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Coding and Documentation Guidelines for APPs and Teaching Services

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- **Grab Tab** – Click arrow to open/close Control Panel.
- Muted
- View in Fullscreen mode
- **Raise Hand** – When vocal questions/comments are allowed, please select the hand icon to get the presenter's attention. A red arrow means your hand is raised.
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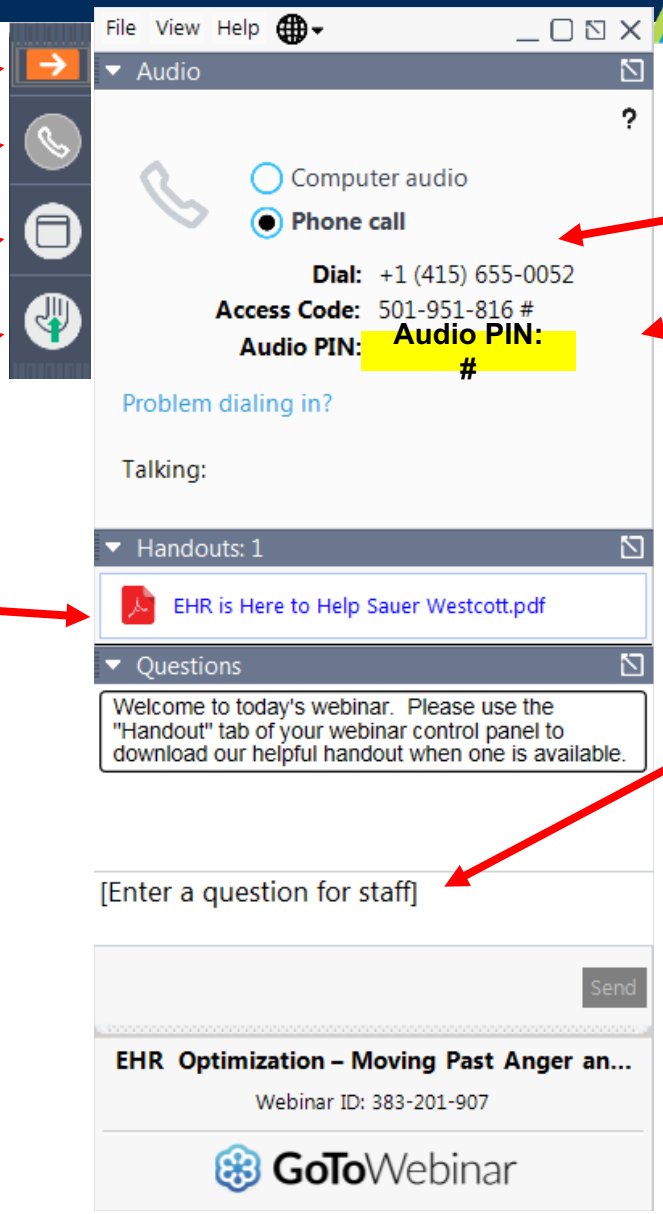

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Telehealth – Today and into the Future

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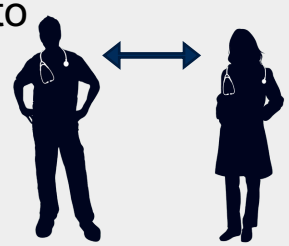
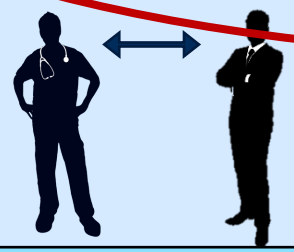
	Telemedicine Tools	Telemedicine Services
Clinician to Clinician 	• Clinicians often communicate through e-mail, video, or both	• Curbside consult • Subspecialty services • Procedural peer mentoring • Emergency and ICU care
Clinician to Patient 	• Video • Phone • E-mail • Remote wireless monitoring • Internet	• Care for chronic conditions • Medication management • Outreach • After hours access • Post-discharge follow-up
Patient to Mobile Health Technology 	• Wearable monitors • Smartphones • Mobile apps • Video • E-mail • Web portals • Games	• Health education • Monitoring of physical activity • Monitoring of diet • Medication adherence • Biometrics for arrhythmia, HF exacerbations

