Department of Veterans Affairs **VHA DIRECTIVE 2005-054**
Veterans Health Administration
Washington, DC 20420 **November 21, 2005**

REVISED BILLING GUIDANCE FOR SERVICES PROVIDED BY SUPERVISING PRACTITIONERS AND RESIDENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for billing insurance carriers for services provided by a health care team, which includes supervising practitioners and residents and/or fellows (residents). ***NOTE:*** *The term "resident" is used throughout this document. This includes those residents referred to as "interns" and "fellows." The term "intern" refers to individuals in their first year of resident training. The term "fellow" is used by some sponsoring institutions and in some specialties to designate participants in subspecialty Graduate Medical Education (GME) programs.*

2. BACKGROUND

a. The Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) has approved the use of a new Healthcare Common Procedures Coding System (HCPCS) Level II Current Procedural Terminology (CPT) modifier for use by Department of Veterans Affairs (VA) Medical Centers effective January 1, 2006. This new modifier is identified as "GR" and is defined by CMS as:

GR - *"This service was provided in whole or in part by a resident at a Department of Veterans Affairs Medical Center or Clinic, supervised in accordance with VA policy."*

b. VHA Handbook 1400.1, Resident Supervision, is the primary guidance for the documentation of care in teaching settings in the VA facilities. This Handbook sets out standards for supervision and documentation of resident-delivered care that is educationally appropriate and ensures the highest standards for quality and safety. It is available on the internet at http://www.va.gov/oaa/VHA_Handbook_14001_html.asp

c. This Directive and the use of the GR Modifier does not change the way care is provided to veteran patients. As is required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Accreditation Council for Graduate Medical Education (ACGME) requirements, a licensed and independent practitioner must still supervise and be responsible for all resident-delivered care. Resident supervision practices and documentation of that supervision at VA facilities is reviewed against the VHA Resident Supervision policy as contained in VHA Handbook 1400.1.

3. POLICY: It is VHA policy that claims must be submitted to all insurance carriers for services that are provided by residents when clinical documentation shows the resident provided care (see VHA Handbook 1400.1).

THIS VHA DIRECTIVE EXPIRES NOVEMBER 30, 2010

4. ACTION: The facility Director is responsible for ensuring that previous guidance issued by the VHA Chief Business Office regarding billing procedures is further implemented by ensuring that:

a. Beginning January 1, 2006, when care is provided in whole or in part by a resident and clinical documentation shows the resident was supervised in accordance with VA policy, the modifier "GR" is attached to each CPT code or encounter with professional charges billed on the Health Care Financing Administration (HCFA) 1500 form in order to denote care provided by a resident under the direction of a teaching physician.

b. The GR Modifier is attached to CPT codes or encounters only by properly-trained coding staff, under the supervision of a Health Information Management Service (HIMS) professional as required by VHA Handbook 1907.1, with accuracy monitoring as required by Handbook 1907.1.

c. Clinical encounters to which the GR modifier is attached to the CPT code are billed to third-party payers using the supervising practitioner's name and credentials.

d. Starting on January 1, 2006, use of the "GC" CPT Modifier is discontinued. If a station has previously applied for and received permission from CMS to utilize the "GE" modifier for resident-run clinics, they may continue to apply that modifier as appropriate.

e. Health Information Management Service (HIMS) and Medical Care Cost Recovery (MCCR) staff institute procedures to ensure compliance with insurance industry standards, as applicable.

f. All appropriate Administrative personnel are aware of the billing policy.

NOTE: *Attachment A contains information pertinent to the implementation of this Directive.*

5. REFERENCES

a. VHA Handbook 1400.1.

b. VHA Handbook 1907.1.

c. VHA Chief Business Office website at: http://vaww1.va.gov/cbo/.

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Business Office (16) is responsible for the contents of this Directive. Questions should be addressed to 202-254-0362.

7. RESCISSION: VHA Directive 2004-009 is rescinded. This VHA Directive expires November 30, 2010.

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Under Secretary for Health

Attachment

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ATTACHMENT A

RESIDENT BILLING OVERVIEW

1. Introduction History

a. In 2003, the Centers for Medicare and Medicaid Services (CMS) ruled that the teaching physician requirements (Physicians at Teaching Hospitals (PATH) guidelines) by CMS are to avoid fraud and overpayments in institutions where Graduate Medical Education (GME) support has been paid by CMS. Since Department of Veterans Affairs (VA) medical facilities do not receive either direct or indirect medical education funds from CMS, it has been determined that VA can submit claims for care that is provided by residents in a properly supervised environment without regard to PATH guidelines.

b. The modifiers that apply to resident provided care (GC and GE) apply more specifically to care provided under PATH guidelines. At the request of VA, CMS has instituted a new modifier "GR" for resident provided care, effective January 1, 2006.

