

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2303</b>	<b>Date: September 14, 2011</b>
	<b>Change Request 7378</b>

**NOTE: Transmittal 2247, dated June 24, 2011, is being rescinded and replaced by Transmittal 2303, dated September 14, 2011. Section 100.1.1C had been clarified concerning the use of residents with less than six months in a GME approved program. Section 100.1.8B1 has been clarified concerning physician requirements when using the GC modifier. This instruction is being reissued to change Implementation date July 26, 2011 to Implementation date October 14, 2011 on the Transmittal Sheet and Business Requirement. This instruction was previously issued with the wrong Implementation date of October 14, 2011. The correct Implementation date is July 26, 2011. The Transmittal number and date issued, and all other information remains the same.**

**SUBJECT: Teaching Physician Services**

**I. SUMMARY OF CHANGES:** Effective January 1, 2011, section 4103 of the Affordable Care Act provided coverage for annual wellness visits (HCPCS codes G0438 and G0439). These codes are included under the primary care exception. The policies concerning late night admissions and the mix of residents under the primary care exception have been clarified. The policies concerning the interpretation of diagnostic radiology and other diagnostic tests and the use of the GC and GE modifiers, which were inadvertently omitted during previous manual updates, are included in this CR. This CR instructs contractors to recognize and implement manual updates.

**EFFECTIVE DATE: June 1, 2011**

**IMPLEMENTATION DATE: July 26, 2011**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	12/100/100.1.1 - Evaluation and Management (E/M) Services
R	12/100/100.1.2 - Surgical Procedures
R	12/100/100.1.8 - Physician Billing in the Teaching Setting

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

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**SUBJECT: Teaching Physician Services**

**Effective Date: June 1, 2011**

**Implementation Date: July 26, 2011**

## I. GENERAL INFORMATION

**A. Background:** The teaching physician policy concerns the criteria and documentation requirements for making payments under Part B to a physician who involves residents in patient care services

**B. Policy:** Effective January 1, 2011, section 4103 of the Affordable Care Act provided coverage for annual wellness visits (HCPCS codes G0438 and G0439). These codes are included under the primary care exception. The policies concerning late night admissions and the mix of residents under the primary care exception have been clarified. The policies concerning the interpretation of diagnostic radiology and other diagnostic tests and the use of the GC and GE modifiers, which were inadvertently omitted during previous manual updates, are included in this CR. This CR instructs contractors to recognize and implement manual updates.

## II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)								
		A / B  M A C	D M  M A C	F I  I E R	C A  I E R	R H  H I	Shared-System Maintainers			
					F I S	M C S	V M S	C W F		
7378.1	Contractors must apply the policy concerning late night admissions, where the resident initially sees the patient and the teaching physician sees the patient the next day.	X			X					
7378.2	Effective January 1, 2011 contractors must recognize HCPCS codes G0438 and G0439 under the primary care exception.	X			X					
7378.3	Contractors must recognize that teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the primary care exception.	X			X					
7378.4	Contractors must continue applying the policy concerning the interpretation of diagnostic radiology	X			X					

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I    	C A R R I E R	R H H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
	and other diagnostic tests. Medicare does not pay for an interpretation under the physician fee schedule if the teaching physician only countersigns the resident's interpretation.										
7378.5	Contractors must continue recognizing the GC and GE modifiers for teaching physician services.	X			X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I    	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
							F I S S	M C S	V M S	C W F	
	None										

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

X-Ref Requirement Number	Recommendations or other supporting information:
	None

**Section B: For all other recommendations and supporting information:**

### V. CONTACTS

#### Pre-Implementation Contact(s):

For payment policy questions contact Kenneth Marsalek at 410-786-4502 or [Kenneth.Marsalek@cms.hhs.gov](mailto:Kenneth.Marsalek@cms.hhs.gov). For questions concerning billing modifiers, contact Claudette Sikora at 410-786-5618 or [Claudette.Sikora@cms.hhs.gov](mailto:Claudette.Sikora@cms.hhs.gov).

#### Post-Implementation Contact(s):

Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*:**

No Additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

### **Section B: For *Medicare Administrative Contractors (MACs)*:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## 100.1.1 - Evaluation and Management (E/M) Services

(Rev.2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)

### A. 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, 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.

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.

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/she would document an E/M service in a nonteaching 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.

#### 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.

#### 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.

#### *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.*

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.”

(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.)

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.”

Scenarios 3 and 4:

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

Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

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.

## **B. 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 redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

### **C. Exception for E/M Services Furnished in Certain Primary Care Centers**

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:

<b>New Patient</b>	<b>Established Patient</b>
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: *HCPCS code G0402* (Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment).

*Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).*

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 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 in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's FI. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the FI that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

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. *Teaching physicians may include residents with less than 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 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 6 months in a GME approved residency program.*

Teaching physicians *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.

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 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.

Residency programs most likely qualifying 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.

## **100.1.2 - Surgical Procedures**

**(Rev.2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)**

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

### **A. Surgery (Including Endoscopic Operations)**

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

#### **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 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.

### **3. Minor Procedures**

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

### **4. Anesthesia**

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. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist and the service is furnished prior to January 1, 2010, 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.

For anesthesia services furnished on or after January 1, 2010, 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 §50 B. and §0 K.

## **5. 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.*

## **100.1.8 - Physician Billing in the Teaching Setting**

**(Rev.2303, Issued: 09-14-11, Effective: 06-01-11, Implementation: 07-26-11)**

### **A. B/MAC and Legacy Carrier Claims**

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

### **B. Billing Modifiers**

*Effective January 1, 1997, 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 sections 100.1 through 100.1.6 of this chapter, as applicable. Claims for services meeting these requirements must show either the GC or GE modifier as appropriate and described below.*

#### **1. Teaching Physician Services that Meet the Requirement for Presence During the Key/Critical Portion of the Service**

*Claims for teaching physician services in compliance with the requirements outlined in sections 100.1 -100.1.6 of this chapter must include a GC modifier for each service, unless the service is furnished under the primary care center exception described in section 100.1.1C (refer to number 2, below). 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 sections 100.1 through 100.1.6.*

***2. Teaching Physician Services Under the Exception for E/M Services Furnished in Primary Care Centers***

*Teaching physicians who meet the requirements in section 100.1.1C of this chapter must provide their contractor with an attestation that they meet the requirements. Claims for services furnished by teaching physicians under the primary care center exception must include the GE modifier on the claim for each service furnished under the primary care center exception.*