

August 31, 2001

**BILLING GUIDANCE FOR SERVICES PROVIDED BY
TEACHING PHYSICIANS AND RESIDENTS**

1. PURPOSE: This Veterans Health Administration Directive provides guidance for billing insurance carriers for services provided by a health care team, which includes attending physicians and residents and/or fellows (residents). *NOTE: The term fellow is used by some sponsoring institutions and in some specialties to designate participants in subspecialty graduate medical education programs. Because the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), treats 'fellows' identically to 'residents,' the term resident will be used throughout this document. Residents who have the title Chief Resident are considered residents.*

2. BACKGROUND: *NOTE: This directive is being re-issued to provide a clarification regarding optometry residents (subpar. 2d) and to provide additional information regarding the primary care exception criteria (Att. A, par. 13). Since the original directive was issued, the Revenue Office has received further guidance from the Centers for Medicare and Medicaid Services and Trailblazer Health Enterprises, LLC, on how to handle VHA sites that may wish to apply the Primary Care Exception criteria. There are differences between the requirements necessary for educational supervision of residents and the documentation requirements necessary in order to bill for services provided by attending physicians and residents.*

a. Procedural requirements for supervision of residents as part of graduate medical education are contained in VHA Handbook 1400.1. *NOTE: Decisions must be made that ensure that the structure of the health care provider workforce balances educational supervision requirements with issues of billing for patient care services.*

b. Specific payers, such as CMS or other third party insurers, apply specific guidelines for documentation of patient care services that are acceptable for purposes of third-party billing.

c. In general, patient care services provided by residents cannot be submitted for billing unless certain criteria are met. These criteria may vary with the participating third party insurer, so each insurance carrier must be contacted to determine if, and under what circumstances, it reimburses for resident-provided care.

d. This document specifically addresses the documentation requirements associated with CMS's administration of the Medicare program, and by association, Medicare supplemental insurance carriers. Accordingly, this billing guidance covers only the following types of providers - medical, podiatry, dental, and osteopathic residents. Optometry residents are not treated as residents under Medicare. Optometry residents are considered licensed or license-eligible practitioners for the purposes of Medicare reimbursement. For Department of Veterans Affairs (VA) reimbursement purposes, an optometry resident should be licensed by a state but not necessarily in the state in which the resident is employed by VA. Psychology intern or resident services cannot be billed whether or not the interns or residents are supervised.

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Psychology post-doctoral fellow services can only be billed if the fellow is licensed and credentialed to provide such services.

3. POLICY: It is VHA policy that, within the environment of Reasonable Charges, VHA is committed to meeting Medicare standards when billing: Medigap; Medicare supplemental insurance plans; plans coordinating benefits with Medicare; and other insurers applying Medicare guidelines that require the presence of a Teaching Physician (in VHA practice, the Attending Physician) while the resident provides medical care to a patient. ***NOTE:** In these cases, to bill for care provided by the resident under the Teaching Physician's name and credentials, the medical record documentation must meet Medicare's requirements.*

4. ACTIONS: The facility director is responsible for ensuring that VHA staff accurately reflect health care services delivered, and identify the person providing the care on a claim by:

- a. Coding the health care services for each patient from the medical record, and identifying the person who provided care.
- b. Validating the documentation of health care services in the patient's medical record.
- c. Instituting procedures to ensure compliance with Medicare and insurance industry standards, as applicable.
- d. Validating and monitoring the automated encounter form data to facilitate the coding and billing process.

***NOTE:** Attachment A contains information pertinent to the implementation of this Directive.*

5. REFERENCE: None.

6. FOLLOW-UP RESPONSIBILITY: The VHA Revenue Office (174) is responsible for the contents of this Directive. Questions should be addressed to 202-273-8198