Integration with EMR-Data Analytics

Five Key Trends supporting Telehealth

- Continuous innovation in consumer technology market – capital investment
- Continuous advancement of EMRs and Clinical decision tools - technology
- Projected shortages in health professional workforce – resource utilization
- Reorganization of delivery and financing of medical care – incentivizing telehealth
- Growth of consumerism in health care – convenience and real-time access to healthcare

NEJM, 2017

General Information

- Friday, March 13, President Trump announced the lifting of restrictions on telehealth – CMS to provided guidance March 17th.
- Several commercial payers following suit.
- Telehealth waiver will be effective until the PHE declared by the Secretary of HHS.
- Qualified providers should inform their patients that services are available via telehealth.
- Not limited to patients only with COVID-19
- Services onsite via video or through a window are not reported as telehealth.

CMS Telehealth Guidelines

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What We Know?
What Has Changed?

1 Originating Site	2 Services	3 Qualified Providers
Individual receiving the service must be located @ telehealth originating site – rural area and in a medical facility	CMS "approved" list of telehealth services	The service must be furnished by a physician or authorized practitioner
CMS Waiver = All settings including the pts home.	CMS Waiver = these services may be provided to patients by professionals regardless of patient location.	This is not changed by the waiver.

CMS Telehealth Guidelines

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What We Know?
What Has Changed?

1 Eligible Beneficiary

Service must be furnished to an eligible telehealth individual – established relationship.

CMS Waiver = a policy of "enforcement discretion".

HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

2 Communication

Service must be furnished via an audio and video interactive tele-communication systems.

CMS Waiver = authorize use of telephones that have audio and video capabilities.

HHS will exercise enforcement discretion and waive penalties for HIPAA violations to serve patients in good faith through everyday communications technologies (Facetime and Skype)

3 Reimbursement

Services are described by HCPCS codes and paid under the Physician Fee Schedule.

Medicare uses the facility payment rate when services are furnished via telehealth.

CMS Waiver = flexibility to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

The encounter was performed at a “Distant Site”, as defined by CMS.

Eligible distant site practitioners are as follows:

- Physician
- Physician Assistant
- Nurse Practitioner
- Nurse - Midwives
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Clinical Social Workers
- Registered Dieticians/ Nutritional Professionals

Examples of Covered Telemedicine Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Examples of Covered Telemedicine Services

Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Modifiers and POS

Modifiers

- ✓ **GT** – Via Interactive Audio and Video Telecommunications systems (CAH)
- ✓ **GQ** – Via Asynchronous Telecommunications system (Hawaii and Alaska)
- ✓ **95** – Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications system (report only with codes from Appendix P)
- ✓ **G0** – Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

Place of Service (POS)

- ✓ **02** – Telehealth – The location where health services and health related services are provided or received, through a telecommunication system.

(*Note: This Telehealth POS code does not apply to Originating Site facilities billing a facility fee.)

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Originating Site

Q3014 – Telehealth originating site facility fee

In a health care facility (even if the facility is not in a rural area, etc.) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee.

2020 Fee Schedule $26.65

Claim Submission – Qualified Provider

Professional Claims

- CPT or HCPCS code
- POS code 02
- Correct Modifier – No additional requirements
- Reimbursement MPFS

Originating Site Claims

- Billed separately to Medicare Part B with Q3014

Documentation Requirements

- Same as for a face-to-face encounter
- Information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented.
- Established visits typically do not require a visual exam
- Telehealth consultation, emergency department or initial inpatient G codes are time based
- Best practice suggests that documentation should include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.

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Overview of Virtual Care Coding

Virtual Check-In

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1 G2012

Brief communication technology-based service, e.g. virtual check-in, by a **physician or other qualified health care professional** who can report evaluation and management services

No frequency limits

National CMS = $15 (non-facility) (wRVU 0.25)

2 GUIDANCE

- Established patient only
- Not originating from a related EM service provided within the previous 7 days or leading to an EM/service in 24 hours
- Require patient consent prior to performing and billing the service
- Not limited to only rural areas or certain locations.

3 CMS Information

- ✓ Several communication technology modalities, such as **audio/video, secure text messaging, email, or use of a patient portal.**
- ✓ Telephone calls that involve only clinical staff cannot be billed.
- ✓ Generally pt. initiated by providers can education on availability.

