

Common Medicare and Medi-Cal Documentation Standard for E/M Services

Medicare and Medi-Cal have different teaching physician rules. Adopting separate documentation standards for the two, to satisfy each, would add complexity to the teaching physician's task yet have no relation to patient care. By adopting a higher standard that incorporates both standards, as done here at UC Davis, documentation is simplified and the risk of billing error reduced. There is a cost, though slight. Certain services that might be billable under one standard but not the other are not billed. At UC Davis, it is rare for a teaching physician to act in a manner such that only one of the two rules is met.

The one divergence to the combined standards for E/M services is the Medicare primary care exception. UC Davis adopts that Medicare standard, but solely for Medicare patients. The primary care exception is not used for billing for Medi-Cal services. On November 22, 2002, Medicare markedly changed the documentation standards for billing for teaching physicians' E/M services. This document explains the changes and describes how the Medicare and Medi-Cal requirements are combined.

While the teaching physician regulation that was effective on July 1, 1996 remains unchanged, the November 2002 revision of the Medicare Carrier Manual Instructions (CMI) makes important positive changes in the documentation requirements by reducing the amount of personal documentation that the teaching physician must provide when a resident also writes a note. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. Further, the revisions address other issues, including:

- the use of documentation by students for determining E/M level (ROS and PFSH only);
- some minor revisions for anesthesia services, endoscopies, surgeries, and the primary care exception (see CMI or the compliance department for more information); and
- increased supervision requirements for time-based psychotherapy codes.

These changes affect our documentation standards for federal and state payers. Documentation standards for billing private payers are unchanged.

Background

In December 1995, HCFA published new regulations effective July 1996 that detailed when a teaching physician could appropriately bill Medicare for patient care services in which a resident also is involved. The regulations were intended to reduce substantially the ambiguities engendered by the previous HCFA guidelines for E/M services. They require, with one narrow exception, that the teaching physician be present to perform or observe the "key portion" of any service or procedure for which payment is sought and provide further guidance on the documentation required in the medical record to substantiate that such services were performed. Soon after the rules were issued, CMS also published a revised CMI to provide additional information needed to implement the new rules. Despite the increased clarity under the new rules and CMI, some of the documentation requirements were considered to be overly burdensome and impeded both the delivery of patient care services and the teaching process.

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CMS has been examining the regulatory burden on physicians and attempting to provide relief when feasible. Over the past year, the Agency has worked with AAMC through the Group on Faculty Practice Steering Committee to identify burdensome aspects of the supervising physician requirements that could be addressed through revisions to the Carrier Manual Instructions rather than through changes in the regulation. The revised CMI should significantly reduce the documentation burden on teaching physicians for E/M services when a resident also is involved in the care of a patient. **It is important to note that with very limited exceptions, a teaching physician still must write a personal note and, unless the service is provided under the Primary Care Exception, must be present for or perform the “key portion” of the service.**

Summary of Revisions

Definitions

Among the definitions that CMS has added to the Carrier Manual Instructions are:

Resident: “The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of “resident”. Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.”

Documentation: “Notes recorded in the patient’s medical record by a resident and/or teaching physician or others as outlined in specific situations regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated and typed or handwritten. Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify at a minimum the service furnished, the participation of the teaching physician in providing the service and whether the teaching physician was physically present.”

Physically present: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

Documentation Instructions for E/M Services and Common Scenarios

Medicare

CMS has clarified that for purposes of payment, Evaluation and Management (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
- The participation of the teaching physician in the management of the patient.

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Medi-Cal

The distinction between the Medicare and Medi-Cal requirements for teaching physicians can be described as follows. Both Medicare and Medi-Cal require that the teaching physician perform some medical service. Medi-Cal requires “direct service”, while Medicare requires “personal service”, generally coupled with physical presence. It is not necessary in all instances for the teaching physician to be physically present to bill Medi-Cal.

“Direct service” for Medi-Cal billing is service by the attending physician that is more than passive supervision, but may be carried out by the hands and mind of the resident and is intended to benefit the patient’s condition. To translate that to an E/M encounter, one would look for active faculty participation in the patient’s care (e.g., contributing to the plan of treatment), not passive teaching supervision, when deciding whether a service can be billed by the teaching physician.

Scenarios

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1:

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.

Where a resident has written notes, the teaching physician’s note may reference the resident’s note. The teaching physician must document that he or she performed the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. 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.

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 or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity and the level of the service billed by the teaching physician.

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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 or 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 or key portions of the service, and participated in the a management of the patient. The teaching physician's note should reference the resident's note. 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.

Following are examples of minimally acceptable documentation for each of these scenarios:

This is minimally acceptable documentation. There are a number of situations in which, for the purposes of patient care, more will be written. Note that the same phrases can be used in scenarios 1 and 3. The documentation below satisfies both the Medicare and Medi-Cal requirements described above.

Scenario 1:

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

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care we made as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate." (NOTE: In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2:

Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan we developed as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan we made."

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Scenario 3:

Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”

Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan we developed 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 resident’s finding and plans we developed as written.”

Follow-up Visit: “I saw and evaluated the patient. 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.” 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; and
- A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

CMS’ view is that, since the documentation burden is markedly reduced, stamps, dictation macros, or preprinted forms cannot be used to produce the linking language for E/M services.

Summary

To add the two notes, your documentation must show that:

- You saw the patient
- You reviewed the resident’s note, and agreed or revised the findings
- You actively participated in the care, by either documenting involvement in the development of the plan or by changing the plan.

Common questions

Q: If a patient is admitted late in the night, what happens when the teaching physician writes a note the next day?

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A: A note the next morning can refer to the prior night's note by the resident. The attending can bill for the admission the day of the attending physician's note, with the level determined by the combination of the two notes.

Q: If a resident performs an eight-point examination, all of which is medically necessary, and the attending repeats the key three points, how many points can be counted in determining the level of E/M service?

A: The combination of the two notes (if properly linked) may be used to calculate the level of service. The attending need not repeat the entire resident's service, only the key elements. However, if part of the resident's service is not medically necessary (e.g., a very extensive write-up for a minor problem), only the medically necessary portion may be billed.

Q: Can more than one teaching physician refer to, confirm, and use a resident's documentation?

A: No. The teaching physician would refer to the note of the resident who is on service with him/her. If it is unclear which resident note the teaching physician is referring to, he/she should clarify that in his/her note.

Q: I have some old forms with preprinted attestations. Can I use those in combination with the new reduced documentation rules?

A: If you use the new style of reduced teaching physician documentation for E/M services, you must not use preprinted "linking language". CMS representatives are very clear on this point.

Please contact the compliance office at 916-734-8808 if you have any further questions. A copy of this information can also be found on the Compliance Website: <http://www.ucdmc.ucdavis.edu/compliance/guidance/coding/>.

RESOURCES:

1. Association of American Medical Colleges. "*Revisions to Medicare Carrier Manual Instructions on Supervising Physicians in Teaching Settings*": <http://www.aamc.org/advocacy/library/teachphys/phys0042.htm>.
2. Medicare Claims Processing Manual, 100-4, Chapter 12, Section 100.1-100.2.
3. Code of Federal Regulations, 42 CFR 415.172(b), 42 CFR 413.78(e)(3)(ii), 42 CFR 415.170.