

UC RIVERSIDE HEALTH (UCRH)

Policies and Procedures for Teaching Physician
BILLING COMPLIANCE

UC RIVERSIDE HEALTH (UCRH) POLICIES AND PROCEDURES FOR TEACHING PHYSICIAN BILLING COMPLIANCE

UNIVERSITY OF CALIFORNIA, RIVERSIDE

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In our effort to further our mission of providing quality health care to our patients, at the same time, advancing the prevention of fraud, abuse and waste in our health care delivery system, we have developed and implemented our UC Riverside School of Medicine Compliance Program. This Program addresses effective internal controls that promotes adherence to applicable federal and state laws, and program requirements of federal, state and private health care plans. The Compliance Program applies to all operations involving professional fee billing and documentation, clinical research, conflict of interest and industry relations conducted throughout our health care delivery system.

The UC Riverside Health Policies and Procedures for Teaching Physician Billing Compliance are important components of our Compliance Program in our role of teaching medical students and training residents.

These Policy and Procedures are intended to clarify the requirements for Teaching Physician services and billing and to state UCRH policies designed to promote compliance with these requirements. The policies and procedures set forth in this document are based upon the interpretation of the applicable regulations and government interpretations, advice of legal counsel, and determinations by the Compliance Officer. These policies and procedures are in response to the Medicare regulations which became effective July 1996 (replacing IL 372) as well as CMS transmittal changes to the regulations since that time.

Unless otherwise specifically provided, these policies and procedures apply with respect to all physician services for which a claim is to be submitted by or on behalf of the UC Riverside School of Medicine, any subdivision of the University, or any physician for a service furnished in his or her capacity as a University faculty member (including full-time, part-time, ILP, and any other physicians who are members of any University compensation plan), and any physicians for whose services the University or related entities may bill or receive any economic benefit (e.g., certain voluntary faculty).

With your help, we can achieve our goals of providing quality health care services, health professional training and biomedical research in compliance with all laws and regulations.

Sincerely,

A handwritten signature in black ink, appearing to read "G. Richard Olds". The signature is fluid and cursive, written over a white background.

G. Richard Olds, M.D.

Vice Chancellor for Health Sciences

Dean, UC Riverside School of Medicine



UCRH POLICIES AND PROCEDURES FOR TEACHING PHYSICIAN BILLING COMPLIANCE

Preface

These Policy and Procedures are intended to clarify the requirements for Teaching Physician services and billing and to state UCRH policies designed to promote compliance with these requirements. The policies and procedures set forth in this document are based upon the interpretation of the applicable regulations and government interpretations, advice of legal counsel, and determinations by the Compliance Officer. These policies and procedures are in response to the new Medicare regulations which replaced IL 372 and became effective July 1996. The February 2003 revisions reflect the November 22, 2002, CMS transmittal changes to the regulations.

Unless otherwise specifically provided, these policies and procedures apply with respect to all physician services for which a claim is to be submitted by or on behalf of the UC Riverside School of Medicine, any subdivision of the University, or any physician for a service furnished in his or her capacity as a University faculty member (including full-time, part-time, ILP, and any other physicians who are members of any University compensation plan), and any physicians for whose services the University or related entities may bill or receive any economic benefit (e.g., certain voluntary faculty). The only exceptions to these policies and procedures shall be set forth in Departmental Appendices, which set forth department-specific policies, interpretations, definitions, and procedures. Nothing in any Departmental Appendix shall be construed to excuse compliance with these UCRH Policies and Procedures for Teaching Physician Billing Compliance.

Nothing in this document shall be construed to eliminate the necessity of complying with specific practice and documentation requirements imposed by particular payors (including Medi-Cal). For convenient cross-reference and comparison, Medi-Cal requirements are identified in the footnotes throughout this document in bold text.

These Policies and Procedures address the requirements for Teaching Physician services, but are not intended to provide an exhaustive statement and explanation of all regulatory requirements applicable to physician services, and shall not be construed to excuse failure to comply with any other regulatory requirements.

Introductory Considerations

The general question addressed by these Policies and Procedures is not: “When can a Teaching Physician bill for services furnished by a resident?” Rather, the question is: “When has a Teaching Physician furnished a professional service that is discretely billable?” The focus of analysis regarding Teaching Physician involvement in patient care and documentation must be on the Teaching Physician. In applying the Medicare Teaching Physician regulations¹ it is important to remember that physician services in institutional settings generally must (1) be “personally furnished for an individual beneficiary by the physician;” (2) “contribute directly to the diagnosis or treatment of an individual beneficiary;” and (3) “ordinarily require performance by a physician.”²

At UCRH, the policies and procedures set forth in this document are applicable not only to Medicare patients, but to all patients, regardless of payor source, except to the extent that specific requirements of a particular payor (e.g., Medi-Cal) would not be fully satisfied by compliance with these general policies and procedures, which are based upon the Medicare rules. For example, claims may not generally be submitted to Medi-Cal unless the Teaching Physician personally furnished the services.³

¹ 42 C.F.R. §§ 415.150 - 415.208, 60 Fed.Reg. 63135-63148, 63181-63188 (December 8, 1995); as amended 61 Fed. Reg. 59490 (November 22, 1996).

