



Society for  
Maternal – Fetal  
Medicine

# Coding with Medical Trainees



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# Learning Objective



Upon completion of this lecture, the participant will be able to:

- Define the role of the medical trainee as compared to the teaching physician (attending)
- Describe documentation requirements when billing with a medical trainee
- Understand documentation and billing with required level of supervision for a medical trainee
- Perform the correct documentation as the teaching physician when billing E&M codes and supervising a medical trainee



# Definitions



## 1) The teaching physician (attending)

A physician who is NOT a resident but who involves residents in the care of their patients. Does NOT have to hold a faculty appointment to be considered a teaching physician

## 2) The Resident

A physician who participates in an approved ACGME program. This would include residents and fellows in programs approved by the ACGME for direct GME federal funds. In some cases the resident may NOT be in an approved GME program, but is perhaps only authorized to practice in a hospital setting under direct supervision.



# Definitions continued - resident



Faculty or 'staff' appointment of residents does NOT alter their resident status

They are in an approved ACGME program

Even if the hospital does NOT include them in the FTE count of residents it doesn't matter – the idea is that they would be ELIGIBLE to get direct GME funds

For example, if a GME accredited program counts only their OBGYN residents in the FTE count and their MFM fellows are not included in that number – for the purposes of billing, the MFM fellows are still considered “residents” simply because they are training under the institution which has an accredited GME program and is eligible for GME direct compensation.

# Definitions continued



Why is this distinction relevant?

- CMS/Medicare only pays for services provided by the teaching physician
- CMS/Medicare allows the use of the resident note to support billing of services by the teaching physician

# Definitions continued



## Where do Fellows fall in?

If they are in an approved ACGME program then they are a subcategory of resident (PGY 5, 6, 7 for MFM). They have completed the requirements for eligibility for first board certification in subspecialty (i.e. completed ob/gyn residency and written boards).

If they are NOT part of a GME program, then they are NOT considered a resident or have a 'pgy' attached to them, then they may need to be separately credentialed and bill under their own name/license/NPI

To check if your GME program is approved:

- AMA Directory of GME programs
- ABMS annual report and reference handbook
- ABOG

# When can fellows bill on their own?



## RARELY

If they are NOT in an ACGME approved program (so an unlisted program, or not yet credentialed program) that is the federal government is not providing direct GME payment to the hospital/facility. Then teaching physician rules do NOT apply and the fellow is considered an 'ATTENDING'.

Services outside of the scope of MFM – i.e. moonlighting. This may or may not be allowed and could bill under the Fellows provider number (NPI)

Medicare only pays for services provided by the teaching or attending physician – not a trainee. If a fellow provides services to a patient with private insurance, not a federal or state payor plan, the department's written protocol defines the billing provider. Most departments defer to using the teaching provider as the billing provider given that many private insurance plans follow Medicare billing rules.

# Fellows and billing continued




CMS has developed a quick reference table which reviews the qualifications required for a resident to function independently as a primary services provider.

This is most useful when considering moonlighting services. If an MFM fellow moonlights at another hospital, covering as a general OBGYN, they would be regarded as a primary provider at that alternate hospital and bill under their own credentials – thus why they must be fully licensed to practice medicine in the state where the services are rendered.





## Requirements for Coverage of Services Furnished in Intern's or Resident's Capacity as a Physician



Setting	Requirements
1. Outside the facility where the intern or resident has the training program	<b>All</b> of these requirements must be met: <ul style="list-style-type: none"><li data-bbox="620 330 1611 426">• The services are identifiable physician services, the nature of which require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition and</li><li data-bbox="620 443 1576 506">• The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State where the services are performed</li></ul>
2. In an outpatient department or emergency room of the hospital where the intern or resident is in a training program	<b>All</b> of these requirements must be met: <ul style="list-style-type: none"><li data-bbox="620 576 1534 672">• The services are identifiable physician services, the nature of which require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition</li><li data-bbox="620 689 1586 752">• The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State where the services are performed and</li><li data-bbox="620 768 1580 832">• The services furnished can be separately identified from those services that are required as part of the training program</li></ul>

# Definition of the teaching setting



The teaching setting is defined as a location in which payment for resident services is made under direct GME payment. This includes freestanding clinics which allow resident involvement when the hospital incurs the cost of the resident or fellow. This can include SNF (skilled nursing facilities) or HHA (home health agencies) in which GME payments are made on the basis of reasonable cost.

