

**THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER-HOUSTON  
MEDICAL SERVICE RESEARCH AND DEVELOPMENT PLAN/  
UT PHYSICIANS**

**ACKNOWLEDGEMENT OF MSRDP/UTP PRACTICE GUIDELINES**

**I, the undersigned faculty member, by signing this document, acknowledge receipt of a copy of the Medical Service Research and Development Plan (MSRDP)/ UT Physicians (UTP) Guidelines. Furthermore, I acknowledge that the MSRDP/UTP Guidelines were discussed with me and I had the opportunity to ask clarification. MSRDP/UTP representatives answered all my questions regarding the MSRDP/UTP Guidelines to my satisfaction.**

**I understand that MSRDP/UTP personnel will generate billing claims on my behalf for professional services that I render as a physician. The billing claims will be based upon documentation provided by me. I understand that any false claims, false statements, false documents, undocumented services or improperly documented services, or any concealment of a material fact regarding professional services rendered by me may be prosecuted under applicable federal and/or state law and the knowing submission of false claims may subject me to criminal charges, civil penalties, and/or forfeitures.**

**I understand that in my capacity of teaching physician, I can involve residents in the care of my patients, but I am ultimately responsible for the management of the patient's condition. I also understand that all bills for my services as a teaching physician will be subject to the relevant Medicare rules on payment for these services.**

**I agree to conduct my medical practice within the context of the MSRDP/UTP Guidelines. Furthermore, I acknowledge and understand that all professional services I render must be documented in the patient's medical records according to the MSRDP/UTP Guidelines, appropriate hospital/institutional by-laws, and applicable federal/state regulations.**

<b>Name of Faculty Member</b>	<b>Department</b>
<b>Signature</b>	<b>Date</b>

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**BILLING AND DOCUMENTATION GUIDELINES**

INTRODUCTION: Written documentation in the clinical patient chart is of primary importance for communication among clinical care providers. Documentation must be contemporaneous, comprehensive and complete in order to facilitate and coordinate clinical care. Written documentation is also used for other purposes, including medical-legal review, support for clinical research and quality assurance.

Written documentation provides support for charges submitted by faculty for payment for medical services. The following guidelines are intended to help faculty understand issues relating to billing and clinical documentation. **For billing purposes, MSRDP/UTP expect faculty to follow Medicare's billing and documentation guidelines consistently for all patients.** Payors differ in funding source (e.g., Federal, State, Commercial, Private), in payment structure (e.g., fee for services, discounted fee for service, capitation), in process (e.g., Primary Care Provider, Precertification, etc.) and in documentation requirements (e.g., physical presence, "Teaching Physician," "Attending Physician"). It is important that MSRDP/UTP members be attentive to written documentation, and recognize that good documentation not only improves care, but also improves the ability of MSRDP/UTP to collect for services and reduce faculty medical-legal exposure.

While the complete guidelines for individual payors billed by MSRDP/UTP are beyond the scope of this document, it is important that each MSRDP/UTP member be familiar with documentation guidelines in general, and with the specific requirements of his/her most frequent payors. As Medicare and Medicaid are each frequent payors for the overall practice plan, this document will discuss these payors in some detail. Unless otherwise directed by the MSRDP Board, physicians **MUST** follow the Medicare guidelines as specified below. **In selected settings pre-approved by the MSRDP Board,** where another payor is essentially the only payor, that payor's guidelines should be used. Generally, documentation at the level required for Medicare should meet the requirements of most payors, and shall be used by teaching physicians.

## **I. MEDICARE GUIDELINES**

A teaching physician is one who involves residents in the care of his/her patients. The teaching physician must be a faculty member and must endeavor to make certain that each of his/her patients recognizes him/her as the responsible physician. Residents will not be patient's main physicians. Medical students may never evaluate or treat patients independently without the supervision of a teaching physician.

There are two circumstances under which a faculty physician may bill for services provided to a patient:

1. The faculty personally provides identifiable services to the patient without involving a resident, OR
2. The faculty member qualifies as a "teaching physician" in accordance with the requirements specified below and documents his/her patient care as indicated in the following guidelines.

