

**POLICIES AND PROCEDURES
FOR TEACHING PHYSICIAN BILLING COMPLIANCE**

PREFACE

This document expands upon the interim guidelines implemented at UCLA effective July 1, 1996. These Policy and Procedures are intended to clarify the requirements for Teaching Physician documentation and billing and to state UCLA 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, the deliberations and report of the Blue Working Group to the UCLA Teaching Physician Regulations Task Force (July 31, 1996), advice of legal counsel, and determinations by the Compliance Officer.

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 UCLA School of Medicine and Faculty Practice Group, 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 UCLA 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 payers (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 billing for the services of Teaching Physicians, 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

At UCLA, the policies and procedures set forth in this document are applicable not only to Medicare patients, but to all patients, regardless of payer source, except to the extent that specific requirements of a particular payer (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.¹

¹ 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;**

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

(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.

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 payers, 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 In all situations, the services of the residents are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.
- 2.7 In all patient encounters involving fellows in non-approved GME programs, the billing physician shall be the same as the physician providing the service, regardless of their designation as fellow, clinical instructor or senior attending faculty physician.
- 2.8 A medical student is never considered to be an intern or 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 an intern or a resident.
- 3.2. Notwithstanding potentially greater leeway allowed by the Medicare Carriers Manual instructions,² 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 physical presence of a resident in a service meeting the requirement for teaching physician billing.
 - 3.2.2. Limited to patient histories, including review of systems, present history, 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.

² 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.

- 3.3. If the medical student documents E&M services, the teaching physician must verify and redocument the history of present illness (HPI) as well as perform and redocument the physical exam and medical decision-making activities of the service. Medicare does not pay for any service furnished by students.

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 non-hospital 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 non-hospital 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 Services**³

- 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 CMS 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. Teaching physician must be present during the "key portion" of all services to be billed.
- 5.3. For purposes of payment, E&M services billed by teaching physicians require that they personally document at least the following:

³ 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.

- Performance of physical presence by the teaching physician during the key or critical portions of the service when performed by the resident, or personal performance of the key or critical components of the service by the teaching physician
 - The participation of the teaching physician in the management of the patient.
- 5.4 Assigned E&M codes billed by teaching physicians will be a combination of the documentation of both the resident and the teaching physician if the resident was involved with the service.
- 5.5 For all E&M services, the teaching physician must personally document his or her presence and participation in the medical record.
- 5.5.1. For all E&M services, teaching physician documentation may be handwritten, by dictated note, or personally typed by the Teaching Physician.
- 5.5.2. For all E&M services, the teaching physician shall personally sign his or her notes and other medical record entries.
- 5.5.3. In all cases, whoever dictates a note, report, or other medical record entry, shall sign that note, report, or entry.
- 5.5.4. 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 co-signature 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.
- 5.6. For time-based codes,⁴ 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.

⁴ Time-based codes include critical care services (CPT-4 99291-99292), prolonged services (CPT-4 99354-99359, care plan oversight (CPT-4 99375), E&M services in which

6. When the Teaching Physician Personally Performs all the required Elements Services Without a Resident

- 6.1. In the absence of a note by a resident, the teaching physician must document the entire note as he or she would document an E&M service in a non-teaching setting.
- 6.2. If the resident has performed the E&M service independently and has a written note, the teaching physician's note may reference the resident's note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. When billing, the composite of the teaching physician's entry and the resident's entry together must support the medically necessity of the billed service and the level of service billed by the teaching physician.
- 6.3. Examples of minimally acceptable teaching physician documentation.

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."

- 6.4. In no event may a resident's work-up be considered in coding a claim if the teaching physician's services were rendered more than 24 hours after the resident's examination.⁵

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.

