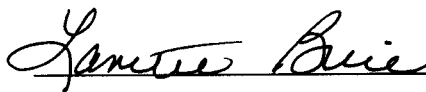
BATON ROUGE, LOUISIANA

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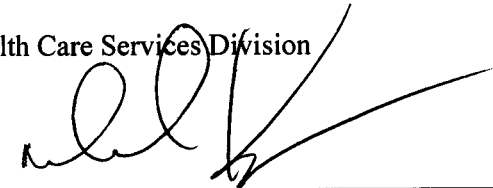
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LSU Health Care Services Division



Deputy Chief Executive Officer Date
LSU Health Care Services Division



Chief Medical Officer Date
LSU Health Care Services Division

LSU HEALTH CARE SERVICES DIVISION
Physicians at Teaching Hospitals Billing Policy

I. Policy Statement:

It is the policy of the LSU Health Care Services Division (HCSD) that all physicians and non-physician employees involved with the charging and billing of professional fees do so in accordance with all applicable federal and state laws and regulations, as well as LSU HCSD policy.

II. Purpose:

To familiarize physicians and non-physician employees involved with professional fee billing about applicable state and federal laws, regulations, and HCSD policies regarding professional fee billing;
To promote the HCSD Compliance Program designed to provide reasonable assurance that all such individuals and departments will follow such laws, regulations, and policies; and
To reduce legal and financial risks by producing claims which are proper and accurate.

III. Scope:

This policy applies to all physicians employed or contracted to provide medical services to the HCSD hospitals and all HCSD employees and HCSD contractors involved in the charging and billing of professional fees. While it is intended to comply with Centers for Medicare and Medicaid Services regulations for physicians at teaching hospitals, this policy shall apply for all patients, no matter their insurance status.

IV. Implementation:

All HCSD hospitals which process professional fee claims must develop procedures to ensure compliance with Centers for Medicare and Medicaid Services (CMS) regulations for Physicians at Teaching Hospitals.

The following policy statements are based on the Medicare Claims Processing Manual, 100-4, Chapter 12, Section 100.

V. Definitions:

For the purposes of this policy, the following definitions apply:

Resident – 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. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the FI. 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.

Student – An individual who participates in an accredited educational program (e.g, a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student. See § 100.1.1 B for a discussion concerning E/M service documentation performed by students.

Teaching Physician – A physician (other than another resident) who involves residents in the care of his or her patients.

Direct Medical and Surgical Services – Services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary (FI) for the hospital.

Teaching Hospital – A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

Teaching Setting – Any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the FI under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.

Critical or Key Portion – 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.

Documentation – Notes recorded in the patient’s medical records by a resident, and or teaching physician or others as outlined in the specific situations below regarding the service furnished. Documentation may be dictated and typed or hand-written, or computer-generated and typed or handwritten. Documentation must be dated, timed 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.

In the context of an electronic medical record, the term ‘macro’ means a command in a computer 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.

Physically Present – 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.

VI. Policy:

A. Payment for Physician Services in Teaching Settings under the MPFS Pursuant to 42 CFR 415.170, services furnished in teaching settings are paid under the Medicare physician fee schedule (MPFS) if the services are:

- Personally furnished by a physician who is not a resident; or
- Furnished by a resident and 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 Section B: 3 of this policy.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the FI.

B. Evaluation and Management (E/M) Services

1. General Documentation Instructions and Common Scenarios

Evaluation and Management (E/M) Services – 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:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, the teaching physician or professional services coder must 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 combined entries into the medical record by the teaching physician and the resident taken together must support the medical necessity of the service.

1. **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. The resident may or may not have performed the E/M service independently; separate and apart from the service the teaching physician may have performed.

In the absence of a note by a resident, the teaching physician must document as he/she would 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/she performed the critical or key portion(s) of the service, and that he/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.

Following are examples of minimally acceptable documentation for:

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 this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

It is also important to note that all of these entries must be followed by the legible signature of the teaching physician as well as the date and the time of the teaching physician's entry.

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/she was present during the performance of the critical or key portion(s) of the service and that he/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.

Following are examples of minimally acceptable documentation for 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."

Each of these entries must be followed by the legible signature of the teaching physician, as well as the date and time of the teaching physician's entry.

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/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.

