Your Presence is Required

The Teaching Physician Rules and Your EHR

HCCA Physician Practice Compliance Conference 2014

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Agenda

► Brief recap of the teaching physician regulations
► Key definitions and principles
► Concerns seen on auditing
  ► Linkage to medical student notes
  ► Correct attestation for surgical services
  ► Do notes stand alone?
  ► Is the documentation medically necessary?
  ► Contradictory documentation
  ► Timeliness of attestations
  ► Physicians documenting services performed with non-physician practitioners in the same way they do a resident service
Payment for physician services in teaching settings

► Paid through the Medicare Physician Fee Schedule (PFS)
  ► Furnished by physician
  ► Furnished by resident if:
    ► teaching physician is physically present during key portion of service
    ► Within an approved GME (Graduate Medical Education) program
Key Definitions and Principles

From the Code of Federal Regulations

► 42 CFR §415.172 (a)
General rule. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

► 42 CFR §415.172 (a)(2)
In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed portion of the service that determines the level of service billed.
From the Code of Federal Regulations

42 CFR §415.172 (b)
The medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by the notes in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.

42 CFR §415.172 (c)
In the case of services such as evaluation and management for which there are several levels of service codes available for reporting purposes, the appropriate payment level must reflect the extent and complexity of the service when fully furnished by the teaching physician.

of the service that determines the level of service billed.

Key Definitions

- Resident - an individual in an approved graduate medical education (GME) program or a physician who is authorized to practice only in a hospital setting.
- Teaching physician - physician (other than another resident) who involves residents in the care of his or her patients.
- Direct medical and surgical services - services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital.
- Physically present - 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.
- Critical or key portion - that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). These terms are interchangeable.
Authorship Issues

- **Attestation** is the act of applying an e-signature to the content, showing authorship and legal responsibility for a particular unit of information.\(^1\)

Key Principles: Presence and Participation

- The two significant principles of teaching physician documentation are presence and participation *presence & participation*

- Presence may not be inferred: it must be stated or “attested” by the teaching physician. Presence is defined in the teaching physician guidelines.
Residents only

- These guidelines apply to medical residents only, those individuals with an M.D. or D.O. degree that meet the definition of a resident. These guidelines do not apply to any other health care service provider other than teaching physicians and residents.

- They do not apply to any kind of student: Nursing, PA, Nurse Practitioner Psychology or otherwise.
- They do not apply to Advance Practice Nurses or Physician's Assistants
- They do not apply to nurses.
- They do not apply to anyone else other than those individuals meeting the definition of a medical resident.

Evaluation and Management Services
Evaluation and Management Services

The teaching physician must 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 a resident.

- The participation of the teaching physician in the management of the patient.

Reviewers will combine the documentation of both the resident and the physician.

Evaluation and Management Services

► Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician for an Evaluation & Management service.

► The combined entries into the medical record by the TP and the resident must support the medical necessity of the service.
Example Attestation

Prior to the patient's discharge today, I was present and participated in the key portions of service as it was rendered. I discussed medical decision making with Dr. S before the end of the encounter. xxxxxx is a 76 y.o. female for follow-up of potential mood disorder and decub. Family concerned. She scores 5 on the geriatric depression scale. Decub improving. Will refer to Dr. xxxxxx. Follow-up as indicated pending results. When the encounter note is complete, my electronic signature will attest to the fact that I reviewed the note and made any necessary corrections, additions or suggestions.

Professor
Department of Family Medicine

Oh wait...what did the resident note say?

visit, and the erythema does blanch. The area is somewhat tender to the touch.

Geriatric Depression Scale given to patient to complete, and she scored a 5, which is right at the cutoff for additional evaluation.

Assessment/Plan:

707.00HR Stage II decubitus ulcer
Comment: Improving.
Plan: Continue Duoderm. I expect that the wound will continue to improve now that her blood sugars have returned to their baseline (<180 mg/dL).

250.00A Diabetes Mellitus, Type II
Comment: Blood sugars now back to her pre-hospitalization levels.
Plan: Continue Glucotrol 16 mg po bid before meals.

V79.0 Screening for depression
Comment: Had a long discussion with the patient regarding her mood disorder. She is uncertain whether she wants to undergo additional testing/counseling at this time.
Plan: I recommended further evaluation with Dr. xxx or Dr. xxx. I attempted to find either of them in clinic to briefly meet the patient, but neither was available. Patient will think about this at home and discuss it with her family. They will then let me know if they want to be referred to Dr. xxx or Dr. xxx.
**E/M Service Documentation Provided By Students**

- The only part of a student's documentation that may be used by the teaching physician is the Review of Systems and Past Medical, Family and Social History.
- The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note.
- If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.