7. RESCISSION: This Directive replaces VHA Directive 2000-047. This VHA Directive expires August 31, 2006.

Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachment

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ATTACHMENT A

INFORMATION CONCERNING BILLING FOR SERVICES PROVIDED BY
TEACHING PHYSICIANS AND RESIDENTS

1. INSURANCE CARRIERS OTHER THAN THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), FORMERLY KNOWN AS THE HEALTH CARE FINANCING ADMINISTRATION (HCFA). Insurance carriers handle billing for residents differently. Therefore, the Veterans Health Administration (VHA) should determine whether or not a particular insurance carrier applies the Medicare teaching physician guidelines. It would be prudent to contact the provider relations representative of each carrier to discuss such issues and request the carrier's policy be submitted in writing.

a. If the insurer applies the Medicare Teaching Physician Guidelines and VHA submits a claim, then VHA must submit the claim in accordance with those Guidelines.

b. If the insurer does not apply the Medicare Teaching Physician Guidelines and the carrier covers the services, VHA may submit a claim showing the resident as the provider for the services rendered. Prior to doing so, it is strongly recommended that VHA facilities ask for written documentation from the carrier indicating that resident services are covered and the guidelines to follow when billing for residents.

2. MEDICARE TEACHING GUIDELINES. According to the Medicare Teaching Guidelines, some of the issues to consider when billing for residents providing care to patients include: whether the Teaching Physician was present with the resident for the key portion of the visit; whether the Teaching Physician was present for the portion of the service that determined the level of service billed; the ratio of Teaching Physicians to residents; and whether the Primary Care Exception Rule applies (see subpar. 15a).

3. PROCEDURES: In order to bill for procedures, the Teaching Physician must be present during all critical and key portions of the procedure, and be immediately available to furnish services during the entire procedure. Definitions are as follows:

a. The **key portion** of a procedure is any portion of the procedure other than the opening or closing of the surgical field, although the opening and closing may be determined as key portions by the Teaching Physician on an individual case basis. For surgical, high risk, or complex procedures, the Teaching Physician determines the key or critical portions of the procedure.

b. **Presence** is defined as next to or adjacent to the resident in the same room attending to the same patient.

c. **Immediately available** is defined as remaining in or near the operating room and not engaged in activities that preclude an immediate return to the procedure. *NOTE: CMS does not define availability solely in terms of geographic location vis-à-vis the operating room.*

4. SURGERY. According to the Medicare Teaching Guidelines a Teaching Physician's presence is not required during the opening and closing of the surgical field unless these

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activities are considered to be key portions of the procedure. During the period in which the Teaching Physician does not have to be physically present, the Teaching Physician must remain immediately available to return to the procedure (i.e., must not be involved in another procedure from which they cannot return). If the Teaching Physician is not immediately available, the Teaching Physician must arrange for another physician (designee) to be immediately available to intervene, should the need arise, in order to bill for the original procedure. This designee must be a physician who is not involved in or immediately available for any other surgical procedure, e.g., cannot be the designee for two simultaneous surgeries.

5. MINOR PROCEDURES OR MINOR SURGERY

a. **Teaching Physician's Presence.** Minor procedures are not defined within Current Procedural Terminology (CPT), although the Medicare rule characterizes minor procedures as those taking only five minutes or less to complete (e.g., simple suturing) that involve relatively little decision-making once the need for the procedure is determined. The Teaching Physician must be present for the entire procedure in order to bill for the service (see subpar. 15b). In general, minor procedures do not require general or regional anesthesia and, due to their brevity, do not have an identifiable key portion.

b. **Documentation Requirements.** In contrast to the requirements for Evaluation and Management (EM) services, the documentation may be provided by either the resident, the nurse, or by the Teaching Physician personally. If the resident provides the documentation, an attestation may be stated as follows (see subpar. 15b):

Procedure performed with (by) Dr. Teaching Physician.
Or: Dr. TP was present during the entire procedure.
Or: Dr. TP observed me perform this procedure.