Example

Verbal patient consent obtained and documented.

A physician or QHCP (APP, NP, PA, etc.) returns a call to a patient lasting 5-10 minutes.

Documentation by the physician or QHCP supports time, context and is authenticated by the provider.

Intent - "check-ins" that do not last more than a few minutes.

Remote Video Eval

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1 G2010

Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward)

National CMS = $12 (non-facility) (wRVU 0.18)

2 GUIDANCE

- 5-10 minutes of medical discussion
- Interpretation with follow-up with the patient **within 24 business hours**
- Not originating from a related EM service provided within the previous 7 days or leading to an EM/service in 24 hours
- Consent Required

3 CMS Information

✓ Follow-up with the patient could take place via phone call, audio/visual communication, secure text messaging, email, or patient portal communication and must be compliant with HIPAA.

Example

Verbal patient consent obtained and documented.

Physicians or QHCP (APP, NP, PA, etc.) reviews photos or video information submitted by the patient to determine if a visit is required.

Provider follows up with the patient within 24 hours with a 5-10 minutes discussion.

Documentation of images/video and encounter are stored.

Digital Communication

No Published changes as of 3/17/2020

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Patient Initiated – However per CMS

"We expect that these services will be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation."

99421	99422	99423
Online digital evaluation and management service, for an established patient, for up to 7 days, **cumulative time during the 7 days; 5-10 minutes**	**Cumulative time during the 7 days; 11-20 minutes**	**Cumulative time during the 7 days; 21 or more minutes**
National CMS = $15 (non-facility) (wRVU 0.25)	National CMS = $31 (non-facility) (wRVU 0.50)	National CMS = $50 (non-facility) (wRVU 0.81)

CPT Codes 99421 -23

Document cumulative time spent over a 7-day period- not resulting from an E&M

INCLUDES

- Cumulative service time within a 7-day time frame needed to evaluate, assess, and manage the patient:
  - Ordering of tests
  - Prescription generation
  - Separate digital inquiry for new and unrelated problem
  - Subsequent communication that is digitally supported (i.e., email, online, telephone)
- Digital service initiated by an established patient
- The service may include more than one provider responding to the same patient

EXCLUDES

- Clinical staff time
- Digital evaluation performed with separately reportable E&M services during same time frame for new or established patient:
- Inquiries related to previously completed procedure and within the postoperative period
- INR monitoring (93792-93793)
- Office or other outpatient visit
- Patient management services (99339-99340, 99374-99380, [99091], 99487-99489, 99495-99496)
- Digital service less than 5 minutes

Online Assessment

No Published changes as of 3/17/2020

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Patient Initiated – However per CMS

"We expect that these services will be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation."

G2061	G2062	G2063
Qualified nonphysician health care professional online assessment, for an established patient, **for up to 7 days, cumulative time during the 7 days; 5-10 minutes** National CMS - $12 (wRVU 0.25)	**Up to 7 days, cumulative time during the 7 days; 11-20 minutes** National CMS - $21 (wRVU 0.44)	**Up to 7 days, cumulative time during the 7 days; 21 or more minutes** National CMS - $33 (wRVU 0.69)

What We Know about e-Visit Codes

- Non-face-to-face “patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.”
- Intended to cover short-term (“up to seven days”) evaluations and assessments that are conducted **online or via some other digital platform**, and likely also include any associated interpretation and clinical decision making.
- 99421-99423 are reserved for physicians and other healthcare practitioners that can directly bill Medicare E/M codes
- G2061, G2062, and G2063 for non-physician practitioners **who are unable to bill E/M services**. CMS physical therapists, occupational therapists, speech language pathologists, clinical psychologists
- No further classification from CMS – limited due to platform and patient initiation

Example

A 75-year-old female with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) submits an online query through her physician's EHR portal about worsening shortness of breath and mild weight gain.

Provider reviews the initial patient inquiry, medical history, documents sent by the patient and/or obtained by clinical staff.

Assess medical condition described in the patient query. Formulate and sends response (eg, a diagnosis and treatment plan and/or request for additional information). Review test results and other reports. Email prescriptions. Conduct follow-up communication with the patient.

Interact with clinical staff to order diagnostic tests, coordinate care, and implement the care plan.

Complete medical record documentation of all communications and time.

