MEDICAL SERVICE RESEARCH AND DEVELOPMENT PLAN AND UT PHYSICIANS

BILLING AND DOCUMENTATION GUIDELINES

UTHealth
The University of Texas
Health Science Center at Houston
# MEDICAL SERVICE RESEARCH AND DEVELOPMENT PLAN AND UT PHYSICIANS
## BILLING AND DOCUMENTATION GUIDELINES

### INTRODUCTION

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### MEDICAID GUIDELINES

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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. Increasingly, written documentation is also used for other purposes, including medical-legal review, support for clinical research, and quality assurance.

Importantly, 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 billing and documentation guidelines to meet the requirements of Medicare. Payors differ in funding source (i.e., federal, state, commercial, and private), in payment structure (i.e., fee for service, discounted fee for service, capitation), in process (i.e., primary care provider, pre-certification, etc.) and in documentation requirements (i.e., 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 reduces faculty medical-legal exposure.

While the complete guidelines for each individual payor 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 Centers for Medicare & Medicaid (CMS) is a frequent payor for the overall practice plan, this document will discuss CMS guidelines in some detail. Unless otherwise directed by the MSRDP Board, physicians MUST follow CMS 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 Medicare requires meets the requirements of most payors, and shall be used.
MEDICARE GUIDELINES

MEDICAL NECESSITY

Medicare pays for services that are “reasonable and medically necessary” for the diagnosis and/or treatment of an illness or injury or a malfunctioning body member.

REASONABLE AND NECESSARY SERVICES

Services and items considered “reasonable and medically necessary” must be established as:

a. Safe and effective;
b. Consistent with the symptoms and/or diagnosis of the illness or injury under treatment;
c. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational or procedures where an assistant at surgery is ordinarily not necessary);
d. Not furnished primarily for the convenience of the patient, the attending physician, other physician or supplier; and
e. Furnished at the most appropriate level of care.

UNREASONABLE AND MEDICALLY UNNECESSARY SERVICES

Services and items considered “unreasonable and medically unnecessary” include those that are:

a. Not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used;
b. Not proven to be safe and effective based on authoritative evidence;
c. Experimental;
d. Not medically necessary in the particular case;
e. Furnished at a level, duration, or frequency that is not medically appropriate;
f. Not furnished in accordance with accepted standards of medical practice; or
g. Not furnished in a setting appropriate to the patient’s medical needs and conditions.

TEACHING PHYSICIAN GUIDELINES

DEFINITIONS

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.

A teaching physician may bill for services provided to a patient under three circumstances:

1. The faculty personally provides identifiable services to the patient without involving a resident; or
2. The faculty was physically present during the critical or key portions of the service furnished by a resident; or
3. Certain evaluation and management (E/M) services furnished by a resident under the conditions outlined below.

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 resident is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term resident, according to Medicare, also includes interns and fellows in the GME program. Residents will not be patients’ main physicians.

Medical students may never evaluate or treat patients independently.

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**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 may not submit a bill. Recognition of the doctor-patient relationship should be demonstrated in the medical record. 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 physician must meet each of the following:

a. Review the patient’s history, the record of examinations and tests, and make frequent reviews of the patient’s progress;

b. Be physically present during the key portions of the service or procedure, except as specified below (see Section I – Primary Care Exception);

c. Confirm or review the diagnosis with the resident and determine the course of treatment to be followed;

d. 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;

e. Be present and ready to perform any service when a major surgical procedure is performed;

f. Be recognized by the patient as his/her physician and be responsible for the continuity of the patient’s care; and

g. Make sure that medical records are complete, accurate, legible and properly documented according to guidelines to support the level of service billed.

Only those services provided by the teaching physician that meet the above criterion and those below constitute billable services.

Claims for teaching physician services involving a resident must include a GC modifier for each service, unless the service is furnished under the primary care center exception. When a physician (or other
appropriate billing provider) places the GC modifier on the claim, he/she is certifying that the teaching physician was present during the key/critical portion of the service, and was immediately available during the other parts of the service.

EVALUATION AND MANAGEMENT SERVICES: INPATIENT/OUTPATIENT

To bill for evaluation and management services, including office visits, hospital care, and follow-up care, the teaching physician must personally document in the medical record his/her presence during the portion of the service that determines the level of service billed.