### **A. Teaching Physician Requirements**

The teaching physician must render "sufficient personal and identifiable medical services" to the patient to exercise full personal control over the case or portion of the case for which a charge is being submitted. This means close active supervision of the resident on the part of the physician. When this control is exercised in absentia or solely by acceptance of responsibility for overall conduct of the case, the physician does not meet the requirements for a teaching physician and thus may not submit a bill. Recognition of the doctor-patient relationship should be demonstrated in the medical records. The designated teaching physician is responsible for the patient's care regardless of the patient's financial status.

To be the "teaching physician", the faculty member must meet each of the following:

1. Review the patient's history, the record of examinations and test, and make frequent reviews of the patient's progress;
2. Be physically present during the key portions of the service or procedure, except as specified below;
3. Confirm or review the diagnosis with the resident and determine the course of treatment to be followed;
4. Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level;

5. Be present for the critical and key portions of a major surgical procedure;
6. Be recognized by the patient as his/her physician and be responsible for the continuity of the patient's care;
7. Make sure that medical records are complete, accurate, legible, properly documented according to guidelines, and support medical necessity and the level of service billed.

Only those services provided by the teaching physician that meet these criteria and those below constitute billable services.

### **B. Evaluation and Management Services: Inpatient/Outpatient**

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) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- Their participation in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician when the teaching physician references the resident's note.

Documentation by the resident of the presence and participation of the teaching physician **is not sufficient** to establish the presence and participation of the teaching physician.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Following are three common scenarios for the teaching physician providing E/M services and minimally accepted documentation:

#### Scenario 1

The teaching physician personally performs all the required elements of an E/M service without a resident. In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.

### Scenario 2

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient.

#### Minimally acceptable documentation:

Initial or Follow-up Visit: "I was present with Dr. Resident during the history and exam. I discussed the case with Dr. Resident and agree with the findings and plan as documented in his/her note."

Follow-up Visit: "I saw the patient with Dr. Resident and agree with his/her findings and plan."

### Scenario 3

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical/key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical/key portions of the service, and participated in the management of the patient. The teaching physician should reference the resident's note.

#### Minimally acceptable documentation:

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with Dr. Resident and agree with Dr. Resident's findings and plan as documented in his/her note."

Following are examples of unacceptable documentation:

- "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;
- A legible countersignature or identity alone.

If there is a change of clinical service during patient's hospitalization, there should be a faculty note in the chart indicating assumption of care. The physician's orders should state that the patient is being transferred from Service A to Service B and the effective date of the transfer.

### **C. Consultations**

Consultations are billable only if requested by a faculty member, not a resident, and documented appropriately in the medical record with a written request signed by the teaching physician.

The intent of the consultation must be to give advice or render an opinion. A consultation must include the review of the patient's history and the examination of the patient, as well as a separate written opinion or recommendation reflective of the consultant's medical decision making.

The medical record must clearly demonstrate the actual services provided by the faculty member and all notes must be detailed enough to support the level of care for which payment is being sought. Brief statements by the consulting physician such as "examined and concur" or "patient seen and I concur" are NOT adequate documentation. The note should indicate the name of the faculty physician requesting the consultation.

### **D. Surgery**

A charge may be made for the surgery when:

1. The surgery is actually performed by the faculty physician acting as chief surgeon; OR
2. The faculty physician who qualifies as a "teaching physician" is present in the operating room during the critical/key portion of the procedure. Presence may not be required during opening and closing. The teaching physician must be immediately available during the entire service (in or near the operating room). During endoscopic procedures, the teaching physician must be present during the entire "viewing portion" of the scope—from the insertion of the scope to the removal.

The operative report/procedure record must show:

1. The faculty physician EITHER
  - A. Actually performed the surgery; OR
  - B. Was present and supervised the critical/key portion of the procedure as performed by the house staff.
2. The operative report and the medical record are signed by the teaching physician. This signature represents that the faculty member personally performed the surgery or was present and supervised a procedure performed by a resident. The report should explicitly state that the teaching physician was present during critical portion of the procedure. The critical/key portion must be defined in the operative note.

3. A note must be written by the faculty member stating the reason for the performance of the procedure.

Billing for the global surgical fee requires that the surgery be performed or supervised as outlined above and that the faculty physician examine the patient preoperatively and postoperatively and document the record accordingly. A personal note by the faculty physician is required, and cosignatures are NOT adequate. Post-op notes should demonstrate continuing care of the patient. Another surgeon may cover post-operatively for the billing surgeon without generating an additional charge.

