

## **MEDICARE PART B TEACHING PHYSICIAN POLICY**

### BACKGROUND

Under Medicare Part A, direct and indirect Graduate Medical Education (GME) payments to teaching hospitals cover the services of residents and the cost of supervising and training residents. On average, teaching hospitals receive approximately \$100,000 per resident. In addition, Medicare makes separate Part B payments to teaching physicians when they personally treat their own patients. Medicare policies recognize that teaching physicians often involve residents in the care of their patients. Medicare Carriers Manual section 15016 outlines the requirements of the Part B teaching physician policy.

### QUESTIONS

Recently, the supervision and documentation requirements of section 15016 have come under scrutiny. In fact, this topic is one of the seven issues of the Physician Regulatory Issues Team (PRIT). Therefore, section 15016 is being revised to clarify and simplify the policy. In particular, the illustrations of the three ways teaching physicians are involved in the services rendered by residents have been revised. More importantly, examples of acceptable and unacceptable documentation have been included. For comparison purposes, the clinical illustrations currently described in section 15016 and the respective draft revisions are attached.

- (1) Do the revised scenarios accurately reflect current clinical situations involving residents and teaching physicians?
- (2) Do the examples of documentation accurately reflect current documentation practices of teaching physicians?

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### **EXCERPTS FROM CARRIERS MANUAL SECTION 15016:**

(1) Illustration 1.--All required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service. If no resident has seen the patient, the physician should document on the same basis he or she would document an E/M service in a nonteaching setting. If a teaching physician's service follows a resident's service, then the teaching physician's documentation should refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family social history in the case of an initial hospital service. However, the teaching physician would have to examine and question the beneficiary to verify the key findings of the resident's notes since he or she was not present during the resident's interaction with the beneficiary.

(2) Illustration 2.--All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the resident's note may document the teaching physician's direct observation, performance, and personal input into the key elements. The teaching physician's personal documentation may be limited. At a minimum, it must include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. The combination of entries must be adequate to substantiate the level of service required by the patient.

(3) Illustration 3.--Selected required elements of the service, for example, history and physical examination are obtained by the resident independently. The teaching physician repeats the key elements of the examination. These elements are discussed with the resident either prior to or after the teaching physician's personal service. In this situation, the resident's note may document the teaching physician's input into the history and medical decision making. The teaching physician's note must include summary comments that revise or confirm the findings of the resident's physical examination and discussion of the history and medical decision making. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

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### EXCERPTS FROM DRAFT REVISIONS TO SECTION 15016:

Scenario 1.--All required elements are obtained personally by the teaching physician without the resident present. If there is no resident's note, then the teaching physician must document on the same basis as he/she would document an E/M service in a non-teaching setting. If there is a resident note, then the teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may refer to the resident's note and the combination of entries must be adequate to substantiate the level of service required by the patient.

Scenario 2.--All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and the resident documents the service. The teaching physician must document his/her presence during the performance of the critical or key portion(s) of the service and the teaching physician's input into management of the patient. The teaching physician may refer to the resident's note and the combination of entries must be adequate to substantiate the level of service required by the patient.

Scenario 3.--The resident provides some or all of the required elements of the service in the absence of the teaching physician and documents the service. The teaching physician performs the critical or key portion(s) of the service in the absence of the resident and discusses the case with the resident either prior to or after the teaching physician's personal service. The teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may refer to the resident's note and the combination of entries must be adequate to substantiate the level of service required by the patient.

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Following are examples of minimally acceptable documentation:

### Scenario 1

Admitting Note: "I performed a complete history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. Patient seen and evaluated. Agree with findings and plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. Patient seen and examined. Agree with the resident's note except that I believe the heart murmur is louder and will obtain an echo to evaluate."

### Scenario 2

Initial or Follow-up Visit: "Present with resident during history and exam. Case discussed with resident. Agree with findings and plan as documented in the resident's note."

Follow-up Visit: "Patient seen with resident. Discussed. Agree with resident's findings and plan."

### Scenario 3

Initial Visit: "Patient seen, evaluated, and discussed with resident. Resident's note reviewed. Agree except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "Patient seen and evaluated. Discussed with resident. Agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the residents finding and plans as written."

Follow-up Visit: "Patient seen and evaluated. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Following are examples of unacceptable documentation:

"Agree with above."

"Rounded, Reviewed, Agree."

"Discussed with resident. Agree."

Note that it is not possible to infer from any of these notes whether the teaching physician was present, evaluated the patient, or had any involvement with the plan of care.