The composite of the attending physician and the resident’s documentation must support the level of service reported and must include:

1. A notation by the teaching physician that he/she personally examined the patient or was physically present during the key or critical portions of the service and discussed the patient’s condition, history, and medical decision making with the resident before the end of the patient encounter;
2. A notation by the teaching physician referencing the resident’s name, when more than one resident has documented in the medical record for the same patient/same and date of service.

Inpatient Documentation Daily Entry Example: Day 1

Entry 1- Orthopedic Resident adds an entry regarding primary treatment for a hip fracture. The patient also has Diabetes.

Entry 2- Orthopedic Fellow also adds an entry regarding hip fracture

Entry 3- Internal Medicine Resident and Attending add an entries regarding Diabetes

Entry 4- Orthopedic Attending Physician’s entry may only reference one of the resident’s documentation he/she wishes to use as a composite for billing purposes.

The appropriate elements of history, examination, and medical decision-making must be documented in the medical record. These “elements” are those that, in the judgment of the teaching physician, best summarize as:

a. The relevant history, physical examination and prior diagnostic tests;
b. Assessment, clinical impression, or diagnosis; and
c. Plans for care.

Co-signatures and brief statements by the teaching physician, e.g., "examined and agree" or “patient seen and I concur” are not adequate documentation.

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

CONSULTATIONS
Consultations are billable only if the following three conditions are met:

1. The requesting physician or appropriate source must document the reason/need for the consultation in the patient's medical record (i.e. patient's plan of care, progress note, physician orders, or consult request form) with a signature by the requesting physician/appropriate source.
2. The consultant is required to document the requesting physician/service and the reason for consultation in the patient's medical record.
3. The consultant is also responsible for preparing and providing a written/dictated report of his/her findings and recommendations to the requesting physician.

A consultation must include the review of the patient's history and the examination of the patient, as well as a 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. The consultant’s note should indicate the name of the faculty physician/service requesting the consultation. Brief statements by the consulting physician such as, “examined and concur” or “patient seen and I concur” are not adequate documentation.

INITIAL HOSPITAL CARE

For the purpose of payment, initial hospital care (in-patient hospital admission) services billed by teaching physicians must satisfy the following conditions:

1. Documentation must include the required three key components (i.e.: history, examination, and medical decision-making) and must meet or exceed the stated requirements in the Current Procedural Terminology (CPT) to qualify for one of the three levels of service.
2. The teaching physician’s documentation must satisfy the teaching physician requirements, as previously stated.

LATE-NIGHT ADMISSIONS

Although a rarity, late night admissions may occur. In the event a resident admits a patient during the late hours of the night, and the teaching physician does not see the patient until later, including the next calendar day, then collaboration of the teaching physician’s documentation and the resident’s note will be contingent upon all of following conditions:

a. The teaching physician’s note must meet the teaching physician requirements.
b. The teaching physician’s note must reference the resident by name. The date of service he/she each saw the patient must be documented (electronically or hand-written) for the entry being used to support the service.
c. The teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may reference the resident’s note in lieu of personally documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history, as long as the patient’s condition has not
changed, and the teaching physician agrees with the resident's note. Or, the teaching physician may personally document the service s/he personally performed.

d. If there are changes in the patient's condition and clinical course at the time the patient is seen personally by the teaching physician, the teaching physician's note must reflect those changes.

e. The teaching physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the teaching physician's and resident's documentation satisfies criteria for a higher level of service. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

If any of the conditions listed above are not met, the level of service will be based solely on the teaching physician's documentation.

Example: “I saw and evaluated the patient on September 1, 2011. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

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**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) portions of the procedure; AND
3. The operative report/procedure record shows 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.

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**TEACHING PHYSICIAN PRESENCE**

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 removal.

When the operative report and the procedure record are signed by the teaching physician, this signature indicates the teaching physician 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.

There must be a note in the patient’s medical record stating the reason the procedure is being performed.

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**GLOBAL SURGERIES**
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 co-signatures are not adequate. Post-op notes should demonstrate continuing care of the patient. Another surgeon may cover post-operatively for the billing surgeon with no additional charge generated.

**ASSISTANT-AT SURGERY**

Assistants at surgery shall be used appropriately and in compliance with CMS policy. All surgeons are responsible for appropriately utilizing assistant-at-surgery services within the professional scope of service. Assistant at surgery services shall be used only when the procedure warrants their use and it is a covered procedure by the Medicare Physicians fee schedule.