Medicare will not make payment for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a resident or fellow available to perform the services unless exceptional medical circumstances exist. Exceptional circumstances, such as emergency, life-threatening situation involving multiple traumatic injuries requiring immediate treatment, would constitute an exception to this policy.

#### **E. Anesthesia**

Charges for anesthesiology services are submitted based upon base units derived from the type and relative complications of the surgical procedure and the underlying patient disease and time units (10,15, or 30 minute time units). The derived total value units are converted to a dollar charge by multiplying by a unit charge that is arrived at by comparison to usual and customary charges within the community as well as individual practice requirements. Reimbursement is based upon the method of the service provided and the specific payor/directive agreement. There are two methods of providing services:

1. those personally provided by the faculty anesthesiologist, and
2. those provided concurrently (two to four cases) as a teaching anesthesiologist/medical direction services to more than one patient (some services being provided by a resident or a CRNA).

The anesthesia record must be signed by the faculty member for each case performed.

#### **Personally Provided Services:**

The faculty anesthesiologist may bill for cases in which he/she personally documents that the following services were provided:

- performs a pre-anesthetic examination and evaluation
- prescribes the anesthesia plan
- performs the procedures

- remains physically present during the entire procedure, and
- provides post-anesthesia care

One resident or nurse anesthetist may or may not be involved in this type of patient care, the defining condition being that the services are provided on *one patient only* for the entire time of the anesthesiology service and that the anesthesiologist remains physically present during the entire procedure. Charges are submitted in full-time units (10 and 15 minute time units).

### **Teaching Anesthesiologist/Medical Direction Services:**

A faculty anesthesiologist will establish a teaching anesthesiologist relationship with each patient. He/she will personally examine the patient, be present at the induction and emergence, and perform other activities (with respect to the distinct segment of the patient's treatment) which distinguish a teaching anesthesiologist relationship, including the performance and documentation of pre and post-anesthesia care. The faculty anesthesiologist may, in these cases, bill for the supervision of such procedure performed by a resident or CRNA.

The portion of the charge derived from time units is submitted based upon a directive/agreement with specific groups of payors. In most cases, there will be *more than one patient* being cared for concurrently.

When anesthesia care is provided by a resident or CRNA, the time units will be submitted based on modifiers for concurrent care as dictated by the payor's guidelines.

The usual method of practice is supervision of not more than two rooms per anesthesiologist. Even under the most emergent or unusual circumstances, medical direction of more than four concurrent procedures will be paid based on the relative value unit and one (1) time unit.

The anesthesiologist must:

- perform the pre-anesthetic examination and evaluation
- prescribe the anesthesia plan
- personally participate in the most demanding procedures in the anesthesia plan (including the induction and emergence)
- insure that all procedures are performed by a qualified individual
- monitor the course of anesthesia administration at frequent intervals
- remain physically present in the operating room suite and be available for immediate diagnosis and treatment of emergencies, and
- provide indicated post-anesthesia care

An anesthesiologist who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot be involved in furnishing additional services to other patients. If the anesthesiologist leaves the operating suite (not available

to respond to immediate needs of the surgical patients), the physician's services to the surgical patients are supervisory in nature and not billable.

The anesthesia records, as well as the pre-anesthesia exam and appropriate post-anesthesia care, must be signed and dated by the faculty member. It is not necessary that the same faculty member provide and document notes for each of these criteria, but the medical record must indicate that the services were furnished by a faculty member and identify the faculty member who rendered them. Faculty are required to sign the record and notes. They are also required to document on the patient's status.

#### **F. Diagnostic Surgical Procedures/Therapeutic Procedures**

Documentation for procedures must clearly indicate that the faculty member personally performed or functioned as the patient's teaching physician and was present in the room at the furnishing of services. If the service was performed by a chief resident or fellow with a faculty appointment, see the attached policy governing their billing.

Documentation should indicate the involvement of the faculty member in the performance of the services. A co-signature or brief note, such as "examined and concur" is NOT adequate.