2. Definitions

a. **GR modifier.** The GR modifier is defined as "This service was performed in whole or in part by a resident at a VA Medical Center or Clinic, supervised in accordance with VA policy."

b. **Physicians at Teaching Hospitals (PATH) Guidelines.** PATH guidelines from CMS detail the supervising practitioner requirements for many types of encounters and patient care services. PATH guidelines have been written to ensure that supervising practitioners deliver a separate and identifiable service in addition to the resident's patient care services.

c. **Graduated Level of Responsibility.** As part of their training program, residents earn progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill.

d. **Supervising Practitioner.** The term “supervising practitioner” refers to licensed, independent practitioners who have been approved by the sponsoring entity to supervise residents.

e. **Resident.** This term (which includes interns and fellows) refers to an individual who is engaged in an accredited graduate training program in medicine (to include all disciplines), dentistry, podiatry, or optometry, under the direction of supervising practitioners.

Definitions *(cont.)*

f. **Student.** The term "student" refers to an individual who is enrolled in a accredited, educational program which leads to a certificate, associate, baccalaureate, graduate, or other professional training degree in a discipline and also includes graduate-level students. Students must be enrolled in baccalaureate, graduate, or other professional training programs. Such trainees may or may not be registered, licensed, or certified in their respective disciplines.

3. Purpose

This attachment summarizes common scenarios associated with resident billing. It is a quick reference guide only, and the scenarios presented are not meant to be all-inclusive as it is impossible to give examples of every billing situation.

4. Table of Contents

The following topics may be found in this attachment:

a. BILLING CONSIDERATIONS

Factors When considering if resident care is billable, review the following factors.

(1) Where the care was delivered.
(2) What type of care was provided.
(3) What documentation is present.
(4) Are the supervising practitioner physical presence requirements met?
(5) Have the supervising practitioner involvement elements been met and documented?
(6) Does documentation follow local policy on timeliness of documentation?
(7) Is resident performing within the scope of their graduated level of responsibility?

NOTE: *Even though CMS has instituted a new modifier for VA, all documentation and established coding guidelines must be considered in order to apply the appropriate modifier for the episode of care.*

c. DOCUMENTATION OF RESIDENT SUPERVISION

(1) ***Documentation*** As set forth in VHA Handbook 1400.1, the following types of documentation are acceptable evidence of resident supervision. The specific type of required documentation varies, depending on the type of service provided:

(a) Independent note from supervising practitioner.
(b) Addendum to the resident progress note by supervising practitioner.
(c) Co-signature by supervising practitioner (not acceptable for pre-op exam, inpatient admission, or new patient to facility's first visit).
(d) Resident note which names the supervising practitioner, and describes level of involvement and/or evaluation, and/or treatment performed by supervising practitioner. Acceptable statements include, but are not limited to:
1. "I have seen and discussed the patient with my supervising practitioner, Dr. X and Dr. X agrees with my assessment and plan."
2. "I have discussed the patient with my supervising practitioner, Dr. X and Dr. X agrees with my assessment and plan."
3. "The supervising practitioner of record for this patient care encounter is Dr. X."

NOTE: *An "identified signer" or "additional signer" within CPRS does <u>not</u> meet the requirement for a co-signature.*

2. Modifier Use Modifiers are used to enhance the description of resident-provided services for billing purposes. The following chart shows their appropriate application.

When…	Then use…
(a) Records indicate that the supervising practitioner: was indirectly involved in the supervision, or the resident documented supervising practitioner presence or concurrence, or the supervising practitioner's note and the resident's note will be used to determine the appropriate Evaluation and Management (E/M) level.	GR modifier, billing in supervising practitioner' name.
(b) Records indicate that: the supervising practitioner wrote stand-alone note (in addition to or in lieu of resident's note) and examined the patient independent of the resident, and resident's note is not used in determining the E/M level of visit.	No modifier, billing in supervising practitioner's name.

c. INPATIENT

(1) Admission An acute or planned normal hospital admission requires the supervising practitioner to:

(a) Physically meet and evaluate the patient within 24 hours of admission
(b) Document findings and recommendations regarding treatment plan in an independent note, or an addendum to the resident note.
(c) Complete the entry by the end of the calendar day following admission.

NOTE: *Night float admissions and Intensive Care Unit(ICU) and Cardiac Care Unit(CC) require the same documentation as an admission during normal business hours.*

(2) ***Continuing Care*** Any of the four types of documentation are acceptable.

(3) ***Inpatient Consultations*** (a) A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for the supervision of these residents.
(b) Any of the four types of documentation are acceptable.