Provides necessary care coordination, etc.

Provider to Provider

No Published changes as of 3/16/2020

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Includes Verbal and written reports from the consultant to the requesting provider. Reporting is time-based and time is cumulative if more than one contact is required to complete the consultation request.

99451

Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, **5 minutes or more of medical consultative time**

National CMS = $37 (wRVU 0.70)

99452

30 minutes or more of medical consultative time

Reported for 16-30 minutes of service on a single date for time If the time spent exceeds 30 minutes, the treating/ requesting physician/QHP may report the appropriate prolonged service codes (99354-99359)

National CMS = $37 (wRVU 0.70)

AMA CPT® - Includes

- Multiple telephone and/or internet contact needed to complete the consultation (e.g., test result(s) follow-up)
- New or established pt with new problem or exacerbation of existing problem and not seen within the last 14 days
- Review of pertinent lab, imaging and/or pathology studies, medical records, medications
- Consent Required

eConsult allows a provider-to-provider consultation.

Examples

99451 - Example - A 75-year-old female with dyspnea on exertion has been evaluated by her primary physician abnormal echocardiogram.

The referring clinician asks a Cardiologist (via shared electronic record, telephone, etc.) for advice on management of the patient.

The intraservice period includes clarifying the nature of patient's problem; obtaining and reviewing data or relevant information; presenting an analysis of patient's problem, including likely diagnosis and suggested management; responding to questions to clarify diagnostic and treatment approach.

Documentation to support time, context, requesting physician and report to requesting physician.

Code 99452 is reported for 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant.

RPM Codes

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99457

Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 20 minutes**

National CMS = $51 (non-facility) (wRVU 0.61)

99458

+ Each additional 20 minutes (List separately in addition to code for primary procedure)

National CMS = $42 (non-facility) (wRVU 0.61)

Not billable with 99091

Example

The provider or clinical staff utilizes the results obtained from an FDA-defined RPM device to oversee the patient's treatment plan.

The device is ordered by a physician or other qualified health care provider and used by the patient for the purposes of collecting, monitoring, and reporting health-related data, including, but not limited to, weight, blood pressure, or pulse oximetry.

This technology allows for the gathering of health data from the patient in one location and the electronic transmission of that data to a provider in a different location for review and subsequent recommendations, particularly in patients with ongoing and/or chronic disease processes.

Documentation supports time, context and provider authentication.

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Chronic Care Management

No Published changes as of 3/17/2020

CCM CPT Codes

*****Refer to complete CMS and AMA CPT coding and billing guidelines

99490	99491	99487	99489
CCM services, at least 20 mins of clinical staff time directed by a physician or QHCP per calendar month, with required elements** Assumes 15 minutes of work by the billing practitioner per month	CCM Services, at least 30 mins of physician or other QHCP time, per calendar month, with the required elements**	COMPLEX CCM Services - Moderate or high complexity medical decision making , 60 mins of clinical staff time directed by a physician or QHCP per calendar month	+ Each additional 30 mins of clinical staff time directed by a physician or QHCP per calendar month (List separately in addition to code for primary procedure)

CCM Add On Codes

*****Refer to complete CMS and AMA CPT coding and billing guidelines

G0506

+ Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services billed separately from monthly care management services

An add-on code to be used with another E/M service for that day

G2058

+Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

Use G2058 in conjunction with 99490. Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.

Principal Care Management (PCM)

*****Refer to complete CMS and AMA CPT coding and billing guidelines

G2064

Comprehensive care management services for a single high risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with required elements

G2065

Comprehensive care management for a single high risk disease services, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with required elements

NOTE:

Disease specific care plan versus comprehensive care plan. “High risk” condition per CMS: expected to last 3-12 months, or more; may have led to a recent hospitalization; patient at significant risk of death, acute exacerbation, decompensation or functional decline.