6. SINGLE AND/OR COMPLEX SURGICAL PROCEDURE

a. A complex surgical procedure is one that requires the special skills of more than one physician, each performing a discrete, unique function integral to the performance of a complex surgical procedure. Alternatively, it is a procedure that may constitute concurrent care relating to a medical condition that requires the presence of, and active care by, a physician of another specialty during surgery.

b. For surgical, high risk, or complex procedures, the Teaching Physician:

(1) Must be present with the patient during all critical and key portions of a single procedure or two "overlapping" procedures;

(2) Determines the key or critical portions of any surgical or complex procedure;

(3) Does not need to be present during opening or closing of a procedure when these are not defined as key portions by the Teaching Physician;

- (4) Must be immediately available to furnish services during the entire procedure, including the opening and closing, if necessary;
- (5) Must not become involved in a second, overlapping procedure until all key portions of the first procedure have been completed;
- (6) Must arrange for another physician to be immediately available to intervene in the first case if the Teaching Physician leaves the operating room, for example, following completion of the key portion(s) of the first procedure, to become involved in the key portion of a second overlapping procedure;
- (7) May not bill for any case if involved with three concurrent procedures; and
- (8) Must personally perform or observe the resident perform the post-operative visit(s) considered by the Teaching Physician to be key visits during the post-operative period.

NOTE: These rules and the following documentation requirements apply to other high risk and complex procedures, such as interventional radiological and cardiologic services, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography (see subpar. 15b).

c. **Documentation Requirements.** When the Teaching Physician performs a single surgical or other complex procedure, the resident or nurse may dictate the report on the Teaching Physician's behalf. If the resident dictates the report, the report must indicate the Teaching Physician's presence during the key portion of the procedure in the form of an attestation in the documentation, or via a simple declarative statement in the body of the report.

For a single procedure, a resident or nurse may document presence of the Teaching Physician:

Entire procedure performed in presence of/with Dr. Teaching Physician and interpretation verified by same. No overlapping procedures.

For overlapping procedures, the Teaching Physician must document personally his/her presence and key portion:

I was present for the key and surgical and imaging portions of the procedure, performed with (by) Dr. Resident. The key portion(s) of this procedure was (were)..... I (or another Teaching Physician) was immediately available thereafter through the completion of the procedure. I have reviewed the films and confirm (or revise) the interpretation of Dr. Resident as.....

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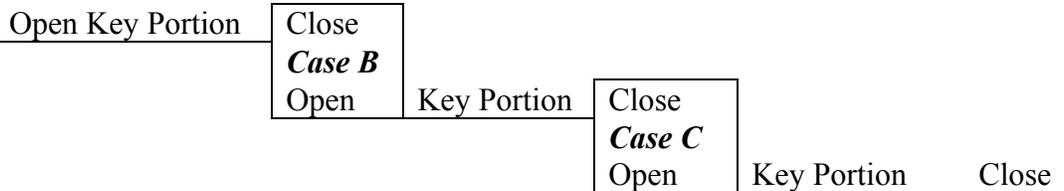
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7. OVERLAPPING SURGICAL PROCEDURES. Teaching Physician documentation requirements for overlapping surgical and complex procedures are more comprehensive. The Teaching Physician must personally document the key portion for each overlapping procedure performed, using patient-specific terms to describe the personal service provided or observed; and that the Teaching Physician personally, or another physician, was immediately available to return to either procedure in the event of complications.

a. The Teaching Physician's personal documentation for two overlapping surgical procedures must provide the name of the other surgeon(s) who remained immediately available for the closing of the first case while the Teaching Physician begins the key portion of a second case.

b. **Illustration of Overlapping Cases** (see subpar. 15b)

Case A



c. **Documentation Requirements**

(1) In the preceding illustration, if one Teaching Physician performs the key portion(s) for Cases A, B, and C, the Teaching Physician must document the Teaching Physician's presence during the key portions of each case, and if necessary, also document that the Teaching Physician, or another Teaching Physician, was assigned to be immediately available for the opening and closing of Cases A, B, and C. Each preceding case is a billable procedure since the key portions of each case do not overlap and are not performed concurrently by the Teaching Physician.

(2) If a key portion of one procedure overlaps with the closing or opening of a second procedure, the Teaching Physician must document that immediate availability was assigned to another physician for the second overlapping case.

I was present and I participated during the critical and key portions of this procedure, and Dr. Jones was immediately available during the remainder of the procedure. I interpret the critical and key portions of this procedure to have been.....

OR:

I was present and I participated during the entire procedure except for the opening and/or closing which overlapped with the opening and/or closing of another case. The overlapping portions were non-key portions and I remained immediately available.