(4) ***Transfers*** Inter-service or inter-specialty transfers, including transfers between different levels of care (ICU, Extended Care (SNF), Hospice) require the following:

(a) The resident's note from the transferring floor or service must describe the supervising practitioner's involvement in decision to transfer patient.
(b) The receiving supervising practitioner must treat the patient as a new admission (see subpar. 4c(1) Inpatient Admission), unless the same supervising practitioner will be providing care for the patient.

NOTE*: Documentation may only be either an independent note or addendum by the supervising practitioner.*

(5) ***Discharge*** The discharge note should at a minimum include:

(a) A description of the supervising practitioner's involvement in decision to discharge patient.
(b) Supervising practitioner's co-signature.

(6) ***Examples*** The following table shows some inpatient billing examples:

(a) **If the resident…**	**And the supervising practitioner…**	**Then…**
Performs H&P, and writes treatment plan.	Does not see patient within 24 hours.	Professional services are not billable for the admission note.

	Sees patient within 24 hours, and writes separate progress note.	Visit is billable under the supervising practitioner with GR modifier.

(b) **If the night-float resident…**	**And the supervising practitioner…**	**Then…**
Admits patient at 11:30 pm, and performs H&P	Sees and/or examines patient the next morning, and writes independent note	Professional services are billable under the supervising practitioner with GR modifier.
	Sees the patient for the first time 48 hours later, and writes addendum to resident's note, modifying treatment plan	Professional services are not billable.
(c) **If the specialty service resident…**	**And the supervising practitioner …**	**Then…**
Sees the patient on an inpatient specialty consult request. Documents the exam. Mentions the supervising practitioner involvement.	Writes an addendum with modifications.	Professional services are billable under the supervising practitioner with GR modifier.

d. **OUTPATIENT**

(1) ***Routine Ancillary services***

The following services require only resident level documentation.

(a) Physical Therapy,
(b) Speech Therapy,
(c) Laboratory or radiology studies, or pharmaceuticals,
(d) Therapeutic procedures which are part of the resident's assigned level of responsibility.

NOTE: *These activities are considered part of normal course of patient care, and require no <u>additional</u> documentation on the part of the supervising practitioner over and above setting-specific requirements.*

(2) New Encounters

(a) **Definition**

1. A "new" encounter is described as the patient's first visit to the facility.
2. This definition of "new" patient is applicable to the documentation requirement for supervision of resident-provided care. Coding personnel will still apply all applicable standards for the level and type of service provided following the CPT definition of "new patient" in which a patient is considered "new" if they have not been seen in the clinic within the past 3 years.

(b) **Documentation.** A new outpatient encounter consists of the following:

1. Independent note from the supervising practitioner, or
2. An addendum from the supervising practitioner, or
3. Resident's note contains a description of the supervising practitioner's involvement.

(c) **Miscellaneous**

1. Co-signature by the supervising practitioner is not considered sufficient documentation of supervision.
2. The supervising practitioner must be physically present in the clinic during clinic hours.

NOTE: *While Optometry residents are Licensed Independent Practitioners (LIP), when they are engaged in a VA residency program, they fall under the resident supervision requi*rements. *Once their program is complete, they regain their LIP status.*

(3) Consultations Any of the four types of documentation are acceptable.

(4) Continuing Care Any of the four types of documentation are acceptable.

(5) ***Examples*** The following chart provides some examples for outpatient billing when the staff is present during clinic hours:

If the resident…	And the supervising practitioner…	Then…
Sees new patient in outpatient clinic. Writes clinical note with no mention of the supervising practitioner involvement.	Co-signs note.	Professional services are not billable.
Sees new patient in cardiology clinic. Writes clinical note. Documents the supervising practitioner involvement	Co-signs note.	Professional services are billable under the supervising practitioner with GR modifier. ***NOTE:*** *The resident's documentation of supervising practitioner involvement makes this billable.*

e. **EXTENDED CARE (SNF)**

(1) ***Admissions***

(a) Extended care facilities are designed to care for those who need assistance with activities of daily living or with medical needs. A nursing home is one type of extended care facility, but not all extended care facilities are nursing homes. An extended care facility is needed when someone has a condition that is likely to last for a long period of time, or for the rest of the individual's life.

(b) Extended care admission requires the supervising practitioner to:

1. Physically meet and evaluate the patient within 72 hours of admission.
2. Document findings and recommendations regarding treatment plan in either an:
   a. Independent note, or
   b. Addendum to the resident note.

(2) ***Continuing Care*** The supervising practitioner must be identifiable for each resident's patient care encounter. Any of the four types of documentation are acceptable.