Resources

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf

https://www.cms.gov/files/document/se20011.pdf

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Helpful Acronyms

Acronym	Description
APP	Advance Practice Practitioner
APN	Advanced Practice Nurse
CNS	Certified Nurse Specialist
PA	Physician Assistant
NPP	Non-physician Practitioner
NP	Nurse Practitioner
NPI	National Provider Identifier
CMS	Center for Medicare & Medicaid Services
MAC	Medicare Administrative Contractor

Physician Assistant

- If state law, it is sufficient to comply with Medicare statutory requirements for supervision.
- If NO state law, physician supervision means working relationship with one or more physician to supervise the delivery of health care services
  - Document (at the practice level)
  - PA's scope of practice
  - The working relationship with supervising physician

APP Documentation (NP, PA)

- Finalizing broad modifications to the documentation policy so that physicians, PAs, and APRNs (nurse practitioners, CNS, certified nurse-midwives and CRNA) can review and verify (sign and date), rather than re-documenting, notes made in the medical record by other *physicians, residents, medical, physician assistant, and APRN* ***students,*** *nurses, or other members of the medical team*.
- Not necessary to re-document history
- Review and verify documentation
- NO IMPACT in regards to SPLIT SHARED service guidelines.

Concepts and/or Considerations

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It's Not Just About the Billing?

- Credentialing and Privileging
- APP Utilization and Metrics
- Regulatory Compliance State and/or Scope of Practice
- Reimbursement and Billing Guidelines and Policy

APPs – Key to Care Teams

Services as defined by CMS are “the type considered physician services”