² See 42 C.F.R. § 415.102(a), previously codified at 42 C.F.R. § 405.550(b).

³ Medi-Cal regulations provide at 22 Cal. Code of Regs. § 51503(l):

(l) The Medi-Cal program, through its intermediary, will pay allowable Medi-Cal rates for direct patient care services in a teaching setting when directly provided by teaching physicians only when such services are provided and billed in accordance with program policies and regulations of the Department of Health Services and when:

- (1) They are performed for necessary treatment of the patient;
- (2) They are not an exercise of teaching supervision without direct patient care services being provided;
- (3) They do not duplicate any medical services billed by any other provider, and
- (4) The teaching physician is not on salary or contract to the hospital for the direct patient care services provided.

No professional fees are payable for services provided independently by residents or students in a teaching setting.

Policies and Procedures

1. Definition of “Teaching Physician”

- 1.1. Teaching Physician means a physician (other than a resident) who involves residents in the care of his or her patients.
- 1.2. Fully licensed physicians who are not participating in a graduate medical education program recognized by the ACGME or ABMS may be considered Teaching Physicians.
- 1.3. Regardless of the designation “fellow” or “clinical instructor” an individual enrolled in an approved GME program as defined below may not be considered a physician unless the moonlighting criteria set forth below are satisfied.

2. Definition of “Resident”

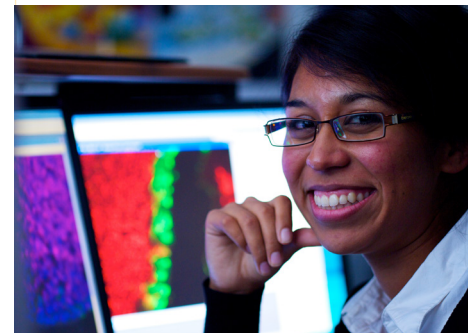
- 2.1. Determining whether a medical trainee is considered a “resident” for purposes of these Teaching Physician policies and procedures is essential to determining whether claims may be submitted by or on behalf of the trainee, or whether a Teaching Physician must establish and document sufficient personal participation in the care of the patient to permit billing by the Teaching Physician for services in which the trainee was involved.
- 2.2. The term “resident” means one of the following:
 - (1) An individual who participates in an approved GME program, including programs in osteopathy, dentistry, and podiatry.
 - (2) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital (e.g., temporary or restricted licenses, unlicensed graduates of foreign medical schools).
- 2.3. Approved graduate medical education (GME) program means (1) a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatric Medicine Education of the American Podiatric Medical Association, (2) certificate programs in specialties and subspecialties recognized by the American Board of Medical Specialties (ABMS), or (3) programs that “may count towards certification of the participant in a specialty or subspecialty listed in the current edition “of either: The Directory of Graduate Medical Education Programs (AMA), or The Annual Report and Reference Handbook (American Board of Medical Specialties).”
- 2.4. The term “resident” includes “interns” and “fellows” in approved GME programs. The term “fellow” has no distinct meaning and has no impact

upon whether a trainee is considered to be a “resident” for purposes of these policies and procedures. While some individuals who are designated as “fellows” may qualify to be treated as Teaching Physicians for some services and payors, the title given to the individual is not a determining factor.

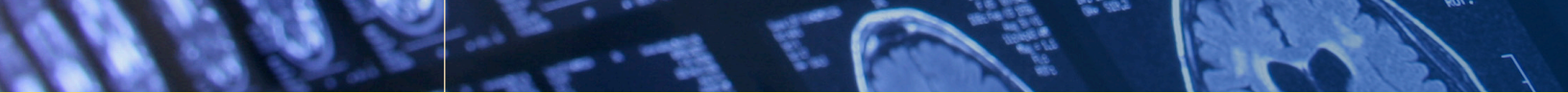
- 2.5. The fact that an individual hospital does not choose to include an eligible individual in its full-time equivalency count of residents does not change that individual’s status as a resident in an approved GME program.
- 2.6. A medical student is never considered to be a resident. See additional policies and procedures regarding medical students in Section 3 of these policies and procedures.

3. Use of Medical Students

- 3.1. A medical student is never considered to be a resident.
- 3.2. Notwithstanding potentially greater leeway allowed by the Medicare Carriers Manual instructions,⁴ any contribution of a medical student to the performance of a service billable by a Teaching Physician must be:
 - 3.2.1. Performed in the physical presence of a Teaching Physician, or
 - 3.2.2. Limited to patient histories, including review of systems, past family history and social history. Under these circumstances, a Teaching Physician must review and confirm key items of the history prepared by the medical student if the Teaching Physician intends to rely on the medical student’s history note to establish any part of the service for which the Teaching Physician wishes to bill.
- 3.3. Neither a Teaching Physician nor a resident may rely on any aspect of a physical examination performed by a medical student.
- 3.4. Students may document services in the medical record. The documentation of an E&M service by a student that may be referred to by the TP is limited to documentation related to the ROS and PFSH. The TP may not refer to a student’s documentation of physical findings or medical decision making in his or her personal note. If the medical student documents E&M services, the TP must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making.