#### **G. Exception to the Physical Presence Requirement**

Teaching physicians providing E/M services with a GME program granted primary care exception may bill Medicare for the first three levels of E/M services, for new and established patients, provided by residents. Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. To qualify for the exception, all the following criteria must be met:

1. The services must be furnished in an outpatient center or other ambulatory entity;
2. Residents must have completed six months of a GME approved residency program;
3. No more than four residents may be directed at any one time;
4. Patients must be an identifiable group who consider the center as their source of continuing health care;
5. The teaching physician must not have other concurrent responsibilities (including the supervision of other personnel) at the time and must be immediately available;
6. The teaching physician has the primary medical responsibility for patients cared for by the residents;
7. The teaching physician ensures that services are appropriate to the patient's need, are reasonable and necessary;
8. The teaching physician reviews the resident's care provided by the resident during or immediately after the patient's visit;

9. The teaching physician documents the extent of his/her participation in the services. Under the exception rule, the teaching physician must still write a personal note that indicates he/she: Reviewed patient-specific information from the resident's history, exam and plan of care as well as any labs/tests/records/etc., and that the review occurred with the resident while the patient was still in the clinic or immediately after the resident saw the patient. If the review does not occur within these parameters, the service is not billable.

Phrases such as “Discussed and agree with resident’s assessment and plan” are not adequate for billing purposes.

## **H. Pathology/Radiology Services**

The services performed by the faculty member would have to be meaningful from the point of view of patient care and not merely a pro forma review of the report for purposes of authorization, validation, or teaching.

Radiologists and Pathologist must:

1. Personally perform the service or review the interpretation of a pathologic or radiologist examination or procedure with a resident prior to the release of the report for use by physician and as a permanent part of the medical record.
2. Participate in complex procedures to the degree necessary to assure optimal quality and appropriately supervise residents carrying out any procedures. Be present for the key portion of studies where procedural codes are used. Either resident or teaching physician will document the teaching physician’s presence in near proximity throughout the procedure in order to bill a procedure code (i.e., a non-70000 series CPT code).

The interpretation should be signed and dated by the faculty member as evidence of this personal involvement. The report should explicitly state that the teaching physician was present.

## **I. Psychiatry**

The teaching physician can fulfill the physical presence requirements by concurrent observation via a two-way mirror or video camera for the entire session, followed by immediate consultation with the resident. Review after the service is over is not sufficient for the teaching physician to submit a bill. The teaching physician must be “present” during the entire therapy session in order to bill.

## **J. 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, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is 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.

## **K. Billing for Chief Residents and Fellows**

1. Medicare Part A reimburses the hospital for Medicare's share of reasonable cost of training residents and fellows.
2. Residents, chief residents, and fellows in approved training programs may not bill for their professional services to Medicare Part B or Medicaid, at the level for which they are being trained.
3. Physicians currently classified as chief residents and fellows in non-formal training programs may be classified as faculty at the rank of instructor or higher. Faculty may bill Medicare Part B and Medicaid for their professional services.

## **L. Billing for "Moonlighting" Residents and Fellows**

Residents and Fellows in approved training programs, who, pursuant to a written contract, perform professional services that are not related to their training program, and perform those services in an outpatient department or emergency department of a hospital in which their training program is located may bill for their services if:

1. The services are identifiable physician services and meet the appropriate conditions for payment: and
2. The physician is fully licensed to practice medicine; and
3. The services performed can be separately identified from those services required under the training program

A "Teaching Physician" may not bill for services provided by "Moonlighting" Residents and Fellows.

## **II. MEDICAID GUIDELINES**

### **Personal Supervision vs. Direct Supervision**

Physician services include those reasonable and medically necessary services ordered and performed by a physician or under the personal supervision of a physician that are within the scope of practice of his profession as defined by state law. The physician must examine the patient, make a diagnosis, establish a plan of care, and

document these tasks in the appropriate medical records for the patient before submitting claims. If such documentation is not present in the appropriate medical record, then any payment made may be recouped. The services are covered whether furnished in the office, patient's home, hospital, nursing facility, or elsewhere. To be payable by Medicaid, the services must be performed by the physician personally or by a qualified person working under the personal supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided.

If the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient in a teaching setting as an approved and accredited training program by the appropriate accreditation agencies, the physician's services are covered. For major surgical procedures and other complex and dangerous procedures or situations, the attending physician must be physically present during the procedure or situation to provide personal and identifiable direction. If personal and identifiable direction is not provided or is not appropriately documented, any payment for services may be recouped. The attending physician must demonstrate that personal and identifiable direction was provided by following the criteria below:

- Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after the patient's admission and before the patient's discharge.
- Confirming or revising the patient's diagnosis
- Ensuring that any supervision needed by the interns or residents is provided
- Making, in the patient's medical record, appropriate daily documentation of the task identified above before submitting the claim.

Approved, MSRDP Board 06/26/96