When qualified residents are available to perform as assistants at surgery, they will be utilized in that capacity.

One of the following criteria must be met for a UTHealth physician to act as the assistant at surgery:

1. All residents are engaged in patient care or educational activities or are otherwise not physically available to assist, or
2. The residents who are available to assist are not qualified to assist in that procedure, or
3. Individuals who have not finished their residency are never qualified to assist in a specific procedure, or
4. There are exceptional medical circumstances (defined below).

When another attending physician, physician assistant, nurse practitioner, nurse midwife, or clinical nurse specialist provides assistant at surgery services, append the following statement to the operative note, indicating by the surgeon’s attestation that a qualified resident was unavailable:

“I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.”

**MODIFIERS FOR ASSISTANT AT SURGERY**

**Modifier -82:** When a qualified resident is unavailable and it is appropriate within the scope of the surgical service provided to utilize another faculty/attending physician for that service, append the Modifier -82 to their surgical service reporting data.

**Modifier –AS:** When a qualified resident is unavailable to provide assistant at surgery service and the procedure warrants an assistant at surgery and the assistant bears the designation of physician assistant, nurse practitioner, nurse midwife or clinical nurse specialist, a non-physician practitioner may bill as an assistant at surgery and must append the –AS modifier.
If the person who assists at surgery is a surgical technician, a first surgical assistant, scrub nurse or bears any other title than those listed, the service is not payable by Medicare and is not billable to the patient.

Exceptional Circumstance

In certain instances, an assistant-at-surgery may be paid, as an exception to the above rules:

a. A documented exceptional medical service (i.e., emergent service, multiple trauma);
b. When a physician has a written, across the board, policy never to engage the use of resident services (typically not a surgeon involved in GME training services); or
c. Complex medical procedures requiring a team of surgeons (i.e., transplant services, coronary bypass procedures)

MINOR PROCEDURES

For procedures that take only a few minutes (five minutes or less) to complete, e.g. simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

ANESTHESIA

Anesthesia services are billed based on a basic unit value derived from the type of surgical procedure performed plus time units in 15-minute increments plus modifying units. The derived total 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.

An anesthesiologist may either:

1. “Personally Perform” the anesthesia service, either alone or with one Certified Registered Nurse Anesthetist (CRNA) or resident;
2. “Medically Direct” between two and four concurrent anesthesia procedures involving CRNA’s or residents; or
3. “Medically Supervise” anesthesia procedures involving more than four concurrent cases or involving fewer than four procedures during which the anesthesiologist is performing other services while directing concurrent procedures.

PERSONAL PERFORMANCE (ALONE OR WITH ONE RESIDENT OR CRNA)

The faculty anesthesiologist may bill for cases in which:

1. He/She personally performs the procedure alone;
   a. When both the anesthesiologist and a CRNA are involved in a single procedure; or
   b. When both the anesthesiologist and a resident are involved in a single procedure.

The anesthesiologist must be continuously and personally present throughout the entire procedure. The Anesthesiologist cannot be involved in providing any other anesthesia services.
The teaching anesthesiologist must document in the medical record that he or she was present during all critical (or key) portions of the procedure, including induction and emergence and physically present for diagnosis and treatment of emergencies. The teaching physician’s presence is not required during pre and post-op visits.

**MEDICAL DIRECTION (TWO, THREE, OR FOUR CASES)**

The faculty anesthesiologist may bill for medical direction when medically directing two, three, or four concurrent cases involving CRNA’s or residents. Medical direction is a covered service only if the anesthesiologist performs the following seven services:

1. Performs a pre-anesthesia examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures of the anesthetic plan, including induction and emergence;
4. Ensures that any procedures in the anesthetic plan that the anesthesiologist does not perform are performed by a qualified individual;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated post-anesthesia care.

All seven of these services noted above must be provided and documented or the anesthesiologist has not provided medical direction and may not bill for medical direction services. An anesthesiologist who is medically directing concurrent anesthesia procedures cannot be involved in furnishing additional services except for the following:

- Addressing an emergency of short duration in the immediate area;
- Administering an epidural or caudal anesthetic to a laboring patient;
- Performing periodic rather than continuous monitoring of an OB patient;
- Receiving patients entering suite for the next surgery;
- Checking on or discharging patients in the PACU;
- Coordinating scheduling matters.