⁴ The Medicare Carriers Manual provisions would permit consideration of a medical student’s services furnished outside the physical presence of a teaching physician, such services could only be considered if both (1) the physical presence of a resident throughout the time the medical student was furnishing service is documented in the medical record and (2) the criteria for teaching physician billing in connection with services furnished by that resident (as discussed below) are also fully satisfied and documented in the medical record. See Medicare Carriers Manual, Part 3, HCFA Pub. 14-3, § 15016.A.

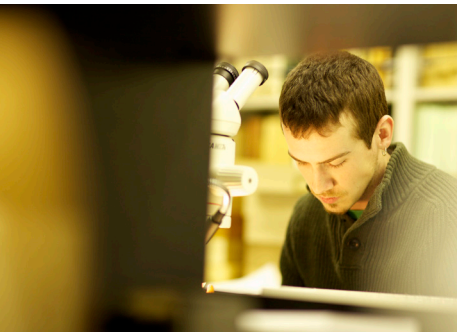


4. Use of Moonlighting Residents/Fellows

- 4.1. When a service furnished by a resident qualifies to be treated as a moonlighting service, the service may be billed as a physician service in the name of the resident under the Medicare Fee Schedule. However, unless a resident satisfies the moonlighting requirements no claim may be submitted for the resident's services under the Medicare fee schedule.
- 4.2. Inpatient services of a resident in a hospital participating in the resident's approved GME program are not covered as moonlighting physician services and may not be separately billed.
- 4.3. Services of a resident in a hospital participating in the resident's approved GME program that are not related to the GME program in which the resident participates can be covered as moonlighting physician services (payable under the Medicare physician fee schedule) if furnished:
 - (1) in an outpatient or emergency department, and
 - (2) all of the following criteria are met:
 - (a) The services are identifiable physician services.
 - (b) The resident is fully licensed in the state.
 - (c) The services performed can be separately identified from those services that are required as part of the approved GME program.

These requirements must be reflected in a written contract between the resident and the hospital, which is subject to review by the Medicare carrier.

- 4.4. Services furnished by a resident in nonhospital settings or hospitals other than those participating in the resident's approved GME program are covered as physician services and billable in the resident's name under the physician fee schedule if the following requirements are met:
 - 4.4.1. The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry in the State in which the service is performed.
 - 4.4.2. The time spent in patient care activities in the nonprovider setting is not included in a teaching hospital's full-time equivalency resident count for the purposes of direct GME payments.
- 4.5. No bill may be submitted for Teaching Physician services associated with moonlighting residents.



5. Evaluation and Management Services⁵

- 5.1. Evaluation and Management (E&M) services include initial hospital care, emergency department visits, new patient office visits, consultations, subsequent hospital care, established patient office visits, and certain other services such as psychiatric evaluations. Since the 1992 revision of the AMA's CPT-4 coding manual, which is incorporated in the HCFA common procedure coding system (HCPCS), the level of E&M service billable has been determined based upon a combination of factors set forth and defined in guidelines published by CMS and the AMA. These factors include the extent of history, scope of physical examination, and the complexity of medical decision-making involved in the service.
- 5.2. A Teaching Physician may personally perform all the required elements of an E&M service without a resident or **must be present with the resident during the "key or critical portions" of all services to be billed with.**
- 5.3. The key or critical portion⁶ of an E&M service is that part of the service that the Teaching physician determines is (are) a critical or key portion .
 - 5.3.1. For psychiatric services, the Teaching Physician's presence may be satisfied by concurrent observation using a one-way mirror or real-time video equipment (audio only equipment does not satisfy this exception to the physical presence requirement).
- 5.4. For all E&M services, Teaching Physician must personally document in the medical record his or her presence during the key or critical portions of the service when those services are performed by the resident and his or her (the TP) participation⁷ in the management of the patient.

⁵ For Medi-Cal patients, the teaching physician's presence during the key portion (or indeed the entire service) is not sufficient. Medi-Cal requires the teaching physician to personally furnish the services that are billed to Medi-Cal. A resident may assist the teaching physician in the care of his or her patients, but for Medi-Cal patients the teaching physician must always personally furnish direct patient care as opposed to supervision of the resident.

⁶ CMS has explained that: "[T]he teaching physician should have considerable discretion determining the key portion of the service, and we do not anticipate that carriers will deny claims submitted based on this discretion, as long as the claims are documented in accord with our guidelines." 60Fed.Reg. 63144-63145. Accordingly, the content of the teaching physician's note is essential to establishing the teaching physician's right to bill for E&M services to Medicare patients.

