Supervising Residents: A Primer for Community Preceptors

This document, along with the **Resident Supervision *ESSENTIALS* For Community Preceptors** handout grew from a need identified by the Credentialing & Supervision Workgroup of the Wisconsin Collaborative for Rural GME (WCRGME) and prepared by Kim Goffard and Rosa Retrum of the UW Fox Valley Family Medicine Residency program and WCRGME Director, Kara Traxler. Many thanks to Dr. Stuart Hannah, Dr. Allen Last, and Dr. William Schwab for their review and recommendations.

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Introduction to Resident Physician Supervision

Thank-you for precepting a resident physician! This document we hope will serve as an introduction to the supervision of residents and offer some details that are commonly asked about by preceptor groups.

This work represents a compilation of resources already available related to supervision, but organized in a resource format. Requirements from the Accreditation Council of Graduate Medical Education (ACGME) are largely copied verbatim to avoid misinterpretation. There is a works cited page at the end of this document to aid in clearly giving credit to works cited and for ease of accessing the original information.

Also covered are items related to billing questions when working with residents outside of an ACGME designated educational Family Medicine Practice (in general, community preceptor sites are NOT FMP's according to the ACGME).

Note: In this document the terms "preceptor", "faculty", "attending physician", "supervising physician, and "teaching physician" are used interchangeably -- they all mean you!

Part 1: Supervising Residents ACGME and Related Requirements

Definition of Supervision by the ACGME and related requirements

(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.
- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may

include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

Levels of Supervision Family Medicine

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification 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.

Resident Progressive Authority

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

- **Program director responsibilities**: The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

- **Faculty member's responsibilities**: Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

- **Senior resident as supervisor responsibilities**: Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

- **Supervising residents on the transfer of a patient/end of life decisions:** Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

- **Resident scope of authority:** Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- **Supervision of First Year residents:** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
- **Faculty supervision assignments:** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
- **Resident Clinical Responsibilities:** Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

Graduated Resident Supervision Grid for Community Preceptors

Post Graduate Year (PGY)	Procedure supervision requirements	Patient Care Supervision Requirements
PGY-1 (intern) First 6 months	Faculty must be physically present for procedure	Direct
PGY-1 (intern) Second 6 months	Faculty must be physically present for procedure	Indirect with Supervision *Immediately* Available
R2 Resident	Faculty must be physically present for procedure	Indirect with Supervision Available
R3 Resident	Faculty must be physically present for procedure	Indirect with Supervision Available

Helpful FAQ's/Scenarios

Labor and Delivery

***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 examples)

***Question:* What are some examples of indirect supervision?**

Examples are as follows (ACGME, 2012)***:***

- **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).

Evaluating Residents

We ask attending physicians to evaluate residents at the end of their rotation. Over the next year you may notice a change in than language and look of resident evaluations. We would like to move to an electronic system that we feel would be easier for community faculty to complete, but that is not yet established. Watch for information on that. In the mean time we would like to introduce you to the Family Medicine Milestones language.

"The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context." (ACGME, 2013). The residency program faculty will consider feedback from preceptor/attending evaluations of residents in progression through the Family Medicine Competency Milestones.

The Six Competencies

The ACGME has put forth 6 competencies which are described in the 2013 Glossary of terms as "specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs. These include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice." The Family Medicine Milestones "are developmentally-based family medicine-specific attributes that family medicine residents can be expected to demonstrate as they progress through their programs. Organized around the six ACGME core competencies, each group of related milestones includes an introductory statement that describes the specific emphasis of family medicine within that competency." (ACGME, 2013). The program faculty assesses the residents in terms of their progression through the milestones twice a year. The progression is followed from a new resident with some experience to the goal of a resident graduate. For your information the following levels are assigned to resident progression through the competencies (ACGME, 2013):

- **Level 1**: The resident demonstrates milestones expected of a resident who has had some education in family medicine.
- **Level 2**: The resident is advancing and demonstrating additional milestones.
- **Level 3**: The resident continues to advance and demonstrate additional milestones; the resident consistently demonstrates the majority of milestones targeted for residency.
- **Level 4**: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target. "Level 4" is designed as the graduation target but does not represent a graduation requirement.
- **Level 5**: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

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Part 2: Supervising Residents BILLING Requirements

Introduction:

As a teaching setting involved in the training of physician residents from an approved graduate medical education (GME) program, the Centers of Medicare & Medicaid Services (CMS) provides financial support for your organization and/or that of the residency program that employs the resident.

Supervision and billing rules have changed significantly over the past 20 year. Years ago residents could potentially see patients and the attending could bill even if they did not see the patient themselves. The current rules do not allow for this in clinics unless it is a primary care residency clinic (called the "primary care exception rule"). Currently, all patients must be seen by the attending physician in order to bill for that service.

Teaching Outside of a Designated Residency Clinic:

Residents see patients in many clinical scenarios outside of the officially recognized residency clinic. This can be in community physician's offices, the hospital or skilled nursing facilities. While in certain circumstances residents may have existing billing numbers for Medicare, Medicaid, or other insurers (e.g., for use when moonlighting), **no billing can be submitted in a resident's name** when they are on an educational rotation. This is essential to assure that their residency status is not jeopardized. Billing can only be done in the name of the teaching physician under the terms of the supervision guidelines and documentation requirements described below. Preceptors always have the option of not billing for a service provided by a resident if the teaching physician is not able to fulfill the expectations for supervision and documentation.

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, and
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 Furnished
- Participation of the Teaching Physician in Providing the Service
- Whether the Teaching Physician was Physically Present

Examples of Documentation:

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 a 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.

- 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.

- 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.

- 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)…"

Unacceptable documentation

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.

HOSPITAL and/or HEALTH SYSTEM Requirements

Hospital by-laws should address how learners can function within an institution and may additionally specify expectations for supervision. Policies of this type are a requirement of the Joint Commission and other accreditation entities. Similarly, health systems may have administrative guidelines that govern the roles of learners in out-patient clinics. Because these policies vary by location, the teaching physician should become familiar with these requirements, as well.

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