

RESIDENT SUPERVISION ESSENTIALS FOR COMMUNITY PRECEPTORS

Thank you for your interest in precepting resident physicians! We hope this document will serve as a helpful resource to you for the supervision of residents and offer examples of commonly asked questions. NOTE: In this document the terms "preceptor", "faculty", "attending physician", "supervising physician, and "teaching physician" are used interchangeably -- they all mean you!

SUPERVISING RESIDENTS – GENERAL PERSPECTIVE

The level of supervision required depends of the resident's year in the program, academic progress as identified by the program director, clinical comfort, and educational need. Clarification of supervision status should be provided by the program for each resident prior to any rotation. All procedures, no matter how large or small, must be directly supervised regardless of the resident's status in the program.

SUPERVISING RESIDENTS – ACCREDITATION PERSPECTIVE

Definition of Supervision (ACGME, 2007)

Supervision of Residents: In the clinical learning environment, each patient must have an identifiable, *appropriately-credentialed and privileged attending physician* (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. This information should be available to residents, faculty members, and patients. Residents and faculty members should inform patients of their respective roles in each patient's care.

Levels of Supervision

Direct Supervision: the supervising physician is physically present with the resident and patient.

Indirect Supervision:

With direct supervision *immediately available* – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

With direct supervision *available* – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Helpful FAQ's/Scenarios Labor and Delivery Scenarios

Question: What supervision is required during deliveries?

Answer: There must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician or a senior resident in an ACGME-accredited OB/GYN program, a certified nurse midwife or a 3rd year FM resident who has sufficient delivery experience. When a **resident** provides the direct supervision, there **must** be on-site physician faculty supervision immediately available at the hospital (ACGME, 2012).

Question: What constitutes acceptable on site supervision for a PGY-1 (First year) resident caring for a low risk pregnant woman in labor?

Answer: Acceptable supervision for a resident who is providing care for such a patient include: (a) a physician with privileges for providing OB labor & delivery services in the hospital associated with the program, (b) a resident who fulfills written program criteria for the supervision of low risk labor, or (c) a licensed midwife with privileges to provide labor and delivery services in the hospital (ACGME, 2012).

Indirect Supervision (inpatient and outpatient) Scenarios

Question: What are some examples of indirect supervision?

Indirect Supervision with direct supervision immediately available:

The resident is seeing patients in the family medical center and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed (outpatient). The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the labor and delivery department as needed (inpatient).

Indirect Supervision with direct supervision available:

A resident is on call for the family medicine service and needs advice from the physician faculty member in order to manage a patient's care. This can be done either by telephone or electronically. After communication with the resident, if the attending determines additional assistance is needed, the attending physician is available and able to go to the hospital and see the patient together with the resident (inpatient).

Indirect Supervision oversight:

A resident is seeing a patient in either the nursing home or at home, and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident, and evaluate the resident (outpatient and inpatient).

SUPERVISING RESIDENTS – BILLING REQUIREMENTS

IMPORTANT INFORMATION

In order to receive full reimbursement by CMS for services involving residents, the teaching physician must:

- 1) Bill for service under their own name (not the resident's).
- 2) Be physically present during the "critical or key portions" of the Service.
- 3) Provide proper documentation.

Below are definitions, examples and resources to assist you in insuring proper supervision and documentation for reimbursement.

Definitions:

Critical or Key Portion: The part or parts of a service that the teaching physician determines are a critical or key portion.

Intern or Resident: An individual who participates in an approved GME Program or a physician who is not in an approved GME Program but who is authorized to practice only in a hospital setting.

Physically Present: When the teaching physician is located in the same room as the patient (or a room that is subdivided with partitioned or curtained areas to accommodate multiple patients) and/or performs a face-to-face service.

Teaching Physician: A physician, other than an intern or resident, who involves residents in the care of his or her patients.

Teaching Setting: Any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made.

Minimum Documentation Requirements:

- Date of Service
- Teaching Physician Signature
- Service(s) Furnished
- Participation of the Teaching Physician in Providing the Service
- Whether the Teaching Physician was Physically Present

SUPERVISING RESIDENTS – BILLING REQUIREMENTS

Scenario 1 - Teaching physician performs entire encounter separately from the resident. *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.

Minimally Acceptable Documentation for 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 and agree with the documented findings and 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 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 - Teaching physician performs critical or key portions of care **separately** from the resident. *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 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.

Minimally Acceptable Documentation for Scenario 2:

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 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 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."

Scenario 3 - Teaching physician and resident **jointly** provide all of the care (physical presence). *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.

Minimally Acceptable Documentation for Scenario 3:

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 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."

Scenario 4 – Supervision of Procedures: Any procedural activity not exclusively billed with an E/M visit code **must be directly supervised** by the teaching physician for at least the critical portions of the procedure if not the entire encounter. *This includes removal of skin tags, treatment of warts, suturing a wound, performing a vasectomy, etc.*

Minimally Acceptable Documentation for Scenario 4:

Procedure Visit: "I was present for the critical portions of the following procedure(s)..." **(or)** "I was present for the entire duration of the following procedure(s)..."

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.