⁷ For Medi-Cal Services, based on the settlement agreement between the University and The Department of Health Services certain specific requirements apply. The diagnosis must be identified in the record. The teaching physician must sign the record indicating his/her performance of any billed service. Operative reports must identify and contain the name and signature of the surgeon, assistant surgeon (if billed for), or other surgical staff if bills are submitted to

- 5.4.1. For all E&M services, Teaching Physician documentation may be dictated and typed, hand-written or computer generated or typed. Documentation must be dated and must include a legible signature or identity.
 - 5.4.2. For all E&M services, the Teaching Physician shall personally sign his or her notes and other medical record entries.
 - 5.4.3. In all cases, whoever dictates a note, report, or other medical record entry, shall sign that note, report, or entry.
 - 5.4.4. It is not acceptable for a resident to dictate a medical record entry, on behalf of (or for the signature of) a Teaching Physician. A Teaching Physician may enter a cosignature on a note or record as long as the other requirements of these policies (e.g., personally prepared note by Teaching Physician also entered) are also satisfied.
- 5.5. For time-based codes,⁸ Teaching Physician must be present for the entire period of time for which the claim is made. Time spent by the resident in the absence of the Teaching Physician may not be counted.

6. Teaching Physician E&M Examinations Subsequent to Resident Examinations

- 6.1. The Teaching Physician's service to the patient need not occur simultaneously with services furnished by a resident in order for the Teaching Physician to consider the services furnished by the resident in establishing the level of his or her personal services to the patient.² The Teaching Physician's personal service to the patient may occur subsequent to services furnished by a resident without precluding billing or reducing the level of service that may be billed by a Teaching Physician, provided certain medical record documentation requirements are satisfied.¹⁰

Medi-Cal. The teaching physician performing surgery must sign the record for the procedure billed. Documentation of physician involvement by the teaching physician must be included for preoperative and postoperative care, or payment will be reduced to 70 percent of the allowed global fee.

⁸ Time-based codes include, but are not limited to, individual psychotherapy (CPT-4 90804-90829), critical care services (CPT-4 99291-99292), prolonged services (CPT-4 99354-99359, care plan oversight (CPT-4 99375), E&M services in which counseling and/or coordination of care constitutes more than 50% of the encounter and time is considered the controlling factor in establishing the E&M service level. Additional rules apply for anesthesia services.

⁹ Medicare Carriers Manual, Part 3, HCFA Pub. 14-3, § 15016.

¹⁰ For Medi-Cal patients, while analogy to Medicare requirements is not perfect, the teaching physician must always personally verify the essential portions of the patient's history, personally repeat the key portions of the physical

- 6.2. Under these circumstances, to assure appropriate patient care and the Teaching Physician's involvement in the medical decision making for the patient, residents should be instructed to contact the Teaching Physician by telephone promptly following their examination of the patient to discuss the resident's assessment and plan of care for the patient. The resident should document the telephone conversation in the medical record.
- 6.3. Teaching Physicians shall personally see the patient within a reasonable time based on clinical considerations and personally perform and document those services considered to be key or critical and that he/she are directly involved in the management of the patient. The TP's note may reference the resident's note. In no event may a resident's work-up be considered in coding a claim if the Teaching Physician's examination of the patient occurs more than 24 hours after the resident's examination.¹¹
- 6.4. Teaching Physician services shall be billed on the date the Teaching Physician personally examines the patient, even if the resident's examination occurred on the preceding calendar day. Billing and coverage rules, which generally prohibit billing multiple services for a patient on the same day (e.g., subsequent hospital visit on the same day as initial hospital care) also apply under these circumstances.

7. Content of Teaching Physician's Medical Record Notes/Entries¹²

- 7.1. "Seen, examined, agreed" is not sufficient documentation for E&M services.
- 7.2. Whenever a Teaching Physician provides an E&M service to a patient without the assistance or involvement of a resident (or to the extent permitted by these Policies and Procedures, a medical student) the Teaching Physician must prepare a complete note substantiating the level of E&M services provided and medically necessary for the patient.
- 7.3. When a Teaching Physician is physically present with a resident during the key or critical portions of the service and the resident prepares a note for the service:

examination, and actively participate in the diagnosis and the development of the treatment plan, discuss the care with the patient personally, and actively perform all of the services that determine the level of billing. A resident may take an initial history and do his or her own physical examination (in addition to the teaching physician's personal examination), and the resident's notes may be more extensive than those done by the teaching physician.

¹¹ Based upon informal conversations with a Medical Adviser in the CMS Bureau of Policy Development, a 24-hour rule of thumb will continue to be employed as an outside limit, after which services previously furnished by a resident may not be taken into consideration in establishing that a Medicare billable service was provided by a teaching physician or the level of that service.

¹² For Medi-Cal patients, in addition to reflecting the performance of the service by the teaching physician, the record must identify the diagnosis and be signed by the teaching physician indicating his/her performance of any billed service.

- 7.3.1. For initial hospital care, emergency department visits, new patient visits, and consultations, the Teaching Physician's personal note should consist of brief, summary comments making reference to and confirming or revising the resident's findings and entries. At a minimum the note should establish physical presence of the TP during the key or critical portions of the service and the combined entries in the medical record by the TP and resident must support the level of E/M service billed and must support the medical necessity of the services provided.
- 7.3.2. For subsequent hospital care or established patient visits, the Teaching Physician's personal note may consist of brief, summary comments making reference to and confirming or revising the resident's findings and entries. But at a minimum the combined entries in the medical record by the TP and resident must support the level of E/M service billed and must support the medical necessity of the services provided.