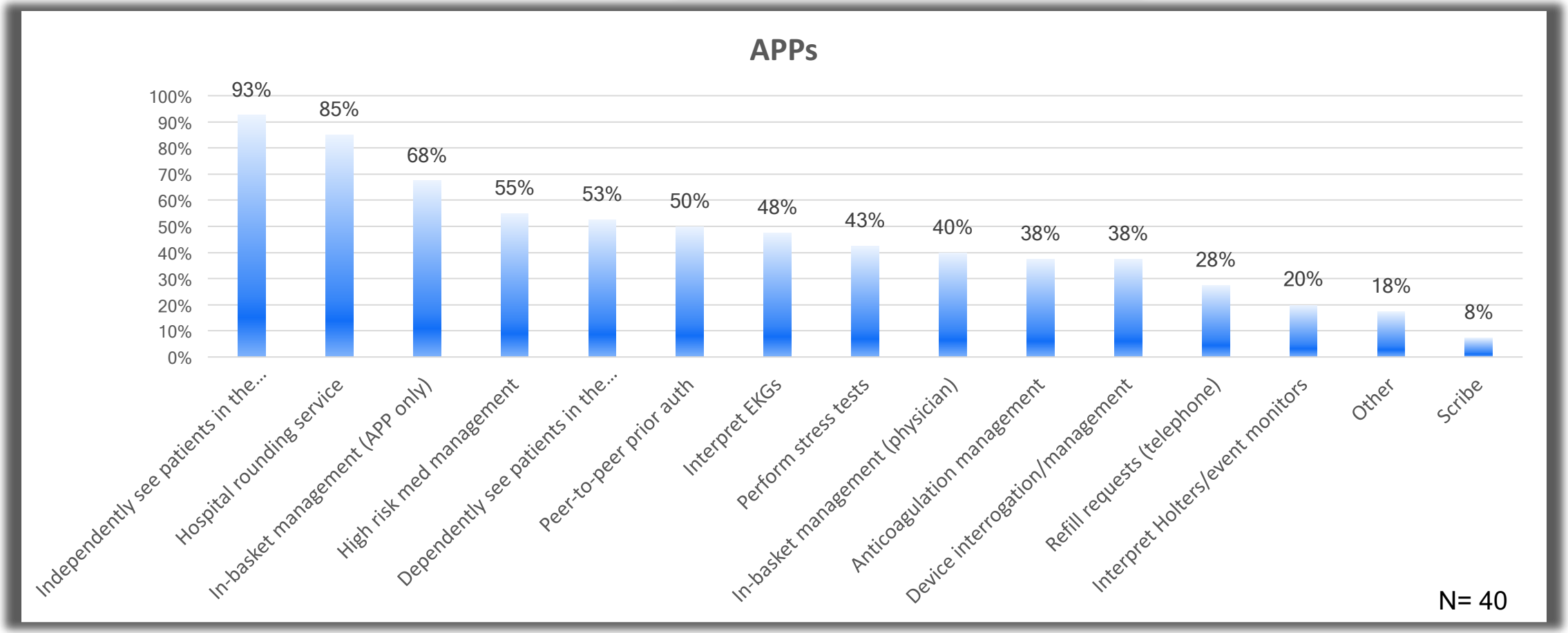
Not clinical support staff

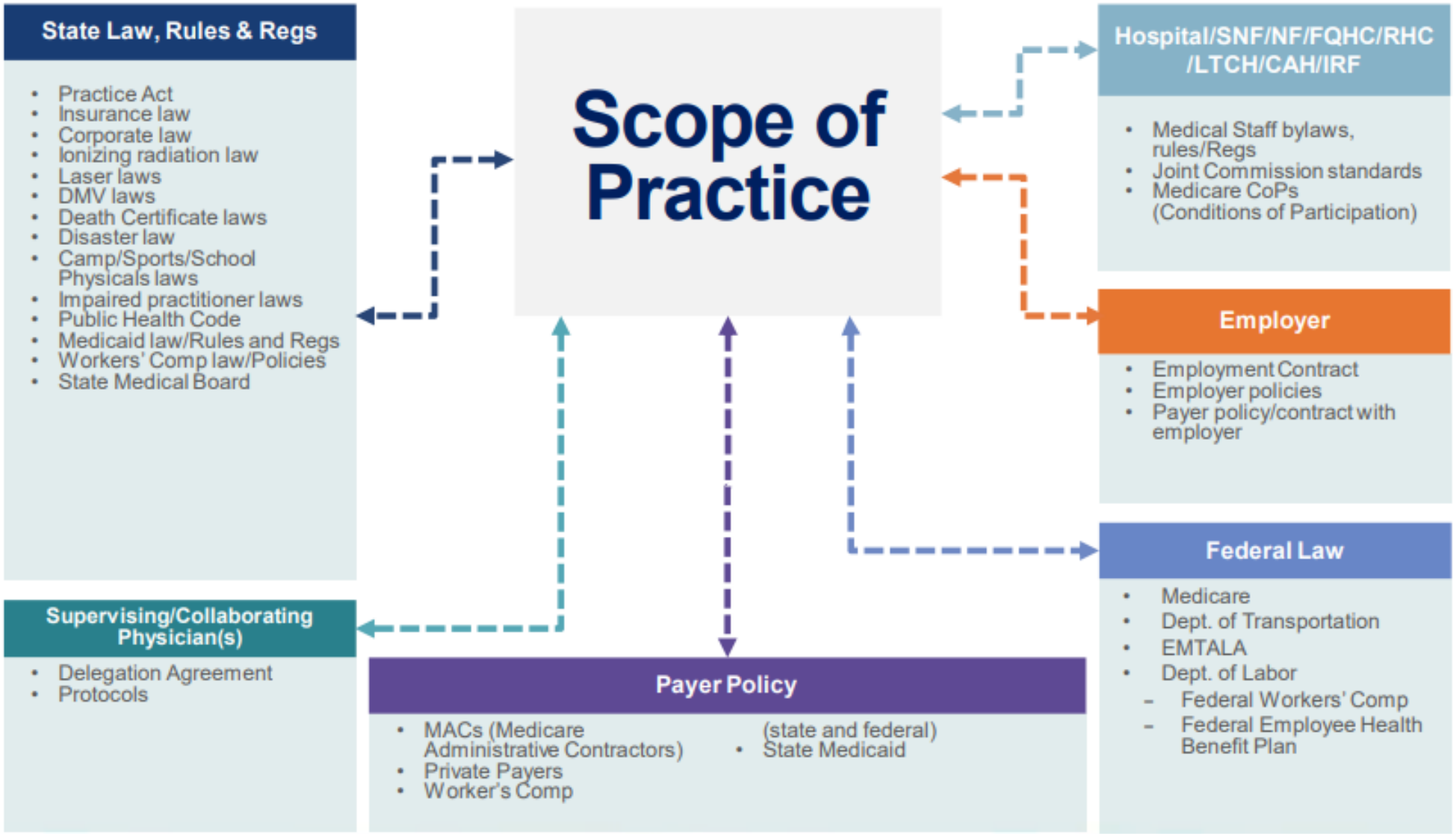
Not scribes

APP Duties

Other Duties:

- Calls from referral providers
- Liaison between RN and physicians
- Supervise hospital cardiac testing
- TAVR coordination
- Tilt table
- Wound care





CMS (Medicare) Definition of Patient Type

New Patient:

An individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Established Patient:

An individual who has received professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Credentialing - CMS Specialty Codes

Are self-designated and describe the kind of medicine physicians, non-physician practitioners or other healthcare providers/suppliers practice.