- 6.5 Teaching physician services shall be billed on the date the teaching physician personally provided the service, 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. **When The Resident Performs the Elements Required for an E&M Service in the Presence of or Jointly with the Teaching Physician**

- 7.1 If the resident documents the service, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. When billing, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of service billed by the teaching physician.
- 7.2 Examples of minimally acceptable teaching physician documentation.
- Initial of Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."
- Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

8. **The Resident Performs some or all of the Required Elements of the Services in the Absence of the Teaching Physician and Documents his/her Service**

- 8.1 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. The teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the services, and participated in the management of the patient. The teaching

physician's note should reference the resident's note. When billing, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of service billed by the teaching physician.

8.2 Examples of minimally acceptable teaching physician documentation

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 NASIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident 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."

9. Medical Necessity Consideration

9.1 Documentation may meet or exceed the guidelines. Therefore, even if the CPT code requires only two of the key components (established patients and follow-up services), the complexity of medical decision-making cannot be overlooked because it is related to the concept of "medical necessity."

9.2 UCLA faculty physicians shall not bill, nor 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.

10. Unacceptable Documentation

10.1 The following examples of documentation are 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.

- "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.

11. **Exception for E&M Services Furnished in Certain Primary Care Centers**

11.1 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:

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

11.2 If a service other than those listed above needs to be furnished, then the general teaching physician 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 exception must maintain records demonstrating that they qualify for the exception.

11.3 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 fiscal intermediary. 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 fiscal intermediary that the entity meets the requirements of a written agreement between the hospital the entity set forth in 42 CFR 413.86(f)(4) (ii).

- 11.4 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. Center must maintain information under the provisions at 42 CFR 413.86(i).
- 11.5 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. They teaching physician must:
- 11.5.1 Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
 - 11.5.2 Have the primary medical responsibility for patients cared for by the residents;
 - 11.5.3 Ensure that the care provided was reasonable and necessary;
 - 11.5.4 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
 - 11.6.1 Document the extent of his/her own participation in the review and direction of the services furnished to each patient.
- 11.6 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:
- 11.6.1 Acute care undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
 - 11.6.2 Coordination of care furnished by other physicians and providers; and
 - 11.6.3 Comprehensive care not limited by organ system or diagnosis.
- 11.7 Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

- 11.8 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 ranges 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.

12. **Surgical Procedures**⁶

- 12.1. The practice and documentation requirements for procedures vary depending upon the type of procedure (*e.g.*, major, minor, endoscopic) 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.
- 12.2. For major surgical 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."
- 12.2.1. To be considered "present", the teaching physician must be in the operating room (and be listed as a surgeon in the operating room record).
- 12.2.2. 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.

⁶ 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.

- 12.3. For "Minor Procedures" and "Endoscopic Procedures" the teaching surgeon must be present in the operating room or procedure room for the entire procedure.

13. Documentation for Minor Procedures

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

14. Definition of "Immediate Availability" for Procedures

- 14.1. 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.
- 14.2. Immediate availability is not defined in terms of geographic location vis-à-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.⁷
- 14.3. To be considered "immediately available" teaching physician must not be involved in another activity from which he or she cannot immediately return.
- 14.4. Mere presence in the hospital and availability by overhead page or pager is not sufficient to establish "immediate availability."
- 14.5. At UCLA hospitals, teaching physicians will be considered immediately available if they are within the hospital and available by page and, able to be present in the

⁷ 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, 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, CMS Pub. 14-3, § 2050, 2070; Medicare Coverage Issues Manual, CMS Pub. 6, § 45-15.

operating room within five to ten minutes. Please check specific departmental appendices for specific interpretations and definitions of immediate availability.

15. Overlapping Procedures

- 15.1. 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.⁸
- 15.2. If the teaching physician wishes to become involved in two overlapping surgeries:
- 15.2.1. The teaching physician must remain physically present during a first procedure until all of the critical or key portions of that procedure⁹ have been completed.
- 15.2.2. 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 non-approved 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.

⁸ 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.

⁹ 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.

15.3 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.

16. Documentation for Major Surgical Procedures¹⁰

16.1. If the teaching physician is present throughout the entire surgery, no personal notation by the teaching physician is required, provided the teaching physician's presence during the surgery is "demonstrated by the notes in the medical record made by the physician, resident or operating room nurse."