As a reminder - CMS (Center for Medicare/Medicaid Services) requires strict adherence to its guidelines in order for to reimburse the provider of the service. Most third-party payers will default to CMS' guidelines. However, some third-party insurers have their own guidelines, and may or may not pay when a resident has seen the patient and provided services. Someone in your organization may need to call that third-party payer to ensure compliance with its policies, especially if you are contractually bound to that payer.

# How do attendings get paid?



CMS (and thus most payers) will reimburse an attending in a teaching institution in the following circumstances

- The attending (who is NOT a resident) personally provides the services
- The resident performs the service but the attending/TP is physically present during the critical/key portion of the services
- The resident performs the services under a primary care exception within an approved ACGME program (modifier –GE)
  - Claims must include the GE modifier, **“This service has been performed by a resident without the presence of a teaching physician under the primary care exception,”** for each service furnished under the primary care center exception. while general OBGYN services may qualify, maternal fetal medicine services do NOT qualify for the primary care exception.



# What does critical/key portion mean?



The attending/TP determines what is a critical or key portion of the scenario/exam

In general the following apply:

- Must be physically present on the premises
- Must be immediately available to provide services during the time/entire service performed by resident
- They have to see the patient at some point 'face-to-face'

Without all 3 it may NOT be considered a payable services

# Levels of supervision



ACGME calls this progressive responsibility

- 1) Direct supervision physically present with resident & patient
- 2) Indirect supervision with direct supervision immediately available (TP is present in the hospital or other patient care site and is available to come over)
- 3) Indirect supervision with direct supervision available (TP is not present anywhere but can be called by phone/email/text)
- 4) Oversight (TP reviews procedures/encounters and gives feedback AFTER care is delivered)



CMS calls this 'Teaching Physician Rules'

- 1) Physically present (TP is in the same room as patient and resident and performs face-to-face services)
  - E/M
  - Minor procedures (<5 min)
  - Endoscopies (insertion through removal)
  - Key/critical portion of surgery
  - Psychiatry (mirror/video)
  - Complex/high risk procedures
- 2) Primary Care Exception (TP supervises up to 4 residents, is on site and immediately available)
- 3) There is NO CMS code for indirect supervision with direct supervision available
- 4) Diagnostic interpretation only (TP reviews the interpretation)

\*\* CMS does NOT define 'immediately available'

# Levels of supervision and concerns



The resident does a delivery (by themselves) the attending arrives for the placenta  
This may be a billable service if the attending was participating in the management of the patient earlier

However 'teaching physician' requirements may NOT have been met (delivery is a key/critical portion)

Consult with your institution's compliance department for specific guidance

The critical or key portions of an operation are those stages when essential technical expertise and surgical judgement are necessary to achieve an optimal patient outcome

\*\*\* According to CMS in order to bill for the delivery procedure code, the teaching physician must be present for the delivery of the infant

# E/M services



The attending/TP must personally document at least the following in their note:

- I performed the service
- I was physically present during the key/critical portion of the service when performed by the resident
- What I did in the management of the patient
- Date/time/sign

**No longer can the resident just document your presence/participation. YOU the attending/TP must WRITE a note or addendum.**

**\*\*\* -GC modifier (certifies that a teaching physician was present during the key portion of the service and was immediately available during the other parts of the service)**

# E/M services continued



In general a combined entry into the EMR is best

- Documentation by the resident AND the attending/TP
- Both must support the medical necessity and LOS selected
- Most importantly the level of involvement of the attending/TP must be well described



