PHYSICIAN AT TEACHING HOSPITALS

PURPOSE:

The purpose of this policy is to set forth the Teaching Physician (TP) and resident documentation guidelines to bill for services conducted in the Emergency Department.

POLICY:

The Centers for Medicare and Medicaid Services (CMS) ruling, effective, July 1, 1996 requires the presence of a TP during key portions of the patients’ examination to receive Medicare Part B payment when a resident is involved in patient care.

- The TP must be present during the key portion of the patient’s visit. (The key portion, identified as the three elements below, determines the evaluation and management level of service to be billed).

The following 3 elements must be documented in the medical record by the TP to bill the E/M level:

1. HISTORY

   History of Present Illness (HPI)/Review of Systems (ROS)/ Past, Family, Social History (PFSH); Example: “I reviewed Hx and agree” or “disagree and why”. Please note: The ROS and Hx agree” or “disagree and why”. Please note: The ROS and PFSH may be taken by the resident and reviewed and referenced by the TP.

2. EXAM

   Documentation must describe TP’s performance of key element of exam;
   Example: “My exam reveals…”

3. MEDICAL DECISION-MAKING

   (MDM) – Documentation must include assessment of diagnosis / plan of care.

In order to bill for the CPT procedures the following must be documented.
1. SURGICAL

Documentation must support TP’s presence during the key portion of the procedure;
Example: “I was present during the _______ (laceration/surgical procedure)’’.

In an effort to capture the information necessary for completion of the above elements CMS has approved use of a template which when completed will fulfill the requirements for evidence of TP participation. EmCare has adopted the use of a template in the form of an attestation stamp. EmCare billing and coding subsidiaries must utilize an attestation when coding or billing for hospital contracts that use residents. An equivalent format or chart section utilized by the hospital may serve as a substitute for the stamp. However, this format or chart section must be separate and distinct for the TP.

PROCEDURE:

The level of evaluation and management service will be determined by the extent of the TP’s participation and documentation of the key elements of the history, physical examination, and medical decision making. The resident may document in the medical record, but the TP must reference the key elements. When the TP repeats key elements of the service previously provided and documented by the resident, the TP’s documentation may briefly summarize confirmation or revision of key elements of the service as listed below:

- Relevant history of present illness and prior diagnostic tests.
- Major findings of the physical examination.
- Assessment, clinical impression or diagnosis.
- Plan of Care.

When all required elements of the service are obtained by the resident in the presence of or jointly with the TP and documented by the resident, the resident’s note should reflect the level of the TP’s direct involvement in observation, performance and personal input into the key elements as listed above. The TP’s documentation would then be limited to confirmation of each component of the resident’s documentation and evidence of the personal involvement and presence during the service. The combination of the TP and resident entries would determine the overall level of service performed.

When selected elements of the service are obtained by the resident independently and the TP repeats one or more of the key elements for which the TP was not physically present, the TP’s documentation must include a summary, revision or confirmation of the resident’s findings for the service for which the TP was not physically present and a discussion of the key elements
provided personally by the TP. The combination of the TP and resident entries would determine the overall level of service.

**Under no circumstances will only the TP’s countersignature of resident’s notes be considered evidence of TP involvement in patient care.**

**Attestation**

In an effort to capture the information necessary for completion of the above elements, CMS has approved use of a template which when completed will fulfill the requirements for evidence of TP participation. EmCare has adopted the use of a template in the form of an attestation stamp. EmCare billing and coding subsidiaries **must utilize an attestation** when coding or billing for hospital contracts that use residents. An equivalent format or chart section utilized by the hospital may serve as a substitute for the stamp. However, this format or chart section must be separate and distinct for the TP. A description of the attestation stamp and the methods for completion follows:

**Briefly, pertinent history is:** The statement which includes either a revision of the resident’s entry or a brief note reiterating the pertinent historical findings that have been reaffirmed with the patient.

**Example:** Resident HPI notes “a patient with chief complaint of abdominal pain and vomiting after breakfast”. TP confirmation includes, “Vomiting coffee ground material”.

**My exam of patient reveals:** Comments may tie in personal observations with resident’s note regarding major findings. These may be recorded here and/or in the line below.

**Of note is:** This may be a continuation of the previous note.

**Example:** For the patient who presented with abdominal pain and vomiting, resident note included “abdomen with tenderness in the mid epigastrium on deep palpation. No guarding or rebound, + distention”. TP note affirms “abdominal distention with + BS, G-tube + for black liquid return”.

**Lab and ancillary studies show**: Document those positive or negative findings which contributed toward establishing your clinical impression.

**Example:** “Chest x-ray with right pleural effusion”.

*This section does not pertain for those patients in which testing was not warranted.

**I confirm the diagnosis of:** This often will be the same as that written by the resident.
Example: The case study used above showed both the resident’s and TP’s documentation to include “Fecal impaction with GI bleed”.

Care plan reviewed. Patient will need Documentation to include a brief global statement of intent. Writing “ICU admit” is appropriate or “antibiotics with LMD follow-up” would also complete this section.

The attestation must be signed by the TP.

The TP/Resident Guidelines for Surgical, High Risk and Complex Procedures

For surgical, high risk and complex procedures, the TP must be physically present for all key portions and immediately available to provide service throughout the entire procedure for which payment is sought. This would mean that the TP must not be involved in other procedures from which he or she will not return. The procedure includes all related preoperative, operative and post operative care of the patient. The TP, resident or operating room nurse, may document the physical presence of the physician for the procedure.

For overlapping surgeries, documentation must illustrate the TP’s presence during the key portion of both. The TP must enter the documentation of the TP’s presence in the key portion of both.

TP/Resident Guidelines for Minor Surgical Procedures

Minor surgical procedures such as simple suturing are common in the emergency department. The TP must be present for the entire procedure for which payment is sought.

The TP Guidelines for X-Ray Interpretations

Payment will be made for interpretations performed by a physician. If the resident prepares and signs the interpretations, the TP must indicate his/her personal review and interpretation through agreement or revision of the resident’s findings.

The TP Guidelines for Critical Care

The TP must be present for the entire time of the care of the critically ill or critically injured patient for which payment is sought. The minimum personal attention requirement for the TP’s attention in order to bill for Critical Care is 30 minutes excluding any time spent performing additionally billable procedures, e.g. intubation, CPR, laceration repair, etc. The time spent by the resident can not be considered part of the TP’s critical care service.