8. Selecting the Level of CPT-4 Coding for the Service

- 8.1. Level of service must be determined based upon the Code descriptions in the current CPT-4 (published by AMA) and the "Documentation Guidelines for Evaluation and Management Services" published by the AMA and CMS.
- 8.2. If a resident has prepared a note for the service and Teaching Physician's note makes reference to the resident's note, the level of service may be established based upon the combination of medical record entries.
- 8.3. Similarly, if a medical student had taken and documented a patient history in the medical record pursuant to § 3.2.2 of these policies and procedures, and the Teaching Physician's note makes reference to the patient history documented by the medical student, the level of service may be established based upon the combination of medical entries, including the patient history documented by the medical student.
- 8.4. Teaching Physicians should bill for the level of service that would have been provided by the Teaching Physician if the Teaching Physician had furnished the service without the involvement of a resident.

9. Surgical Procedures¹³

- 9.1. The practice and documentation requirements for procedures vary depending upon the type of procedure (e.g., major, minor, endoscopic)

¹³ For Medi-Cal patients, the teaching physician must personally perform the procedure and be identified in the medical records as the primary surgeon. A resident may assist the teaching physician in performing the procedure, but the teaching physician must personally perform the service to bill at an unreduced rate.

and whether the Teaching Physician is present for the entire procedure or only for the key and critical portion(s) of the procedure. Two levels of Teaching Physician involvement need to be considered in connection with procedures: (1) physical presence (required during the “key” and “critical” portions) and (2) “immediate availability” required throughout the entire procedure.

- 9.2. For major procedures the Teaching Physician must be: (1) “Present during all critical and key portions of the procedure,” and (2) “Immediately available to furnish services during the entire service or procedure.”
 - 9.2.1. To be considered “present”, the Teaching Physician must be in the operating room (and be listed as a surgeon in the operating room record).
 - 9.2.2. Because there will be variations in what constitutes the key and critical portions of particular procedures, physicians will have flexibility in defining the key and critical portions of particular procedures. Generally, Teaching Physician presence is not required during opening and closing of the surgical field. For some procedures, however, the closing may actually be the key portion of the procedure, e.g., plastic and reconstructive surgeries. For such procedures, the Teaching Physician must be present for the closing.
- 9.3. For “Minor Procedures” and “Endoscopic Procedures” the teaching surgeon must be present in the operating room or procedure room for the entire procedure.

10. Documentation for Minor Procedures

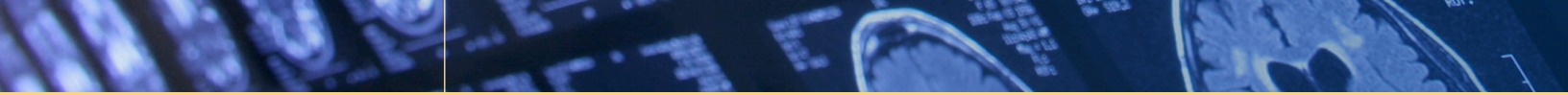
- 10.1. The physician’s presence throughout the entire procedure must be documented in the medical record.

11. Definition of “Immediate Availability” for Procedures

- 11.1. The Teaching Physician must be “immediately available” to furnish services during the entire procedure (including opening and closing) unless he or she has arranged for a “designated physician” to be immediately available to intervene in the original case, should the need arise.
- 11.2. Immediate availability is not defined in terms of geographic location vis-a-vis the operating room. It appears that immediate availability must be interpreted in a common sense manner, focusing upon the Teaching Physician’s ability to return to the procedure and intervene immediately if necessary.¹⁴

¹⁴ While the term “immediately available” is not further defined by Medicare in connection with operating room procedures, the concept has been defined in connection with physician’s office services to require the physician’s presence in the office suite, although not necessarily in the same room, throughout the time services for which the physician will bill are being performed. Furthermore, when these rules are applied in an institutional setting,





- 11.3. To be considered “immediately available” Teaching Physician must not be involved in another activity from which he or she cannot immediately return.
- 11.4. Mere presence in the hospital and availability by overhead page or pager is not sufficient to establish “immediate availability.”
- 11.5. Teaching Physicians will be considered immediately available if they are within the hospital and available by page and, able to be present in the operating room within five to ten minutes. Please check specific departmental appendices for specific interpretations and definitions of immediate availability.