(3) Examples The following chart provides examples of extended care billing:

If the resident…	And the supervising practitioner…	Then…
Performs History and Physical (H&P), and writes treatment plan	Does not see patient within 72 hours.	Professional services are not billable.
	Sees patient within 24 hours, and writes separate progress note.	Visit is billable under the supervising practitioner with GR modifier.

f. EMERGENCY DEPARTMENT (ED)

(1) ED Visit (a) Documentation of an ED visit requires either:

1. An independent note from the supervising practitioner, or
2. An addendum from the supervising practitioner, or
3. Resident's note contains a description of the supervising practitioner's involvement.

(b) A co-signature alone is not sufficient documentation of supervising practitioner involvement in patient care. The supervising practitioner for the ED must be physically present in the ED area.

NOTE: *If the resident is "moonlighting" in the ED, the resident can bill the same as any licensed independent practitioner, in the resident's own name. If the resident is practicing as a resident, supervision documentation requirements must be met and billing will be done under the supervising practitioner's name with the GR modifier attached.*

(2) Consultations Residents are frequently called into the ED for specialty consultations. Any of the four types of documentation are acceptable.

NOTE: *The documentation needs to reflect that a discussion took place with the supervising practitioner while the patient was still in the ED.*

(3) ***Discharge*** Any of the four types of documentation are acceptable.

(4) Emergency situations An "emergency" is defined as a situation where immediate care is necessary to preserve the life of or to prevent serious impairment of the health of a patient. After treating the patient, the resident must do the following:

(a) The appropriate supervising practitioner must be informed of the situation as soon as possible.

(b) The resident *must document the nature of that discussion* on the patient's records.

(c) Additionally, the supervising practitioner may decide to:
1. Write an independent note, or
2. Add an addendum to the record, or
3. Countersign the record.

Emergency situations (cont.)

(d) The following chart provides examples of ED care billing:

If the resident…	And the supervising practitioner…	Then…
Sees patient in ED. Writes clinical note with no mention of supervising practitioner involvement.	Co-signs note.	Professional services are not billable. ***NOTE:*** *Co-signature alone is not sufficient documentation of supervision.*
Sees new patient in ED for cardiology consult. Writes clinical note with no mention of supervising practitioner involvement.	Co-signs note.	Professional services are billable under the supervising practitioner with GR modifier. ***NOTE:*** *The resident represents Cardiology services, and is not under the ED. The supervising practitioner in Cardiology is responsible for monitoring the Cardiology resident's work.*

g. PROCEDURES

(1) Operating Room (OR)

The supervising practitioner is required to personally examine the patient and write a pre-procedure note no earlier than 30 days prior to the procedure. The level of supervision is indicated through the assignment of Levels A-F in the Veterans Health Information Systems and Technology Architecture (VistA) surgical package. These levels are described as follows:

Level	Supervising Practitioner	Resident
A	Performs case	Assists
B	Is physically present, directly involved, is scrubbed on the case.	Performs major portions of procedure.

C	Is physically present, observes provides direction, may not be scrubbed.	Performs entire procedure.
D	Is physically present in the operating room or procedure suite, and is immediately available for supervision or consultation.	Performs entire procedure.
E	Follows up with resident and patient as appropriate.	Performs emergency care. Notifies supervising practitioner .
F	Has authorized the resident to perform a procedure according to their level of responsibility and skill.	Performs non-OR procedure in OR Identifies supervising practitioner.

(2) ***Non-OR*** Routine non-OR procedures done at bedside include:

(a) Skin biopsies.
(b) Central and peripheral lines.
(c) Lumbar punctures.
(d) Thoracentesis or Paracentesis.
(e) Incision and drainage (I and D).

NOTE: *Documentation of supervising practitioner involvement is encouraged. Any of the four types of documentation are acceptable, following setting-specific guidelines.*

(3) ***Procedure Room***

Non-routine, non-bedside, diagnostic, or therapeutic procedures are normally performed in a treatment or procedure room, and the supervising practitioner must be physically present in the procedural area. These procedures include, but are not limited to, the following high-risk procedures:

(a) Endoscopy,
(b) Cardiac catheterization,
(c) Invasive radiology,
(d) Chemotherapy, and
(e) Radiation therapy.

NOTE: *Documentation of supervising practitioner involvement is encouraged. Any of the four types of documentation are acceptable, following setting-specific guidelines.*

NOTE: *Neither the supervising practitioner nor resident need to be present during the administration of either chemotherapy or radiation therapy, since therapy delivery is a function of associated health personnel.*

(4) Examples

The following chart provides OR and procedures billing examples.

If the resident…	And the supervising practitioner…	Then…
(a) Performs a level B-D procedure.	Co-signs the operative report within the local documentation timelines.	Professional services are billable under the supervising practitioner with GR modifier. ***NOTE:*** *The OR Nurse must list the supervising surgeon in the VistA Surgery Package.*
(b) Performs a level B-D procedure.	Does not sign the operative report, or signs the operative report outside the local documentation timelines.	Professional services are not billable.