The teaching anesthesiologist must perform all services required for medical direction.

The patient’s medical record must reflect that the anesthesiologist performed each of the steps required for medical direction. The anesthesiologist must specifically document that he/she performed the pre-anesthesia examination/evaluation, was present during the most demanding procedures (including induction and emergence where applicable), monitored the course of anesthesia at frequent intervals, remained physically present in the Operating Room Suite, and provided indicated post anesthesia care.

**MEDICAL SUPERVISION**

If an anesthesiologist is medically directing five or more overlapping cases, the service must be billed as medical supervision. Supervision is reimbursed based on the basic value unit of the procedure and one
time unit, if anesthesiologist can document he/she was present at induction. Medicare does not recognize medical direction by anesthesiologist if he/she is involved in more than four concurrent procedures. Anesthesia charges are submitted with modifiers to indicate concurrent care as dictated by the payors’ guidelines. Medicare billing rules are very specific with regard to the requirements for billing for medical direction and the exceptions to those requirements. Other federal health care programs, private carriers, and managed care organizations have not imposed the same billing rules for anesthesia services.

**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.

Documentation should indicate the involvement of the faculty member in the performance of the services. A co-signature or a brief note, such as, “I examined and concur, appended to the resident’s note is not appropriate.

**EVALUATION AND MANAGEMENT SERVICES – PRIMARY CARE EXCEPTION RULE**

There is one exception to the physical presence requirement of the teaching physician and it applies only to primary care centers and only to the first three levels of new and established patient evaluation and management services. To qualify for the exception, all the following criteria must be met:

1. The service must be furnished in an outpatient center or other ambulatory entity;
2. Residents must have completed six months of training;
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 at the time;
6. The teaching physician assumes the management of patients seen by the resident;
7. The teaching physician ensures that services are appropriate to the patient’s need;
8. The teaching physician reviews the resident’s decision making with the resident during or immediately after the patient’s visit;
9. The teaching physician documents the extent of his/her participation in the services;
10. Physician indicates resident involvement under the direction of a teaching physician by designating the “—GC” modifier on their charge documents; and
11. Physician indicates the primary care exception by designating the “—GE” modifier on their charge documents.

**PATHOLOGY/RADIOLOGY SERVICES**

The services performed by the faculty member must be meaningful as it pertains to patient care, not merely to perform a review of the report for purposes of authorization, validation, or teaching.

Radiologists and pathologists must:
• Personally perform the service or review the interpretation of a pathologic or radiological examination/procedure with a resident prior to the release of the report for use by physician and as a permanent part of the medical record.
• 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 the resident or teaching physician will document the teaching physician’s presence during the procedure. The teaching physician must be present in near proximity throughout the procedure in order to bill a procedural code (i.e., a non-70000 series CPT code).

Interpretation

If the teaching physician’s signature is the only signature on the interpretation, Medicare assumes he/she is indicating he/she personally performed the interpretation of that diagnostic test. If the resident prepares and signs the interpretation, the teaching physician is required to document that he/she personally reviewed the image, the resident’s interpretation, and either agrees or edits the findings. Teaching physician’s co-signature of a resident’s interpretation will not be considered for reimbursement.

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.

TIME-BASED CODES

Time-based procedural/evaluation and management codes are determined by the length of the teaching physician’s presence during the service only. Time spent by the resident in the absence of the teaching physician is not reimbursable.

For example, the resident documents his/her total visit and counseling time with the patient is 60 minutes. The teaching physician total visit and counseling time is 35 minutes. The services would be billed based on the teaching physician’s 35 minutes spent with the patient.

BILLING FOR CHIEF RESIDENTS AND FELLOWS

Medicare Part A reimburses the hospital for Medicare’s share of reasonable cost of training residents and fellows.

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.
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.

BILLING FOR “MOONLIGHTING” RESIDENTS AND FELLOWS

According to a written contract, residents and fellows (in approved training programs) who perform outpatient or emergency department professional services that are unrelated to their training program within the hospital they are trained, may bill for their services if:

a. The services are identifiable physician services and meet the appropriate conditions for payment; and
b. The physician is fully licensed to practice medicine; and
c. 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.

SIGNATURE AUTHENTICATION

AUTHENTICATING AND DATING

This policy is not intended to contradict or replace any rules from affiliated hospitals’ documentation standards. This guidance refers to documentation for billing purposes. The provider may always amend the note for patient care or safety reasons.