12. Overlapping Procedures

- 12.1. Medicare Teaching Physician rules also permit a Teaching Physician to satisfy the “immediate availability” requirement by designating another Teaching Physician to be “immediately available” with respect to one procedure while the surgeon begins to take part in a second procedure or another activity that would render the surgeon not available with respect to the first procedure.¹⁵
- 12.2. If the Teaching Physician wishes to become involved in an overlapping procedure:
 - 12.2.1. The Teaching Physician must remain physically present during a first procedure until all of the key portions of that procedure¹⁶ have been completed.
 - 12.2.2. In these cases, the Teaching Physician shall designate another Teaching Physician to be immediately available with respect to the first procedure when the Teaching Physician becomes involved in the second procedure.
 - (1) The designated physician may not be a “resident,” as defined in these policies and procedures, but may be a qualified, fully licensed physician in a nonapproved education program.
 - (2) The designated physician must not be involved in any other service or activity that would prevent him or her from intervening immediately in the surgical procedure, if necessary.

the Carriers Manual specifies that a physician’s “presence in the facility as a whole” is not sufficient to satisfy the immediately available requirement for direct supervision under those rules. See Medicare Carriers Manual, Part 3, HCFA Pub. 14-3, § 2050, 2070; Medicare Coverage Issues Manual, HCFA Pub. 6, § 45-15.

¹⁵ Certain additional requirements apply to this option, and no additional payment is available for the services of a designated physician because the principal teaching physician will be fully compensated for the entire procedure.

¹⁶ Medicare representatives have explained that a teaching physician may not bill for a procedure if he or she leaves the operating room to become involved in another procedure in between multiple key/critical portions of a single procedure even if the key/critical portions of the procedures do not overlap.

- (3) The same physician cannot serve as the designated physician for more than one procedure at a time.

13. Documentation for Major Surgical Procedures

- 13.1. If the Teaching Physician is present throughout the entire procedure, no personal notation by the Teaching Physician is required, provided “The presence of a Teaching Physician during procedures may be demonstrated by the notes in the medical record made by the physician, resident or nurse.”
- 13.2. If the Teaching Physician is not present for the entire procedure (including during opening and closing):
 - 13.2.1. the Teaching Physician must personally document the key portion of the procedure for which he or she was present; and
 - 13.2.2. the identity of any physician designated to cover the immediate availability requirement for the procedure must be documented.
- 13.3. The Teaching Physician’s note should be a clinically relevant entry describing the portions of the procedure during which the Teaching Physician was present.
- 13.4. The operative report may be prepared by the Teaching Physician or a resident. Whoever dictates the operative report shall sign it. A Teaching Physician may co-sign an operative report dictated by a resident, but this does not eliminate the need for a separate personal entry by the Teaching Physician (unless the Teaching Physician was present for the entire procedure and this is documented in the medical record.

14. Pre-Operative and Post-Operative Services

- 14.1. The Teaching Physician must be “responsible for the preoperative, operative, and post-operative care.”
- 14.2. Preoperative Examination
 - 14.2.1. The Teaching Physician must be present for the preoperative examination whenever the preoperative examination is considered by the Teaching Physician to be a key or critical portion of the global surgical service.¹⁹

¹⁷ For Medi-Cal patients, the diagnosis must be identified in the record; the operative report must identify and contain the name and signature of the surgeon, assistant surgeon (if billed for), or other surgical staff; the teaching physician performing surgery must sign the record for the procedure billed; documentation of physician involvement by the teaching physician must be included for preoperative and postoperative care, or payment will be reduced to 70 percent of the allowed global fee.

¹⁸ For Medi-Cal patients, unless the teaching physician personally furnishes the preoperative visit and the medical record documents the teaching physician's involvement payment is to be reduced from the otherwise allowable global fee.

¹⁹ CMS representatives have explained that unless the pre-op examination (as opposed to the examination in which the need for surgery was determined) is considered by the teaching physician to be a key/critical portion of the surgical service, the teaching physician need not be present for the pre-op examination. Accordingly, in most cases, the pre-op examination portion of the global surgery service can be provided by the resident without teaching physician presence during or after the exam.

- 14.2.2. Even when the Teaching Physician does not consider preoperative examination to be a key or critical portion of the service, the medical record must reflect that a pre-op examination was conducted. Thus, it is appropriate for the Teaching Physician to indicate that he or she reviewed the resident's pre-op examination prior to the surgery by co-signing the resident's pre-op examination note.

14.3. Postoperative Visits²⁰

- 14.3.1. The Teaching Physician need not be present for all postoperative visits, but must determine which post-operative visits are considered "key" and thus require the Teaching Physician's presence.
- 14.3.2. If the global surgery period extends beyond the discharge, CPT-4 coding modifiers for less than the global package apply.
- 14.3.3. The Teaching Physician shall prepare a personal note for each key post-surgical follow-up visit for which he or she was present. The physician's note for post-surgical follow-up visits need not satisfy the criteria for an E&M service, but must be a clinically relevant entry in the medical record. This may be a brief note, but "Seen, examined, agreed" or similar entries are not sufficient.
- 14.3.4. Generally, the Teaching Physician should furnish the same number and frequency of follow-up visits to teaching patients as the physician would provide to nonteaching patients.
- 14.3.5. If surgical services have been performed by a resident without Teaching Physician presence, the Teaching Physician may bill for follow-up visits with appropriate coding modifiers.

15. Definition of "Minor" Procedure²¹

- 15.1. Procedures that "take only a few minutes to complete, *e.g.*, simple suture, and involve relatively little decision making once the need for the operation is determined."²²
- 15.2. Procedures that require more than five (5) minutes to complete are considered major procedures for purposes of these policies and procedures.