16.2. If the teaching physician is not present for the entire procedure (including during opening and closing):

16.2.1. The teaching physician must personally document the critical or key portion of the procedure for which he or she was present; and

16.2.2. The identity of any physician designated to cover the immediate availability requirement for the procedure must be documented.

16.3. The teaching physician's note should be a clinically relevant entry describing the portions of the procedure during which the teaching physician was present.

16.4. 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.

¹⁰ For Medi-Cal patients, unless there is documentation in the medical record that the Teaching Physician personally furnished a post-operative visit on each day of a patient's inpatient stay, and, as required, outpatient care during the remainder of the post-operative follow-up period, payment is to be reduced from the otherwise allowable global fee.

17. Pre-Operative and Post-Operative Services¹¹

17.1. The teaching physician must be "responsible for the preoperative, operative, and post-operative care."

17.2. Preoperative Examination

17.2.1. 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.¹²

17.2.2. 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.

17.3. Postoperative Visits¹³

17.3.1. The teaching physician need not be present for all postoperative visits, but must determine which post-operative visits are considered "key or critical" and thus require the teaching physician's presence.

17.3.2. If the post-operative period extends beyond the discharge, CPT-4 coding

¹¹ 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.

¹² 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.

¹³ 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.

modifiers for less than the global package apply.

- 17.3.3. 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 "Patient seen and evaluated" or similar entries are not sufficient.
- 17.3.4. Generally, the teaching physician should furnish the same number and frequency of follow-up visits to teaching patients as the physician would provide to non-teaching patients.
- 17.3.5. 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.¹⁴

18. Definition of "Minor" Procedure¹⁵

- 18.1. 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."¹⁶

¹⁴ For Medi-Cal patients, a Teaching Physician may bill for the entire post-operative period only if that Teaching Physician personally visits the patient on each day of the inpatient stay and, personally provides outpatient visits as required during the remainder of the post-operative follow-up period. Claims for post-operative follow-up services by a Teaching Physician who did not perform the operation may not exceed 30% of the global charge for the surgery.

¹⁵ For Medi-Cal patients, endoscopic procedures must be performed by the teaching physician.

¹⁶ CMS 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.

18.2. Procedures that require more than five (5) minutes to complete are considered major procedures for purposes of these policies and procedures.

18.3 The teaching physician must be physical present and directly participating for the entire length of the minor procedure.

19. Endoscopic Procedures¹⁷

19.1. For diagnostic procedures using an endoscope, the teaching physician must be present during the entire viewing.

19.1.1. The entire viewing includes insertion and removal of the device.

19.1.2. Viewing through a monitor in another room is not sufficient.

19.2. "Endoscopic operations" (*i.e.*, therapeutic services performed through an endoscope) are subject to the general rules for surgical procedures. See Sections 12-16 of these policies and procedures.

20. Other Complex or High-Risk Procedures¹⁸

20.1. 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.

20.1.1. Complex or high-risk procedures include, but are not limited to, Interventional radiologic and cardiologic supervision and interpretation codes, Cardiac catheterization, Cardiovascular stress tests, and Transesophageal echocardiography.

¹⁷ For Medi-Cal patients, endoscopic procedures must be performed by the teaching physician.

¹⁸ For Medi-Cal patients, the Medi-Cal requirements for surgical services, which are set forth above, must be satisfied.

20.2. Key/Critical Portion of Other Complex and High-Risk Procedures

20.2.1. 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.

20.2.2. Whenever a department has determined that an Other Complex or High Risk Procedure has separately identifiable key/critical portions,¹⁹ that department shall submit those procedures for inclusion in the Departmental Appendix to these Policies and Procedures.

20.3. 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.

20.3.1. 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.²⁰
- (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

¹⁹ CMS believes that in most cases there will not be separate key portions for these procedures.

²⁰ 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.

physician's note may be in addition to a procedure note prepared by a resident.

20.3.2. 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.

21. Diagnostic Interpretation Services²¹

21.1. 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.