Health care providers (authors) must authenticate and date all documentation entered into the medical record in a timely manner. The “printed on” date is not acceptable for partially populated or structured progress notes that require handwritten documentation by the provider for completion.

DEFINITIONS

Author: Any person making an entry or documenting into the medical record.

Entry: All documentation in the medical record including, but not limited to, progress or chart notes, orders, procedures, operative notes, consultations, etc.

Authentication: The signature and credentials/discipline of the author documenting in the medical record.

Signature: The author’s written signature, written initials with a signature stamp, or electronic signature. Use of a signature stamp without written initials is not acceptable.

GENERAL DOCUMENTATION

HANDWRITTEN DOCUMENTATION
Handwritten documentation must be legible, dated, and authenticated with author’s signature and discipline at the time of service by the author.

- Handwritten documentation includes, but is not limited to, the following:
- Handwritten inpatient, structured or template progress notes
- Handwritten consultations
- Handwritten, typed, or structured outpatient progress/chart notes
- Handwritten discharge summaries.

**OUTPATIENT PROGRESS NOTES**

Outpatient progress/chart notes must be documented at the time of service. Dictated notes must be authenticated at the faculty member’s next clinic session or within two weeks (whichever comes first).

**OPERATIVE NOTES**

Operative notes and procedures must be documented directly after completion of the procedure/operation performed and authenticated within 48 hours from the date of transcription unless supervising faculty member is unavailable (e.g. out of town) in which case authentication is expected within two weeks.

**VERBAL ORDERS**

Verbal orders are to be used infrequently and must be documented in the patient’s medical record. The ordering/prescribing physician must sign and date the verbal order within 48 hours of the entry.

**Interpretation At Outlying Locations**

Interpretations of procedures (e.g. cardiac/pulmonary) performed at outlying locations (e.g. LBJ) must be completed and authenticated by the billing provider within two weeks.

**ADMISSION HISTORY & PHYSICAL (H&P)**

H&P’s must be documented and authenticated within 24 hours of the admission by the admitting provider. Due to possible delays with transcription or Electronic Health Record work-flow, the authentication of the record must be completed within 24 hours of the receipt of the note tasked by the resident. The author must include the date of service and time of entry when documenting the H&P.

**CONSULTATIONS**

Dictated consultations must be documented within 24 hours and electronically signed within 48 hours from the date of transcription unless supervising faculty member is unavailable (e.g. out of town) in which case authentication is expected within two weeks.

Handwritten consultations must be documented and authenticated at the time the service was provided.

**DISCHARGE SUMMARIES**
Discharge notes must be documented on the day of discharge and authenticated within 48 hours of performing the service by the attending faculty unless supervising faculty member is unavailable (e.g. out of town) in which case authentication is expected within two weeks.

**ADDENDUM**

Addendum to progress notes must have the current date and reference the date and name of the provider in the previously documented note. (e.g. “This is an addendum to my note dated XXX or to the note of Dr. Resident/Fellow or NPP dated XXX.”)

**RESIDENT SERVICES**

Residents/fellows involved in patient care must document all chart entries prior to leaving the clinic each day.

Inpatient services performed by a resident/fellow must be documented and authenticated at the time of service.

Handwritten (or typed) and structured notes documented by the resident must be authenticated at the time of service.

Dictated notes documented by a resident/fellow must be authenticated at the resident’s next clinic session or within two weeks (whichever comes first).

**NON-PHYSICIAN PRACTITIONERS**

**BILLING OPTIONS**

**DIRECT BILLING**

PAs, NPs, CNSs, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel and under direct physician supervision, they may be covered as "incident to" services, in which case, the "incident to" requirements would apply.

**"INCIDENT TO" BILLING**

For office/clinic (POS 11) services of an NPP to be covered as “incident to” the services of a physician, the services must meet all the requirements for coverage specified within the “incident to” criteria. For example, the services must be an integral, although incidental, part of the physician’s personal professional services and they must be performed under the physician’s direct supervision. “Incident-to” does not apply to Hospital settings (see below).