²⁰ For Medi-Cal patients, unless there is documentation in the medical record of Teaching Physician involvement in postoperative care, payment is to be reduced from the otherwise allowable global fee.

²¹ For Medi-Cal patients, endoscopic procedures must be performed by the teaching physician.

²² HCFA has not promulgated a list of "minor" procedures for purposes of the Teaching Physician regulations. CMS representatives have further explained that while a simple suture is considered a minor procedure, repair of a laceration that will require more than "5 minutes or so" could be treated as a major surgical procedure for purposes of the teaching physician rules.

16. Endoscopic Procedures²³

- 16.1. For diagnostic procedures using an endoscope, the Teaching Physician must be present during the entire viewing.
 - 16.1.1. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope.
 - 16.1.2. Viewing through a monitor in another room is not sufficient.
- 16.2. “Endoscopic operations” (i.e., therapeutic services performed through an endoscope) are subject to the general rules for surgical procedures. See Sections 9-13 of these policies and procedures.

17. Other Complex or High-Risk Procedures²⁴

- 17.1. Other Complex and High-Risk Procedures include procedures for which national Medicare policy, local Carrier policy, or CPT-4 code description indicates that personal (in person) supervision by a physician is required.
 - 17.1.1. Complex or high-risk procedures include, but are not limited to: Interventional radiologic and cardiologic supervision and interpretation codes; Cardiac catheterization; Cardiovascular stress tests; Transesophageal echocardiography.
- 17.2. Key/Critical Portion of Other Complex and High-Risk Procedures
 - 17.2.1. Whenever the CPT-4 procedure code description for a service includes the term “supervision,” the Teaching Physician shall be present for the entire service defined by that CPT-4 code. For these codes no distinct key/critical portions is recognized.
 - 17.2.2. Whenever a department has determined that an Other Complex or High-Risk Procedure has separately identifiable key/critical portions,²⁵ that department shall submit those procedures for inclusion in the Departmental Appendix to these Policies and Procedures.
- 17.3. The Teaching Physician billing for an Other Complex or High Risk Procedure shall be present for all of the key/critical portions of the procedure.²⁶

²³ For Medi-Cal patients, endoscopic procedures must be performed by the teaching physician.

²⁴ For Medi-Cal patients, the Medi-Cal requirements for surgical services, which are set forth above, must be satisfied.

²⁵ CMS believes that in most cases there will not be separate key portions for these procedures.

²⁶ CMS representatives have confirmed that to the extent there were a distinctly identifiable key portion or portions of the Other Complex or High Risk Procedure a teaching physician must be physically present only for the key/critical portions rather than the entire procedure.

17.3.1. If the Teaching Physician's department has determined that there are distinct key/critical portion(s) for a particular complex or high-risk procedure:

- (1) The Teaching Physician must be present during the key and critical portion(s) of the procedure.
- (2) The Teaching Physician must also be immediately available throughout the entire procedure to intervene or confer with the resident if necessary. (Availability within the Medical Center by page or telephone is not sufficient to satisfy the immediate availability requirement.)
- (3) The Teaching Physician must document the key/critical portions of the procedure for which he or she was present in a note or medical record entry personally written or dictated by the Teaching Physician. The Teaching Physician's note may be in addition to a procedure note prepared by a resident.

17.3.2. If the Teaching Physician's department has not identified a key portion with respect to another complex or high risk procedure:

- (1) The Teaching Physician must be present in the room in which the procedure is furnished throughout the entire procedure.
- (2) The Teaching Physician's presence throughout the procedure must be documented in the procedure note.

18. Diagnostic Interpretation Services²⁷

- 18.1. These rules apply to interpretations of diagnostic tests or images (professional component services). To the extent a service involves a procedure instead of an interpretation only, the rules governing procedures (please see above) must be followed. These rules are not specialty specific, but apply whenever a Teaching Physician will bill for an interpretation service code.
- 18.2. All diagnostic interpretations shall be performed by or reviewed with Teaching Physician.
- 18.3. To bill based on review of a resident's interpretation, the Teaching Physician must review both the test/image/slide/strip and the resident's interpretation report.²⁸

²⁷ For Medi-Cal patients, the Teaching Physician must personally perform the interpretation and that interpretation.

²⁸ Some Medicare carrier issuances appear to require that to bill in connection with the review of a resident's interpretation (as opposed to the direct interpretation of the test/image by the teaching physician), that the teaching physician must review the resident's interpretation "with the resident," legal counsel has informally confirmed with HCFA medical officers that the resident need not be present when the teaching physician reviews the image and report.

