

**Testimony to the Practicing Physicians Advisory Council
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I am Dr. Albert Bothe, Jr., Executive Director, University of Chicago Faculty Practice Plan, Compliance Officer and Professor of Clinical Surgery, University of Chicago Medical School, and Medical Director, University of Chicago Health Plan. I am also a member of the Association of American Medical Colleges' (AAMC) Group on Faculty Practice Steering Committee and Chair of the Steering Committee's Subcommittee on Legislative and Regulatory Issues. The AAMC represents the nation's 125 accredited medical schools, approximately 400 major teaching hospitals and health systems, over 91 professional and scientific societies, over 100,000 faculty members, and the nation's medical students and residents. The volume of services provided nationally by faculty physicians to Medicare patients is notable, representing approximately \$2.5 billion in annual net revenue. In some academic medical centers as much as 37.4% of total net revenue is derived from Medicare services. My testimony addresses your agenda item on Documentation Requirements for Teaching Physicians.

I welcome this opportunity to provide comments on the topic of teaching physician documentation requirements, as it is a topic of great interest to the AAMC's constituent community. Let me also add that we are quite appreciative of the willingness of staff of the Centers for Medicare and Medicaid Services (CMS) to reexamine this issue, which specifically and uniquely affects teaching physicians.

Before I begin I would like to note briefly that I do not agree with the characterization of Graduate Medical Education payments under Medicare Part A as it is included in the background statement from CMS. However, Part A payments are not the topic of discussion today, so I will not comment further. Staff of the AAMC would be pleased to speak with CMS staff interested in pursuing this topic further.

There is a 35 year history of Medicare requirements that a teaching physician is obligated to comply with when he or she submits a bill for a service in which a resident is involved. At issue over the years has been the extent to which a teaching physician must be present during a service in which a resident is involved, and the documentation that must be provided to support the level of a bill submitted to Medicare. Starting in 1967, The Centers for Medicare and Medicaid Services (CMS) and its predecessor organizations have issued a number of regulations, intermediary letters, memoranda and other documents that attempted to clarify the requirements. These efforts were not successful, and, in 1995, HCFA issued a new rule that superceded the old pronouncements. It became effective as of July 1, 1996.

While the 1996 rule provided clarification of some long-standing issues, the AAMC continues to receive numerous constituent requests for clarification of various aspects of the rule. Many key issues can be clarified and addressed through revisions to the Medicare Carrier Manual Instructions (CMI), while others would require regulatory changes.

Overall, I believe that the direction in which CMS is moving as it considers revision to section 15016 of the Carrier Manual Instructions is a very positive step toward reducing the regulatory burden of Medicare program requirements and providing clearer direction for teaching physicians.

Let me turn to the questions posed by CMS staff in the documents prepared for your consideration today: (1) Do the revised scenarios accurately reflect current clinical situations involving residents and teaching physicians, and (2) Do the examples of documentation accurately reflect current documentation practices of teaching physicians?

In general, I believe that the use of scenarios and examples of documentation are helpful. Overall, the proposed changes reduce the need for duplicative documentation requirements which teaching physicians are now required to perform. Specifically, when all required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident, the teaching physician's personal documentation must currently include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. This should not be necessary. The proposed scenarios are a major step forward in reducing redundancy while ensuring adequate documentation of the presence and participation by the faculty member.

It will be important for CMS to develop additional examples that address areas of continuing confusion, such as the use of medical students as scribes and the ability of the teaching physician to refer to medical student documentation other than for the review of systems and past family and social history.

There also are specific aspects of the primary care exception that warrant clarification, for example:

- ❑ A clear statement of the options available to the teaching physician when a visit that has been scheduled under the Primary Care Exception, and therefore is expected to be a level 1, 2 or 3 new or established patient visit, unexpectedly becomes a level 4 or 5 visit, would be very useful.
- ❑ The use of the 1:4 ratio of faculty to residents under the Primary Care Exception continues to be a source of questions. For instance, is it acceptable to use the Exception in a setting in which there may be 7 residents and 2 teaching physicians? Under such circumstances, must each faculty member supervise a designated 3 or 4 of the 7 residents, or can they essentially provide "cross-coverage" of the entire 7 residents between them?
- ❑ I would like to note for the record that the AAMC continues to receive questions about the potential expansion of the Primary Care Exception to other ambulatory services and settings. One such example would include the ability to apply the Exception to certain services traditionally identified by the Preventive Medicine Services CPT codes. I recognize that any expansion of this exception would require rulemaking, and urge CMS to consider doing so.

Clarification also is needed about the application of the teaching physician regulation to psychiatry services. Currently, a teaching physician must be present for, or observe directly, the entire patient visit in order to bill for a service. However, a teaching physician may also use time-based codes when appropriate to bill for only that portion of the service that he/she personally conducts or observes. It would be helpful to emphasize and clarify the ability to use time-based codes under certain circumstances.

There are other requirements of the teaching physician regulation which address circumstances specific to an individual specialty, such as the requirements for documentation of presence by surgeons. Clarification of these differences could be provided through the scenarios and examples included in the Carrier Manual Instructions.

Finally, we would like to suggest that current deliberations over the Teaching Physician Regulation and the related Carrier Manual Instructions should address the influence of technology on health care delivery. Many academic medical centers and large physician organizations are purchasing or considering the purchase of electronic medical record, or EMR, systems. This trend will raise questions about E&M Documentation Requirements generally. Some of the features of an EMR, such as the ability to copy and edit text, pose specific and unique questions related to teaching physician documentation requirements. Given the trend toward the use of EMRs and their perceived value in addressing issues of safety, quality and administrative simplification, it is important that revisions to the Manual Instructions be flexible enough to take into account changes in practice resulting from adoption of a new technology.

Thank you again for your consideration of these issues and your willingness to hear testimony on the topic today. On behalf of the Association of American Medical Colleges and its constituents we appreciate your efforts.