Following are examples of minimally acceptable documentation for Scenario 3:

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 NSAID's."

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."

Each of these entries must be followed by the legible signature of the teaching physician as well as the date and time of the teaching physician's entry.

Following are examples of unacceptable documentation in any scenario:

"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.

2. E/M Service 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. However, the documentation of an E/M service by a student that may be referred to by the 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 exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.

3. Exceptions for E/M Services Furnished in Certain Primary Care Centers – Clinic Services Only

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

New Patient	Established Patient	Preventive Services
99201	99211	G0402
99202	99212	G0438
99203	99213	G0439

Codes 99204, 99205, 99214, and 99215 can only be charged by the teaching physician if the teaching physician is physically present during the critical key portions of the service, or personally performs the critical key portions of the service.

If a service other than those listed above is furnished, then the general teaching physician policy set forth in Section A of this policy applies. For this exception to apply, a center must attest in writing that all 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.

The services must be furnished in a center 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 direct GME payments. This requirement is not met if the resident is assigned to a physician's office away from the center or makes home visits.

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a) (6)

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- Have the primary medical responsibility for patients cared for by the resident;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This includes a review of the patient's medical history, the resident's findings on physical examination, the 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.

Patients under this exception must 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 training. 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.

4. Staff Physician Documentation for Inpatients

Physician charges for inpatient services will be treated as evaluation and management codes in a non-primary care setting, and so must follow the guidelines in Section VI.B.1 and VI.B.2 of this policy.

NOTE: There may be a delay in a teaching physician seeing a patient if the patient is admitted late at night by a resident. In this instance, the Medicare manual gives specific instructions in the documentation required before the teaching physician may bill for the service. Those instructions are as follows:

When a 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.

Following are examples of minimally acceptable documentation for each of these scenarios:

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."

5. 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.

a. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the patient. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which preoperative visits are considered key or critical and require his or her presence. If the postoperative 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 40 of Chapter 12, of the Medicare Claims Processing Manual 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.

b. 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.

c. 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 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 portion(s) 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/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.

d. 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.

e. Anesthesia

Medicare pays an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical record 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 patient is not sufficient to support Medicare Payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, Medicare pays for the anesthesiologist's services as medical direction. In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, 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.

f. 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.

6. 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/she is indicating that he/she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he/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.

7. Psychiatry

The general teaching physician policy set forth in Section A 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 by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the physical presence requirement. For time-based services such as individual medical psychotherapy, see Section 7 below. 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.

8. 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 from 20 to 30 minutes may be paid only if the teaching physician is physically 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 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 (HCPCS codes 90804 – 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 99358-99359); and
- Care plan oversight (HCPCS codes G0181-G018

9. Miscellaneous

For maternity services, 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. If the teaching physician's only involvement was at the time of delivery, the teaching physician should bill only for the delivery. 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.

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

10. Assistants at Surgery in Teaching Hospitals

a. 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.

b. General

Medicare does 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. A certification that a qualified resident was not available is required:

I understand that 41842(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.

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

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 of the Medicare Claims Processing Manual 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 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 of the Medicare Claims Processing Manual 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 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 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 of the Medicare Claims Processing Manual is not applied.

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.

VII. Responsibility

A. Hospital Administrator

1. Ensures that this policy is disseminated and acknowledged by appropriate staff.
2. Ensures that hospital specific procedures regarding the billing under the Physicians at Teaching Hospital regulations have been implemented.

B. Physicians

1. The teaching physician ensures that accurate documentation of services and supervision is provided in accordance with this policy and applicable state, federal, and academic regulations.
2. The teaching physician is responsible for accurate documentation (as defined in this policy) for all patients, not just those funded by CMS.

C. Compliance Liaison Officers

1. The Hospital CLO will monitor compliance with the Physicians at Teaching Hospitals Billing Policy through the performance of periodic reviews of the documentation contained in patient medical records.

D. Employees

1. HCSD employees involved in the charging and billing of professional fees will ensure that charges assigned and professional fee bills are supported by appropriate documentation and in accordance with the provisions of this policy.

VIII. Consequences

Failure of the teaching physician to properly document and account for supervision in accordance with this policy may result in disciplinary action through the Hospital Medical Executive Committee or the LSU HCSD Chief Medical Officer.