## E/M continued if the attending performs the exam



- I performed an H&P exam (*documents performance of key/critical portion*) and discussed patient's management with the resident. I reviewed the resident's note and agree with the documented findings and the plan of care we developed (*documents management responsibility*).
- TP signature



E/M Documentation if resident performs exam/prepares the note:



- I was present when resident performed **examination (*documents performance of key/critical portion*)**. I agree with the resident's findings and the plan of care we formulated together as documented in the resident's note (***documents management responsibility***).
- TP signature



E/M services if attending performs exam/visit later (after) the resident:



- Hospital Day 4: Patient seen and examined. (*documents key/critical portion*). I agree with the resident's note, except heart murmur is louder so I will obtain an echo to evaluate (*documents management responsibility*).
- TP signature

Note: If there is no resident's note, TP must document as he/she would document E/M services in a nonteaching setting.



# CMS considers the following NOT ok



CMS has determined that the following is unacceptable documentation even when countersigned:

- Agree with above
- Rounded, reviewed, agree
- Discussed with resident and agree
- Seen and agree
- Patient seen & evaluated
- Signature only

Why is this not ok? You can not determine whether the attending was present, evaluated or had any involvement in the plan of care/counseling

# E/M with time based billing



The attending/TP must be present in the room for the period of time for which the claim is being made

For example – 20 minutes of time the attending must be there for 20 minutes

You can NOT add time between you and the resident (if you the attending/TP were not in the room)

# Interpretation of ultrasounds



Interpretation of an ultrasound is billable if the interpretation is reviewed by the attending/teaching physician

- Resident/fellow can prepare the report and interpretation
- Attending/TP must then indicate they have personally reviewed the images, the resident note, and interpretation and agree/edit if indicated

**CMS will NOT pay for an interpretation if the attending/TP just co-signs the resident report**

# Participation in c-section/cerclages



The attending/TP must be present during the critical/key portion – i.e. IN THE OR

The attending/TP must then be immediately available through the surgery

- So within the surgicenter/OR area
- Available immediately by pager, text, call
- Able to return immediately to the operating room
- If the attending can not do these things they must arrange for another qualified attending to be immediately available
- The attending/TP is not required to be there during open/close unless this is a key portion (plastics for example)

You/the attending/TP can NOT be performing surgery or key/critical portion in a different OR/different procedure (i.e. overlapping supervision of surgery)

# Billing a Surgical Assist



In teaching setting, assist is only allowed when *qualified* resident is not available.

Document in the operative report statement that a qualified resident was not available

Use modifier 82

82



# Participation in a 'minor' procedure



If the procedure is < 5 minutes the attending/teaching physician must be present in the room the entire time to bill

- Example Bartholin cyst drainage
- Cerclage removal

# Definitions – Medical Students



One who participates in an accredited educational program (Medical School) that is NOT a GME program

So a MS can NOT also be a resident/intern/fellow

Payment is NOT made for any of their services

# Medical Students



Any contribution of the MS to the patient care must be performed in the physical presence of the attending/teaching physician

Students CAN document in the EMR but the attending/TP must verify all the documentation, findings, decision making

The attending/TP must personally perform the physical exam and MDM activities related to the E/M services

# MS and documentation continued



The attending/TP can refer to the ROS or PMH/PSH/PFMH written by the student

The attending must verify and REDOCUMENT the HPI

The attending must perform and REDOCUMENT the physical exam

The attending must document the medical decision making

Medical students can be 'scribes'

- They must identify they are a scribe, and refer to themselves as a scribe in the note
- They can't have hands on patient care if they are 'scribing'



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Questions?

Resources on next slide



# Resources



## 1. CMS Website

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/teaching-physicians-fact-sheet-icn006437.pdf>

## 2. SMFM Website

<https://education.smfm.org/products/coding-fundamentals-for-mfms>