Appropriate use of specialty codes helps reduce inappropriate suspensions and improves the quality of utilization data

Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers.

Code	Description Physician versus APPs
06	Cardiovascular Disease (Cardiology) - Physician
C3	Interventional Cardiology – Physician
21	Cardiac Electrophysiology - Physician
50	Nurse Practitioner
97	Physician Assistant
89	Certified Clinical Nurse Specialist

CMS Billing for NPPs (APPs)

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DIRECT

- Service provided in any setting solely by the APP
- Billed directly to the payer under the APP
- Payment is 85% of the MPFS.

INCIDENT TO

- Office setting only – POS 11
- Not allowed for new patients or new problems
- Physician face to face with the patient not required.
- Service rendered by the APP – billed under the physician
- Payment is 100% of the MPFS

SPLIT SHARED

- Hospital setting only – POS 21, 22, etc.
- Requires a face to face by the APP and physician
- Applies to initial H&Ps, rounding visits & discharge.
- Services is rendered by the APP and physician – billed under the physician.
- Payment is 100% of the MPFS

Incident-To Billing Details

Incident-To Criteria

- Course of treatment initiated and reflects continued physician participation and management.
- APPs cannot bill incident-to for evaluation of a new or est. pt. with a new problem or with a change in treatment or plan of care.
- Service provided is in the APPs state scope of practice.
- Furnished under direct personal supervision (Physician in the office suite/immediately available.)
- Provided in place of service 11 – Office only
- APP qualifies as an employee of the physician

Documentation Recommendations

- Who performed the incident to service?
- Be able to substantiate
  - The physicians' presence in the office suite during the service/procedure
  - Established patient
  - Established condition

Support Incident-To

Evidence of Physician “Link”

- Co-signature, legibly identify and credentials of the both the practitioner who provided the service.
- Documentation from other dates of service, for example the initial visit establishing the link between the two providers.

Incident To Scenario – Yes? Or No?

- Established patient previously seen by MD with history of Afib. Patient seen today by NPP while MD is present in office suite. Chief Complaint is new symptom of claudication and the NPP orders a LE U/S. MD does not see the patient on this day.

- **Can this visit be billed under the MD's NPI?**
- **Was Incident-to met?**

Split/Shared Service Details

Split/Shared Criteria

- Patient seen, examined, etc. by the APP and physician on the same calendar day – no supervision requirement.
- APP meets the employment criteria (employed, leased, same entity)
- Does not apply to consults, procedures or critical care services.
- May be billed by the physician or APP

Split/Shared Visits Apply To

- Initial hospital visits (99221–99223)
- Discharge management (99238–99239)
- Observation care (99217–99220, 99234–99236)
- Emergency department visits (99281–99285)
- Hospital provider-based office visits (99201–99215)
- Subsequent hospital visits (99231–99233)

Documentation

- The MD must support a face to face service – it is highly suggested that the face to face service be documented with their exam findings….. At a minimum more than what could be obtained from just reading the chart and or nursing notes.
- Simply co-signing the note or statements such as “seen and agree with above” DO NOT QUALIFY.
- Physician should perform and document ultimate medical decision making, as well as a face to face service.

Split/Shared Example

NPP makes morning rounds and see's a patient who is hospitalized for CHF exacerbation. NPP performs the HPI and Exam. Physician from the same practice comes to the hospital after office hours and see's the patient, reviews the NPP's note, does a brief exam, writes orders for labs and makes medication changes. Physician co-signs the note and documents what he/she performed including exam elements and comments on the assessment/plan.

Can this visit be billed under the MD's NPI?

Was Split/Shared met?

Supervision Requirements

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Direct Supervision

Supervising physician is in office suite readily available and without delay, to assist and take over care as necessary.

Personal Supervision

A physician must be in attendance in the room during the performance of the procedure.

General Supervision

The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

CMS on APP Supervision

*"Nurse practitioners, clinical nurse specialists, and physician assistants **are not defined as physicians** under §1861(r) of the Act.*

Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act).