**EHR Considerations**

- Do medical students document in the medical record?
- How is their documentation used by residents and teaching physicians?
- Can your EHR create a specific “note type” for residents?
- Can the EHR prevent the addition of a teaching physician attestation to a student note?
- Is there a policy on how this should be handled in your organization?
Surgical Services

What service allows physician to bill for surgical procedures?

- **Minor surgeries (<5 minutes)**
  - Teaching physician must be present for entire procedure

- **Major procedures (>5 minutes)**
  - Teaching physician must be physically present during the “key potion(s)” of service
  - Must document extent of their participation
  - If two or more services, must document presence for key and critical portions and designate another physician to be present if needed

- **High Risk (such as Interventional Radiology and Cardiac Catheterization; other services as per NCD) – TP must be present for entire service**

- **Endoscopic Services- TP must be present for the entire viewing portion**
  - Open surgical services that utilize endoscopic techniques fall under major procedures category
Just an anecdote

- University practice asked for a review of their surgical documentation based on Teaching Physician guidelines
- Documentation requested for the audit included OR schedules
- Found many cases where physicians were working in multiple rooms
- Unfortunately, attestations all appeared to be for single surgical procedures
- Should have documented presence for key and critical portions and availability of another physician

EHR Considerations

- Physicians using macros/smart phrases/ smart text to enter their required TP attestations
- HOWEVER. If surgical services are overlapping, i.e. running two rooms, the presence and attestation requirements are different
- Do the physicians in your practice understand the difference?
- EASILY auditable area
EHR Concerns

- **Linkage to medical student notes**
- **Correct attestation for surgical services**
- Do notes stand alone?
- Is the documentation medically necessary?
- Beware of contradictory documentation
- Timeliness of attestations
  - Make me the author features where resident note is brought forward and teaching physician attests to service…but often days later……
  - Physicians documenting services performed with non-physician practitioners in the same way they do a resident service
Does each note stand alone?

► Notes must contain all the information contributing to the level of service
► The risks.....
  ► Template inserts “Family history reviewed.”
  ► Upon auditing the note, information under the family history section was blank
► Are notes unique with patient specific documentation?
► If macros are used, is patient specific information included?

Prepopulated Documentation or Population by Default

Cardiovascular:
Cranial arteries: Normal
Assessment: Normal
Peripheral vascular system: Normal
Musculoskeletal
Gait and Station: Normal
Muscle strength (upper extremities): Normal
Muscle strength (lower extremities): Normal
Muscle tone (upper extremities): Normal
Muscle tone (lower extremities): Normal
Sensation: Normal
Deep tendon reflexes: Upper and lower extremities: Normal
Coordination: Normal
Neurological
Orientation: Normal
Recent and remote memory: Normal
Attention span and concentration: Normal
Language: Normal
Fund of knowledge: Normal
Cranial Nerves
2nd: Normal
3rd, 4th, 6th: Normal
5th: Normal
7th: Normal
8th: Normal
9th: Normal
11th: Normal
12th: Normal
Meningeal signs: NONE

Believe it or not, this comprehensive exam was done in an ED for a finger laceration
What is normal?

► Normal can have different meaning based on frame of reference. Is it normal for this patient? Is it normal for the expected functioning of the organ system?

► Within normal limits or WNL (We never looked?)

► When an EHR prompts a provider to normal values, the provider may inadvertently document an organ system as “normal” when the provider did not in fact examine the organ system. Similarly, when documenting the review of systems, questions about individual organ systems may not have been asked due to a lack of relevance.

Is this note any better?

Physical Exam

General:
- well developed, well nourished, in no acute distress.

Head:
- normocephalic and atraumatic.

Eyes:
- EOMI, nonicteric

Ears:
- hearing grossly intact

Nose:
- nares patent B/L

Mouth:
- MMII

Neck:
- no masses, tenderness, thyromegaly, or abnormal cervical nodes.

Lungs:
- clear bilaterally to auscultation; no rales, rhonchi or wheezing.

Heart:
- regular rate and rhythm, S1 and S2 normal without murmurs, rubs, or gallops

Abdomen:
- soft non-tender, normal bowel sounds, no hepatosplenomegaly or masses noted.

Skin:
- intact

Extremities:
- no LE edema

Neurologic:
- CN 2-12 grossly intact

Psych:
- alert and cooperative; normal mood and affect; normal attention span and concentration.
Was every system examined medically necessary?

- Minimally, there should be the ability to mark an entry “not examined” (exam) or “not asked” (ROS) or to default an entry to “blank” to be compliant.
- Some EHRs will put additional information in bold, CAPS, or in a different color to show the provider’s additions.
- Some providers don’t realize you can delete items pre-populated.