18.4. Documentation for Diagnostic Interpretation Services

- 18.4.1. Documentation must indicate that the physician personally performed the interpretation or reviewed both the test/image and the resident's interpretation.
- 18.4.2. If the Teaching Physician personally performs the interpretation before the results are transmitted (whether orally or in writing) for use in the treatment of the patient:
 - (1) The Teaching Physician may personally dictate the report and sign it for the medical record, or
 - (2) If the resident dictates the report (resident must sign it), the Teaching Physician must also indicate in a personal note signed by the Teaching Physician that he or she has reviewed the test and the resident's note and either agrees with it or edits the findings.
- 18.4.3. If the Teaching Physician has not personally performed the interpretation of a test before the results are transmitted (whether orally or in writing) for use in the treatment of the patient, the Teaching Physician must enter a personal note in the medical record signed by the Teaching Physician and indicating that the Teaching Physician has reviewed the test and the resident's note and that the Teaching Physician either agrees with the resident's note or has edited the resident's findings.
- 18.4.4. A countersignature on the resident's interpretation or dictation is not sufficient.

19. Special Rules for Obstetric Services

- 19.1. The Teaching Physician must be present for the delivery and for any other services requiring intervention by a physician.
- 19.2. Other specific general rules applicable to global maternity services must also be satisfied.
- 19.3. All delivery services are treated as major surgery procedures.

20. Special Rules for Anesthesia Services

20.1. Anesthesiology Services

- 20.1.1 The Teaching Physician shall actively participate in the preoperative consultation and consenting procedure. This shall be documented by the Teaching Physician on the anesthesia record.
- 20.1.2 During anesthetic management of the patient, the Teaching Physician must be present in the operating room for all the key portions of the patient care, including induction, intra-operative management and emergence from anesthesia. This shall be documented by the Teaching Physician on the anesthesia record.

20.2. Pain Management Services

- 20.2.1 It is the policy of the Department that pain management services involving residents shall be provided with both the Teaching Physician and the resident present. Residents shall not independently provide care to pain management patients.
- 20.2.2 When the Teaching Physician is present throughout the entire procedure, no personal notation by the Teaching Physician is required, provided the presence of the Teaching Physician during the procedure may be demonstrated by the notes in the medical record made by the physician, resident or nurse. (If the Teaching Physician is not present during the entire procedure, the Teaching Physician must personally document the key portions of the procedure for which he/she is present and document the identity of any physician designated to cover the immediate availability requirement.)

21. Special Rules for Dialysis Services

- 21.1. Physicians who elect to receive payment under the monthly capitation method need not comply with these Teaching Physician regulations with respect to services covered under the capitation payments.
- 21.2. Physicians who do not accept payment under the monthly capitation method must comply with the specific requirements for fee for service physician services in connection with dialysis services under applicable regulations.

22. Exception for Certain “Primary Care” Clinic Settings²⁹

- 22.1. Only the Division of Family Medicine operates a clinic in which some services will be furnished under the limited exception to the Teaching Physician presence requirement for certain E&M services. **This exception does not apply to UCRH Family Medicine at this time.**

23. Medical Necessity Considerations and Resident Qualifications

- 23.1. Although CMS has yet to develop a clear position regarding the issue, CMS has indicated that it may seek to deny claims for Teaching Physician’s services (as not reasonable and necessary) when a resident is considered fully qualified to furnish the services without supervision.
- 23.2. UCRH faculty physicians shall not bill, or have bills submitted, for Teaching Physician services that are not considered by the Teaching Physician to be medically reasonable and necessary for the diagnosis and treatment of a patient.

²⁹ There is no similar exception to Medi-Cal program requirements.

24. Billing Modifiers for Medicare Claims

- 24.1. Unless one of the exceptions in section 24.2 applies, whenever a resident has been involved in the care of a Medicare patient, the “-GC” billing modifier must be attached to the CPT-4 code describing the service.
- 24.2. The only exceptions to use of the “-GC” modifier at UCRH are:
 - 24.2.1. Services furnished in the Division of Family Medicine at the Family Health Center, which satisfy the criteria for the limited exception to the Teaching Physician presence requirement. These services must be billed using billing modifier “-GE.” **This exception does not apply to UCRH Family Medicine at this time.**
 - 24.2.2. Services in which residents have not been involved. These services are to be billed without either of the new Teaching Physician modifiers.
- 24.3. The Medicare Teaching Physician billing modifiers should not be used automatically because the modifiers represent certifications regarding the circumstances in which the services were furnished, and should be applied only to claims for which those specific circumstances were present.
 - 24.3.1. The use of the -GC modifier certifies that the Teaching Physician was present during the key portions of the service.
 - 24.3.2. The use of the -GE modifier certifies that the services was performed by a resident without the presence of a Teaching Physician, but under the primary care exception. **This exception does not apply to UCRH Family Medicine at this time.**
- 24.4. These modifiers do not affect the amount of payment on a Medicare claim, but are nevertheless mandatory information on Medicare claims.

25. Communications

Any questions about the interpretation or application of these UCRH policies and procedures for Teaching Physician billing compliance should be directed to the Compliance and Privacy Officer.

Reports of instances of possible noncompliance may be made confidentially to the Compliance and Privacy Officer, the Chair of the Department, or the UCRH Compliance Hot Line (800) 403- 4744.



Acknowledgement Statement

*UC Riverside Health (UCRH)
Policies and Procedures for Teaching Physician Billing Compliance*

My signature on this form acknowledges that I have received and read the Teaching Physician's Billing Guidelines.

Name: _____

Signature: _____

Date: _____

Department: _____