However, when these practitioners personally perform diagnostic tests as provided under §1861(s)(2)(K) of the Act, §1861(s)(3) does not apply and they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision or collaboration."

Teaching Physician Guidance

Definitions

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1 **Resident**

- An individual who participates in an approved graduate medical education (GME) program.
- Includes interns and fellows

2 **Student**

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

3 **Teaching Physician**

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

Guidance

1

Critical or Key Portion

That part or parts of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of Medicare teaching physician guidelines, these terms are interchangeable.

2

Physically Present

The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

Teaching Physician Guidelines

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Documentation of E/M Services

For Payment –

Teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and

Participation of the teaching physician in the management of the patient

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

The teaching physician is required to document their presence and participation, but essentially does not need to re-document the content of the service if it was documented elsewhere by physicians, residents, or nurses.

Added provision for students to guidelines

May review and verify (sign/date) notes in a patient's medical record made by other physicians, residents, nurses, students, or other members of the medical team, rather than fully re-documenting the information.

References

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  - Chapter 15, Sections 50-60 and 160-210
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  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf

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- IOM –Pub. 100-04, Claims Processing Manual
  - Chapter 26, Section 10
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf
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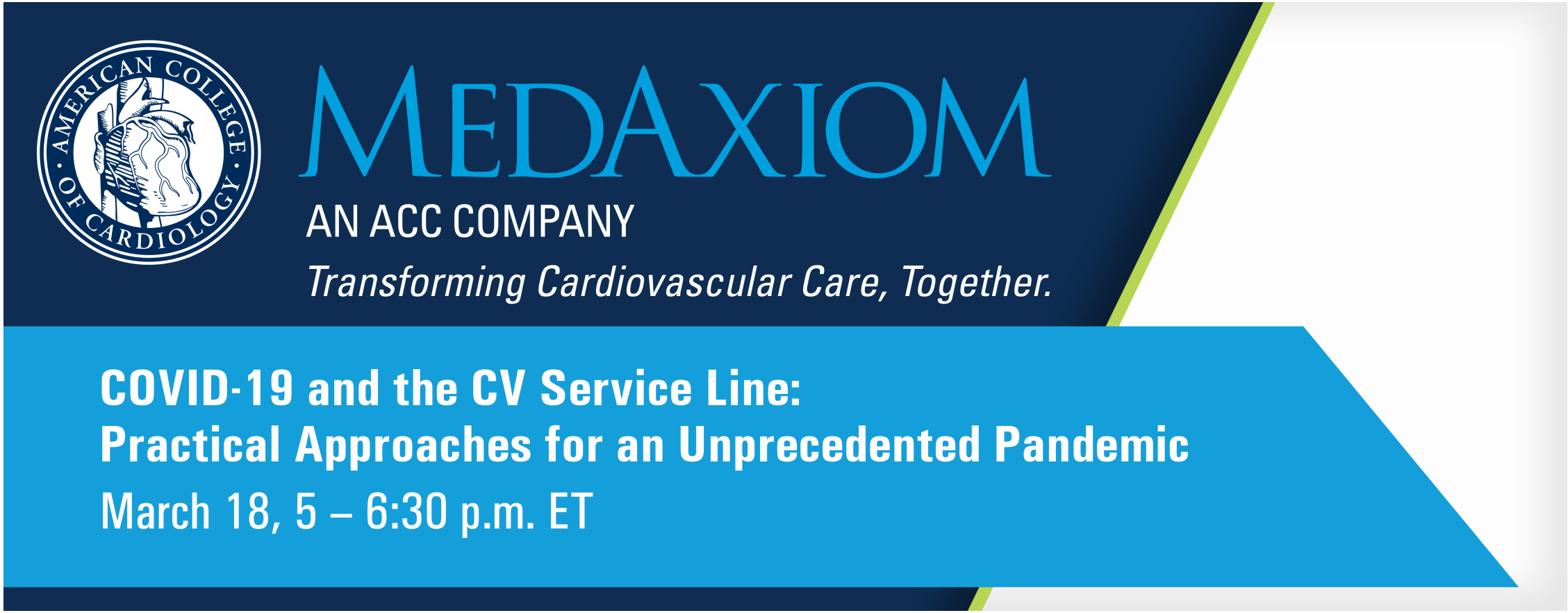

Q&A

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