21.2. All diagnostic interpretations shall be performed or reviewed with a teaching physician.

21.3. 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.²²

21.4. Documentation for Diagnostic Interpretation Services

21.4.1. Documentation must indicate that the physician personally performed the interpretation or reviewed both the test/image and the resident's interpretation and either agreed with it or edited the findings.

²¹ For Medi-Cal patients, the Teaching Physician must personally perform the interpretation.

²² 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 CMS medical officers that the resident need not be present when the teaching physician reviews the image and report.

21.4.2. 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.

21.4.3. 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.

21.4.4. A countersignature on the resident's interpretation or dictation is not sufficient.

22. Special Rules for Obstetric Services

- 22.1. The Teaching Physician must be present for the delivery and for any other services requiring intervention by a physician.
- 22.2. Other specific general rules applicable to global maternity services must also be satisfied.
- 22.3. All delivery services are treated as major surgery procedures.²³

²³ For Medi-Cal patients, all deliveries, including normal deliveries, must be performed by the Teaching Physician. The mere presence of a Teaching Physician during the delivery is not sufficient to justify a bill for professional services by the

23. Special Rules for Anesthesia Services²⁴

- 23.1. Medicare pays a reduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching anesthesiologist must document in the medical records that he/she was present during all critical or key portions of the procedure. The teaching anesthesiologist 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 or nonphysician anesthetist, Medicare pays for the anesthesiologist's service as medical direction.
- 23.2. In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident, the teaching anesthesiologist can bill the usual base units if she/he 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.

24. Special Rules for Dialysis Services

- 24.1. Physicians who have elected to receive payment for dialysis-related services under the Medicare end stage renal disease (ESRD) program based upon the monthly capitation method for dialysis-related services must comply with the requirements of the ESRD program, but need not satisfy additional requirements under these policies and procedures for teaching physician services.
- 24.2. Physicians who do not elect to receive payment under the Medicare ESRD program for dialysis-related services based upon the monthly capitation method, must comply with the specific requirements for fee-for-service physician services in connection with dialysis under applicable regulations, including the

Teaching Physician.

²⁴ CMS Publication 100-04, Medicare Claims, Transmitted 811, Jan. 13, 2008

requirements of these Policies and Procedures if residents have been involved in the services.

25. **Billing Modifiers for Medicare Claims**

- 25.1. Unless one of the exceptions in section 24.2 applies, whenever a resident has been involved in the care of a Medicare patient,²⁵ the "-GC" billing modifier must be attached to the CPT-4 code describing the service.
- 25.2. The only exceptions to use of the "-GC" modifier at UCLA are:
- 25.2.1. Services furnished in the Department of Family Medicine at the Family Health Center, which satisfy the criteria for the limited exception to the Teaching Physician presence requirement (See Departmental Appendix B).
These services must be billed using billing modifier "-GE."
- 25.2.2. Services in which residents have not been involved. These services are to be billed without either of the new Teaching Physician modifiers.
- 25.3. 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.
- 25.3.1. The use of the -GC modifier certifies that the Teaching Physician was present during the key portions of the service.
- 25.3.2. The use of the -GE modifier certifies that the service was performed by a resident without the presence of a Teaching Physician, but under the primary care exception.
- 25.4. These modifiers do not affect the amount of payment on a Medicare claim, but are nevertheless mandatory information on Medicare claims.

26. **Department-Specific Policies and Procedures**

²⁵ Modifier “-GC” is not recognized by the Medi-Cal program or other third party commercial payers. Use of this modifier will result in a denial of reimbursement.

Department-specific policies, definitions, and procedures, if deemed necessary by the department, are set forth in the following Departmental Appendices to these UCLA Policies and Procedures. Faculty members and personnel are responsible for compliance with these Departmental Appendices as well as these Policies and Procedures of general applicability.

Any questions about the interpretation or application of these UCLA policies and procedures for Teaching Physician billing compliance or any Departmental Appendix should be directed to the Compliance Officer or the Chair of the Department.

REVISION

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APPROVAL

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