I was present and I participated during the entire procedure except for the opening and/or closing which overlapped with the key portion of another case. I interpret the key portion(s) of this case to be

..... Dr. Teaching Physician was assigned to be immediately available during the overlapping portions of these cases.

8. ENDOSCOPY PROCEDURES

a. **Teaching Physician's Presence.** The Teaching Physician must be present with the patient for the entire viewing portion of the procedure to bill for procedures performed through an endoscope. This includes insertion and removal of the scope. Viewing the entire procedure through a monitor in another room does not meet the Teaching Physician presence requirement. Performing concurrent endoscopic procedures is not acceptable.

b. **Documentation Requirements.** As with minor procedures, verification of the Teaching Physician's presence must be explicitly stated in the documentation. This statement may be made by residents or nurses and should be countersigned by the Teaching Physician, or the Teaching Physician may make the statement personally.

9. ANESTHESIA. In order to bill for anesthesia involving an anesthesia resident, the Teaching Physician must be present for all critical portions of the procedure, including induction and emergence, and be immediately available to furnish services during the entire procedure. The Teaching Physician's presence must be documented in the medical record. The Teaching Physician's presence is not required during pre-operative or post-operative visits with the patient. If the Teaching Physician is involved in concurrent procedures with more than one resident, or with a resident and a non-physician anesthetist, the Teaching Physician's services are billed as "medical direction" at a reduced rate.

10. INTERPRETATION OF DIAGNOSTIC RADIOLOGY AND OTHER DIAGNOSTIC TESTS. The Teaching Physician must perform the interpretation of diagnostic radiology and other tests, or review any interpretation performed by a resident. If the resident prepares and signs the interpretation, the Teaching Physician must personally review the image and the resident's interpretation and either agree with or edit the findings. The interpretation cannot be billed if the Teaching Physician merely countersigns the resident's interpretation.

11. PSYCHIATRY. For psychiatry services provided by a resident, the presence of the Teaching Physician can be accomplished by concurrent observation of the service using a one-way mirror or video equipment. Audio-only equipment does not satisfy the presence requirement. The Teaching Physician must be a physician. A psychologist cannot be a Teaching Physician; if a psychologist supervises the resident, the service cannot be billed.

12. DIAGNOSTIC TESTS ORDERED BY A RESIDENT

a. Before billing diagnostic or therapeutic services ordered by a resident, it should first be established whether the service is covered by the insurance carrier. If the service is covered, the facility can bill for the technical portion of the procedure under the facility's name.

b. The professional component of a service provided by another physician, who is not also a resident, can be billed under that physician's name. For example, if the resident orders Magnetic Resonance Imaging (MRI) without appropriate attending supervision, the technical portion of the MRI can be billed. The associated MRI interpretation can be billed under the radiologist's name

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only if the radiologist is a staff or attending physician, and the preceding guidelines for radiological interpretation were appropriately followed.

13. PRIMARY CARE EXCEPTION RULE (See subpar. 15c.)

a. When a VHA facility is billing under a Medicare supplemental policy or other health insurance policy following Medicare's Teaching Physician Guidelines, the Primary Care Exception rule may be applied, as long as all relevant primary care exception criteria are met and approval is received from the Medicare carrier. Under the Primary Care Exception Rule, certain evaluation and management codes of lower and mid-level complexity services furnished by residents without the presence of the Teaching Physician may be covered. These include the following:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

b. In order to bill under the Primary Care Exception Rule, approval is required by the Medicare carrier. The VHA Revenue Office and VHA Compliance and Business Integrity Office will seek approval for all Department of Veterans Affairs (VA) sites from Trailblazer, the Medicare carrier all VHA Medicare Remittance Advice (MRA) claims will process through in the future. Sites that meet the specific criteria, file an attestation statement with VHA's Compliance and Business Integrity Office, and receive notification of an implementation date; these are the only sites that should bill under the Primary Care Exception Rule. **NOTE:** *Those sites that do not meet the criteria outlined in this document should not bill for services falling under the Primary Care Exception Rule.*

c. VHA facilities may bill for clinic services where the clinic has been reviewed and deemed to meet the following criteria for the Primary Care Exception Rule. It is the responsibility of the VHA facility to track the criteria necessary for this exception, and document those clinics that meet them, maintaining an appropriate attestation statement of this assessment and finding. This information must be communicated to the following:

- (1) Clinical staff.
- (2) Ambulatory Care staff.
- (3) Revenue Office staff.
- (4) Health Information Management Office staff.
- (5) Compliance and Business Integrity Office staff.

d. This information must be readily available for external and internal audits and reviews and should be updated as changes in clinical rotations (i.e., changes in schedules of residents and attendings) occur.

e. The Primary Care Exception Rule covers such residency programs as family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics and/or gynecology. Psychiatry may qualify in special situations, such as when the program furnishes comprehensive care for chronically mentally ill patients.

f. In order for services to be considered under the Primary Care Exception Rule, the following criteria must be met:

(1) Services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity;

(2) Any resident furnishing the service without the presence of a Teaching Physician must have completed more than six months of an approved/accredited Accreditation Council for Graduate Medical Education (ACGME) residency program;

(3) The Teaching Physician in whose name the payment is sought must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The Teaching Physician must:

(a) Have no other responsibilities at the time of the service for which payment is being sought;

(b) Assume management responsibility for those patients seen by residents;

(c) Ensure that the services furnished are appropriate;

(d) Review with each resident, during or immediately after each visit, the patient's medical history, physical examination, diagnosis, record of tests, and therapies; and

(e) Document the extent of the Teaching Physician's own participation in the review and direction of the services furnished to each patient.

(4) Patients seen in clinics following the Primary Care Exception Rule:

(a) Must consider the clinic to be the continuing source of their health care; and

(b) Be followed by residents who generally follow the same group of patients throughout their residency programs.

(5) The range of services furnished by residents includes all of the following:

(a) Acute care for undifferentiated problems or chronic care for ongoing conditions;

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- (b) Coordination of care furnished by other physicians and providers; and
- (c) Comprehensive care not limited by organ system or diagnosis.

14. REMINDERS

a. If the insurance carrier applies the Medicare Teaching Physician Guidelines and the documentation in the patient's VHA medical record reflects that these guidelines have been met, then VHA should bill for all appropriate charges. The claim form should reflect the Teaching Physician's name in the appropriate box on the claim form.

b. If the insurance carrier applies the Medicare Teaching Physician Guidelines and the documentation in the patient's VHA medical record reflects that the Medicare standards have **not** been met, then VHA should **not** bill for the professional portion of the medical care. For inpatient care, it would be appropriate to bill for the facility services, which include room and/or board and ancillary services; however, the professional fees cannot be billed unless the Teaching Physician Guidelines are met (see subpar. 15d).

c. For Teaching Physician outpatient services, VHA should not bill professional charges when the Teaching Physician Guidelines are not met. If there is an associated facility charge for these services, they may be submitted under the name of the Department of Veterans Affairs on a Universal Billing Form (UB)-92. **NOTE:** *For information concerning when it is appropriate to bill for diagnostic tests ordered by a resident see paragraph 12.*

d. If the insurance carrier does **not** apply the Medicare Teaching Physician Guidelines and considers care by residents as covered services, VHA can bill for covered services delivered by the resident. The insurance carrier's policy concerning Medicare Teaching Physician Guidelines should be in writing and on file with VHA. The claim form should reflect the resident's name in the appropriate box on the claim form.

15. REFERENCES

- a. Medicare Part B Carrier Manual, §15016 Supervising Physicians in Teaching Settings.
- b. Memorandum 99-47, Jordan J. Cohen, M.D., President, AAMC, August 6, 1999, http://www.aamc.org/private/deans/afad/deanmemo/dm1999/99_47.htm
- c. HCFA Carriers Manual Section 15016.
- d. Medicare Hospital Manual, Chapter II, Coverage of Inpatient Hospital Services, §210.6. "Hospital insurance covers the reasonable cost of the services of medical interns or residents-in-training under a teaching program."