**SHARED/SPLIT BILLING**

Applies to Hospital Inpatient (POS 21), Hospital Outpatient (POS 22), and Emergency Department (POS 23) settings. When sharing an E/M service with a physician, Shared/Split guidelines apply. All requirements must be met in order to report these services.
“INCIDENT TO” PHYSICIAN SERVICES

Requirements for "Incident To:"

- The services are commonly furnished in a physician’s office.
- The physician must have initially seen the patient.
- Incident to services may only be provided by the NPP when the patient and the problem being addressed are “established”.
- New patients and new problems must be addressed by the Physician first.
- There is direct personal supervision by the physician of auxiliary personnel, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician.
- The physician has an active part in the ongoing care of the patient.

Auxiliary Personnel Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

SUPERVISION REQUIREMENTS

General Supervision - General Supervision - means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.

Direct Supervision – means the physician must be present and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed, but there in the office.

Personal Supervision - means a physician must be in attendance in the room during the performance of the procedure.

DOCUMENTATION REQUIREMENTS

For “incident to” services that are billed and undergoing medical review, documentation sent in response to the carrier’s request should clearly show the link.

Evidence of the link may include:

1. Co-signature or legible identity and credentials (i.e., MD, DO, NP, PA, etc.) of both the practitioner who provided the service and the supervising physician on documentation entries.
2. Some indication of the supervising physician’s involvement with the patient’s care. This indication could be satisfied by:
   a) Notation of supervising physician’s involvement (the degree of which must be consistent with clinical circumstances of the care) within the text of the associated medical record entry; or
   b) Documentation from other dates of service (e.g., initial visit, etc.) other than those requested, establishing the link between the two providers.
Failure to provide such information may result in denial of the claim for lack of documentation from the billing provider.

**SHARED/SPLIT VISITS**

**Office/Clinic Setting** - Please refer to "Incident to" guidelines above.

Hospital Inpatient/Outpatient/Emergency Department - When a hospital inpatient/hospital outpatient or emergency department E/M service is shared between a physician and an NPP from the same group practice, and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's provider number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record), the service may only be billed under the NPP's provider number.

Examples of Shared Visits:

If the NPP sees a hospital inpatient in the morning and the physician (from the same group practice) follows later with a face-to-face visit with the patient on the same day, the physician or the NPP may report the service. Both providers must document and sign their contribution to the service.

In an office setting, the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP’s name and NPI number.

**Skilled and Non-Skilled Nursing Facilities**

Any E&M Service reported with a Skilled Nursing Facility or Non-Skilled Nursing Facility Place of Service must be performed by the billing physician or NPP. Split/Shared E&M visits cannot be reported in the Skilled Nursing Facility or Non-Skilled Nursing Facility settings.
PHYSICIAN SERVICES

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 VS. DIRECT SUPERVISION

PERSONAL SUPERVISION

Personal supervision means that the physician must be physically present in the room when the service is provided. Some services e.g., invasive procedures or evaluation and management services that require complex medical decision-making, may require personal supervision.

Services that will require personal supervision include:

- Services provided to patients that are clinically unstable or likely to become unstable because of a service.
- Planned medical interventions in which there is reasonable risk of significant morbidity/death following the service.
- Services requiring deviation from expected techniques due to foreseeable risk to the patient life/health.

DIRECT SUPERVISION

Direct supervision means the physician must be in the same office, building, or facility when and where the service is provided and immediately available to furnish assistance/direction.

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.

OUTPATIENT SETTING
A face-to-face encounter with the patient is not required by faculty that are providing direct supervision in an outpatient setting in the context of a GME program. This would not apply to services, i.e., E/M services requiring complex/moderate medical decision-making.

For outpatient services, the supervising physician providing direct supervision to a resident must document that he/she has:

1. Reviewed the patient’s history and examination documented by the resident
2. Confirmed/revised the patient’s diagnosis documented by the resident
3. Determined the course of treatment
4. Assured any needed supervision was provided to the resident, and
5. Confirmed the resident’s documentation supports the level of service billed.

INPATIENT SETTING

For services provided in an inpatient setting, the supervising physician must not only comply with the outpatient documentation requirements noted in the above section, but is also required to personally examine the patient 36-hours after admission, before the patient is discharged, and as needed based on the patient’s condition. In addition, the supervising physician is required to have a face-to-face encounter with the patient on any billed services provided by the resident.

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. Moreover, the supervising physician is also responsible for pre-operative, operative, and post-operative care provided to the patient that is billed to Medicaid.

Revised and approved by The University of Texas Health Science Center at Houston MSRDP Compliance and Ethics Committee on July 19, 2011.