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Internal Medicine Coding Alert

4 Steps Reduce Denials for Teaching Physician Services

Use these techniques to clarify confusing Medicare guidelines

You can ensure that your internist gets paid for E/M services and minor surgical procedures in a teaching setting if you know the documentation and supervision requirements for Medicare's teaching physician rules.

When your internist works as a "teaching physician" (TP) and supervises a resident's services in an office or hospital setting, you will have to report your physician's work using the teaching physician rules, according to the Medicare Carriers Manual (MCM), section 15016.

The MCM defines residents as an intern or fellow who's enrolled in an accredited graduate medical education (GME) program, says **Marti Geron, CPC, CMA, CM**, coding and reimbursement manager at the University of Texas Southwestern Medical Center at Dallas.

Experts offer four field-tested strategies for reporting E/M services and minor surgical procedures using the teaching physician rules.

1. Report Office Consults Based on 'Key Portions'

You can report E/M codes if the TP personally furnishes the E/M service, such as an office consultation (99241-99245), without the resident present, said **Jillian H. Kuruc, MHA, CPC, CCS-P**, a clinical technical editor with Ingenix Health Intelligence in Binghamton, N.Y., during a session on the teaching physician rules at Ingenix's Third Annual Coding, Billing and Compliance Essentials Conference in Orlando, Fla.

If the resident also performed this E/M service, your internist would have to duplicate the "critical and key portions" of the resident's services to bill under this guideline, Kuruc tells Internal Medicine Coding Alert. The TP should define - and be able to defend - those critical and key portions, she adds.

For example, a patient presents with high blood sugar (790.2x) and disorientation (780.4). The TP identifies the physical examination as the visit's key portion. The resident evaluates the patient. Based on the findings, the resident diagnoses the patient with diabetes (250.xx), recommends oral medication and a weight-reduction plan, and bills for a 99203 (Office or other outpatient visit for the evaluation and management of a new patient ...).

The TP also evaluates the patient, performs an exam, and discusses possible diabetes management options with the patient. Medicare requires that the attending physician only document the he or she performed the office visit's critical portion, and that the physician directly cared for the patient.

Remember that the TP doesn't have to duplicate the resident's progress notes, but should refer to the resident's notes and state that the TP reviewed the resident's medical documentation and agrees with the diagnosis, Geron says.

If the resident did not attend the internist's patient evaluation, and also didn't perform a complete E/M service, your physician must bill and document the office visit as he or she would in a non-teaching setting, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

In other words, to support a 99203 claim, the internist would have to document a detailed history, a detailed examination, and low-complexity medical decision-making, coding experts say.

Tip: Don't forget to attach modifier -GC (This service has been performed in part by a resident under the direction of a teaching physician) to 99203 to ensure that your Medicare carrier knows that you are reporting a service under the teaching physician rules.

2. Document Physician Presence for Critical Care

The internist can also perform an E/M service jointly with the resident, Kuruc says. Suppose a patient has a severe anaphylactic reaction in the office. Your internist injects epinephrine (J0170) into the patient, and the resident evaluates the patient's condition. The resident also monitors the patient's reaction to the epinephrine. Overall, the physician and the resident perform critical care services for 35 minutes.

In this case, your physician may be able to report 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), as long as the documentation supports the code.

Here's what to look for in the physician medical documentation:

1. The critical care time did not include the injection, and the physician treated the patient jointly with the resident.
2. The TP directly supervised the resident for the full 35 minutes of treatment.
3. Your internist directly managed the patient's care.
4. The internist references the resident's note in the documentation.
5. The internist supervised the resident during the visit's history and exam.
6. The physician notes a discussion with the resident concerning the epinephrine injection and the critical care.

3. Supervision Guides Surgical Procedure Claims

When you report minor surgeries and endoscopic procedures, you should make sure the physician documents that he or she directly supervised the entire procedure, Kuruc says.

That means Medicare requires the physician's presence in the room. For example, your physician can't view the surgery through a monitor in another room, Pohlig says.

Suppose your internist supervises the resident during the suture of a 2.7-cm knee wound (12002, Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.6 cm to 7.5 cm). To get your internist paid for the 12002, make sure the documentation shows that the physician directly supervised the entire procedure.

4. Know How to Use the Primary-Care Exception

In some cases, Medicare allows a TP to get paid when a resident provides an E/M service without the TP's direct supervision. These cases must fall under MCM's primary- care exception, which refers to E/M new patient codes 99201-99203 and established patient codes 99211-99213.

The primary-care exception applies only to primary- care practices, Kuruc says. But the offices must be located in the outpatient department of a hospital or another ambulatory care entity, not a physician's office away from the center or during a home visit, according to the MCM.

For example, the resident performs dementia assessment on an elderly patient in a teaching hospital's outpatient

department. Because the resident evaluated only the patient's memory loss (780.93), he or she bills a low-level E/M (for example, 99202, Office or other outpatient visit for the evaluation and management of a new patient ...). The internist was present in the department and available for care, but he didn't directly supervise the E/M service. In that case, you could report 99202 for your physician, as long as you can justify the code with the appropriate documentation.

To meet Medicare's documentation requirements for reporting 99201-99203 and 99211-99213 under the exception, make sure you can satisfy the following MCM criteria, which state that your TP should:

7. supervise no more than four residents at a time and must be immediately available to help the resident maintain the primary medical responsibility for the patient's care

8. ensure that the resident provides reasonable and necessary services

9. review the care provided by the resident during or immediately following each E/M visit. This review includes the patient's history, the resident's findings on physical examination, the diagnosis, and the treatment plan. Furthermore, the TP must document the extent of his or her participation in the review and direction of the patient care.

You should also attach modifier -GE (This service has been performed by a resident without the presence of a teaching physician under the primary-care exception) to all services that you report. For example, if you billed a level-two office visit of an established patient, you would list 99212-GE, which would let Medicare know that the resident performed the service under the primary-care exception.