Policy Statement

The purpose of this policy is to provide guidance about teaching physician presence and documentation requirements for Evaluation and Management (E/M) services, including time-based E/M services, when residents are involved in the care of patients.

Scope

This policy applies to Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) School of Medicine Physicians who involve Residents in the care of their patients. It applies to all federal, state and private payers unless a specific written waiver is obtained from the Institutional Compliance Officer (ICO).

This policy does not apply to presence and documentation requirements for E/M services furnished by residents under the supervision of a Teaching Physician in a Primary Care Exception (PCE) clinic setting, which is addressed in BCP EP 4.2 Teaching Physician Requirements for Evaluation and Management Services Provided under Medicare’s Primary Care Exception (PCE) Rule.

Policy

In order to bill for services, the teaching physician shall personally participate in the critical or key portions of any E/M service or time-based E/M service, and personally document his/her participation in the management of the patient’s care. For billing purposes, the resident shall not document the teaching physician’s presence and participation in E/M services, including time-based E/M services.

Definitions

1. **Resident** - An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the FI. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
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. See §100.1.1B ** for a discussion concerning E/M service documentation performed by students.

3. **Teaching Physician** - A physician (other than another resident) who involves residents in the care of his/her patients.

4. **Critical or Key Portion** - That part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). Critical and key are interchangeable terms.

5. **Macro** - A command in a computer or dictation application that automatically generates pre-determined text that is not edited by the user.

6. **Physical Presence** - 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.

**Procedure**

1. **Evaluation and Management Services**

   **A. General Documentation Requirements**

   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) book and any applicable documentation guidelines.

   For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

   • That the teaching physician performed the service or was 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.

   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.
B. E/M Service Documentation Provided By Students

Any contribution and participation of students 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 teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

C. Use of Macros in an Electronic Medical Record

1.) The teaching physician may personally add a macro in a secured (password protected) system to document his/her participation. The macro must be used along with the resident’s and/or teaching physician’s patient specific documentation that supports a medical necessity of the specific services provided and billed.

2.) The resident and teaching physician shall NOT both use macros to document patient specific care.

2. Time-Based Codes

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90804 - 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- Prolonged services (CPT codes 99358-99359); and
- Care plan oversight (HCPCS codes G0181- G0182).
Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

When counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided. In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient’s hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient’s care after the patient has left the office or the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported. The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

3. Medicare Teaching Physician Modifier – “GC”

The “GC” modifier shall be added to E/M and time-based codes billed to Medicare where a resident was involved in providing services (excluding E/M services in a PCE setting) with a teaching physician. For purposes of this policy, “involved” means providing hands-on care to patients and/or watching care or services provided by a teaching physician.

Administration and Interpretation, Revisions or Termination

Refer to Billing Compliance Policy El Paso 1.0 Policy Development and Implementation. Failure to comply with this policy shall result in appropriate disciplinary action. Questions regarding this policy may be addressed to the TTUHSC El Paso Institutional Compliance Officer or Compliance Unit Manager.

This policy may be amended or terminated at any time, subject to approval by the Billing Compliance Committee.
Frequency of Review
This policy shall be reviewed no later than March 1 in each even-numbered year.

Review Date: January 2018, March 2018, October 1, 2021
Revision Date: February 2018, March 2019, October 1, 2021