And we won’t even discuss that dynamic duo who cause so much angst...
Beware of contradictory documentation

► When an EHR prompts a provider to normal values, the provider may inadvertently document an organ system as “normal” when the provider did not in fact examine the organ system.

► Similarly, when documenting the review of systems, questions about individual organ systems may not have been asked due to a lack of relevance.
30.6.1 - Selection of Level of Evaluation and Management Service
(Rev. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

- The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.
- CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.
OIG Compliance Program Guidance for Individual and Small Group Physician Practices

► Timely, accurate and complete documentation is important to clinical patient care.
► The medical record is complete and legible;
► The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer;
► If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training;
► CPT and ICD–9–CM codes used for claims submission are supported by documentation and the medical record; and
► Appropriate health risk factors are identified. The patient’s progress, his or her response to, and any changes in, treatment, and any revision in diagnosis is documented.

Authorship Issues

► Attestation is the act of applying an e-signature to the content, showing authorship and legal responsibility for a particular unit of information.
Working with Non-Physician Practitioners

► Teaching Physician Rules do NOT apply to services done in conjunction with NPPs
► Understand how the services are being performed within your organization
  ► Incident-to
  ► NPP direct billing
► Best practice: Notes should retain the identity of which provider authored each portion of the note
  ► Different Colors?
  ► Different Fonts?

Authenticating Documents with Multiple Sections or Completed by Multiple Individuals “Team Services”

► Some documentation tools particularly assessments are set up to be completed by multiple staff members at different times.
► There must be a mechanism to determine who completed information on the document.
► Identify authors by name and role (e.g., resident, RN, Resident/MD, Teaching/MD, ARNP, PA); documentation should indicate the date last reviewed.
► Staff who have completed sections of the assessment should either indicate the sections they completed at the signature line or initial the sections they completed.
Auditing Considerations

- Can a third-party reviewer differentiate staff notes from TP or residents notes?
- When was the note closed?
- Was all placeholder text removed?
- Were notes cut/copied/pasted from a previous entry?
- Are previous versions of a note available?

The medical record is a legal document. Would you put your name on a document you had not reviewed?
Does your EHR draft letters to the referring physician?

► The opening sentence of a letter or progress note should be crafted carefully in order to support type or category of service being billed.
► In order to bill for a consultation, there must be a request for opinion or advice from the requesting physician to the consulting physician. The use of the word “refer” donates a transfer of care to the receiving physician, and thus only an office visit can be billed. It is important to note that not all initial visits are consultations. For example:
  ► Incorrect language: [Pt Name] was seen in consultation. Referred by: [Dr. Jones]
► This example is a compliance concern because it does not allow a visit to be billed as a consultation because of the use of the word “refer”. The word referral denotes a transfer of care to the physician receiving a referral.

Recommendation

► Suggested Language:
  [Pt Name] is a [age] yr. old [gender] who presents for
  [a New patient visit]
  [an established patient visit]
  [a consultation at the request of *****]
  [a procedure **** to be specified]
  [a well-patient visit; a preventive medicine visit]
Compliance Considerations

► Only teaching physicians should be able to append a Teaching physician attestation
  ► Attestation should be dated and timed
► The residents note and the teaching physician’s note should be identifiable as linked in the medical record
  ► TP attestation can be appended to the resident’s note
  ► Notes can be linked so that they are printed as a pair.
► Have a menu of options for TP attestations
  ► E&M
  ► Surgical Services

Recommendations

► Know what EHR tools are used in your practice or institution
► Understand how the notes are created. What CAN be done is often different from what is COMPLIANT
► Shadow practitioners in a clinic, ED or other care settings to see how they are really using the system
► Be involved in the development of the training curriculum
► Print the record to see what it actually looks like
Recommendations

► Perform an audit immediately after implementation and then approximately six month post implementation
► Develop policies around authentication, copy and paste and other problematic functions
► Update Compliance Work Plan and incorporate into your risk assessment

Questions?

► What does a company know?
► When and what should it disclose?
► When should it launch a recall—legal, practical and ethics standards?
References

- [http://www.healthit.gov/providers-professionals/how-attain-meaningful-use](http://www.healthit.gov/providers-professionals/how-attain-meaningful-use)
- **Legal Documentation Standards**
  [http://ahimaltcguidelines.pbworks.com/w/page/46505521/Legal%20Standards#AuthenticatingDocumentswithMultipleSectionsorCompletedbyMultipleIndividuals](http://ahimaltcguidelines.pbworks.com/w/page/46505521/Legal%20Standards#AuthenticatingDocumentswithMultipleSectionsorCompletedbyMultipleIndividuals)

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References

- [http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html](http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html)
- [https://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Health-Care-Reform-Releases.aspx](https://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Health-Care-Reform-Releases.aspx)