Rules vs. Reality

CODING FOR PHYSICIANS AT TEACHING HOSPITALS (PATH)

By Holly Louie, RN, CHBME

Coding for teaching physicians presents unique challenges and requires an in-depth understanding of rules that vary by site of service and type of service. The reality of how faculty physicians teach and supervise clinical practice is frequently at odds with these rules. Physicians and coders often rely on local carrier policies for various clinical scenarios; what they may not realize is that the rules for teaching physicians often conflict with the policy—and that the rules take precedence. As a result, coding errors are common and are an ongoing focus of Medicare as well as the Office of Inspector General (OIG).

The rules apply to "residents" in an approved program, but not when they are moonlighting or performing services that are not part of their approved program. The term resident includes fellows, but not students.

A few of the most common errors and pitfalls are described below. Each example assumes that appropriate medical-record documentation supports the teaching physician's personal service to the beneficiary.

Primary Care Exception:
In this context, primary care does not mean that the teaching physician provides primary care. It means that the physician has a specialty recognized as primary care in the rules, and the site has qualified to provide care under the exception criteria. The exception applies to Evaluation and Management (E&M) services, not procedures, and allows residents who have completed at least six months of training to provide care to patients without the teaching physician's personal presence. However, the teaching physician must be physically present in the office and immediately available. The resident's findings and plan must be reviewed with the teaching physician before the patient is discharged and a four-to-one ratio of residents to faculty must be maintained.

Radiology:
Radiology residents may interpret most diagnostic films as long as the teaching physician reviews the films and interpretation for accuracy and makes any necessary revisions or corrections. This review may be done concurrently with the resident or at a later time. Two significant exceptions to this scenario occur when: 1) the radiology exam is a "viewing," such as endoscopy, and/or 2) the service is defined as radiology supervision and interpretation (S&I).

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In these two cases, the personal presence of the teaching physician is required in order to have a billable service. S&I service is an example of how confusing Medicare policies can be. One carrier has a policy stating that in the office setting, personal supervision of staff by the teaching physician is not required for cardiac stress tests as long as the physician is physically present in the office and immediately available to the staff (direct supervision). If the same case involves a resident, however, then the personal supervision of the physician is required. It is difficult to explain to a client why a non-physician needs less supervision than a licensed physician!

Medical Necessity:
As residents progress through their specialty program, less involvement and supervision by the teaching physician are necessary. Senior residents are typically teaching junior residents at the same time they are learning more complex topics and procedures. Medicare policy states that once the resident is competent to perform a service independently, the services of the teaching physician are no longer medically necessary. The classic example is a senior family practice resident who moonlights as an attending emergency-department physician. Obviously if the resident can repair a complex laceration independently on Saturday night, a teaching physician is probably not needed to supervise a simple repair on Monday. Consider working with your client to obtain resident proficiency reports by type of service/procedure and establishing guidelines for questionable cases.

Critical Care:
Only the time spent by the teaching physician can be counted in critical care time. Time spent by the resident or fellow is not included in any calculations.

Date Discrepancy for E&M Services:
It is common for residents to accept and admit "unassigned" patients from the emergency department. It is also common for the resident to communicate with the attending physician by phone, especially if the patient is admitted at night. While it may be acceptable for the teaching physician to see the patient subsequent to the resident, it is not correct to backdate for billing purposes. The teaching physician's first billable service occurs on the date when personal service is provided to the beneficiary.

Reality Check:
Personal involvement of the teaching

physician in every visit in every case with every resident, as required to bill Medicare, is an unrealistic expectation. It is not how residency training programs are structured or function. Understanding this basic principle will help you work with your clients to assure coding and billing are accurate and supportable. Don't fall into the trap of advising physicians to document specific statements for billing purposes. In a number of well-publicized cases, the teaching physician documented personal presence and involvement which was not provided. ■

For the complete guidelines, see Transmittal 1780 11/22/02 http://www.cms.hhs.gov/manuals/pm_trans/R1780B3.pdf

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Question of the Month

Q. Do the automatic update features contained in Microsoft Windows software violate HIPAA Security Provisions?

A. The following response is from Microsoft:
Microsoft understands there may have been some confusion about the impact of the Windows 2000 Professional Service Pack 3 End User License Agreement (EULA) and the Windows XP Professional Service Pack 1 EULA with regard to a customer's compliance with the rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of the EULA for Microsoft's products and updates is to clearly communicate the rights of customers to use these products while highlighting Microsoft's rights as the provider of the software. We are constantly trying to improve our licensing based on feedback from customers so the terms are clear and transparent.

We would like to reassure our healthcare customers of the meaning of the specific terms in these EULAs:

- Nothing in Microsoft's EULA for Windows 2000 Professional SP3 or Windows XP Professional SP1 would result in a healthcare customer being out of compliance with HIPAA.
- The terms of these EULAs do not authorize or allow Microsoft to have access to any personal information or personal data. The technology that helps deliver critical security and reliability enhancements for the operating system does not have the ability to take personal information from a customer's PC and send it back to Microsoft.
- If healthcare customers choose to use the Windows Update or Auto Update features in Windows in order to keep their environment current with the latest security updates, they can be assured that no personal information or data is accessed, viewed, captured or stored by Windows Update or Auto Update. Windows Update and Auto Update simply take a snapshot of various components of a user's system, such as their Operating-system version number, Internet Explorer version number, version numbers of other software, and Plug and Play ID numbers of hardware devices in order to create a list of recommended updates for their particular system. But it does not gather personally identifiable information. Please refer to Microsoft's Windows Update Privacy Statement at http://v4. windowsupdate.microsoft.com/en/default.asp (under "About Windows Update") for more information.
- "Automatic Updates," the feature in Windows Update which gives end users the ability to choose and receive updates to keep their computers up to date. This feature comes turned off; a user must elect to turn it on or it will not operate.

If you turn Automatic-Updates on, you are presented with three notification option settings:

1. To download the updates automatically and have Windows Update notify you when they are ready to be installed
2. To have Windows Update notify you before downloading any updates and notify you again before installing them on your computer
3. To turn off automatic updating so that you can update your computer manually. When enabled, "Automatic Updates" will automatically download updates to itself to ensure that it can complete the important task of downloading and installing the latest critical updates.

The following link offers a white paper, "Managing Automatic Updating and Download Technologies in Windows XP," with instructions on how administrators can manage Automatic Updates within their own IT environment.

Microsoft's response courtesy of Randal Roat, vice president & corporate compliance officer, The TriMed Group. Randy can be reached at rroat@trimedgroup.com.