Teaching Compliance Protocol for New England Eye

September 4, 2013

The participation of students in a variety of patient care locations is paramount to achieving our mission. New England Eye's (NEE) attending doctors comply with all payers' policies and regulations.

Centers for Medicare and Medicaid Services (CMS) states[1]:

> *Evaluation and Management Documentation Provided by Students*
>
> Any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements (other than the review of systems [ROS] and/or past, family, and/or social history [PFSH], which are taken as part of an E/M service and are not separately billable). Students may document services in the medical record; however, the teaching physician may only refer to the student's documentation of an E/M service that is related to the ROS and/or PFSH. The teaching physician may not refer to a student's documentation of physical examination findings or medical decision making in his or her personal note. If the student documents E/M services, the teaching physician must verify and redocument the history of present illness and perform and redocument the physical examination and medical decision making activities of the service.

To summarize, the attending doctor is personally responsible for performing and documenting all elements of billable services as required by payers, and may only refer to his/her own examination of the patient for diagnoses, treatment, and management.

The Compliance Committee of New England Eye has approved the following teaching compliance protocol.

NEE Fee Based Sites follow Medicare Teaching Guidelines. (Exhibits 1&2)

[1] Department of Health and Human Services,, Centers for Medicare & Medicaid Services, FACT SHEET: Guidelines for Teaching Physicians, Interns, and Residents. Accessed on 8/1/2013: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/gdelinesteachgresfctsht.pdf

Exhibit 1

New England Eye (NEE)
Medicare Teaching Guidelines

To assure compliance with Medicare requirements for billing and reimbursement of comprehensive exams for new and established patients (CPT codes 92004 and 92014), NEE adheres to the CPT definition of a comprehensive exam. CPT 2012 defines a comprehensive eye exam as follows:

> ***Comprehensive ophthalmological services*** describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

From this definition NEE interprets the essential elements of a comprehensive eye exam (for which the attending doctor is personally responsible for performing and documenting, except 1.b. and 1.c. below) to include the following minimum data set:

1. Comprehensive eye and health history and history of present illness
    a. History of present illness, physical exam findings and medical decision making must be documented by attending doctor.
    b. Optometry students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the attending is limited to documentation related to the review of systems and/or past family/social history.
    c. The attending may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the student documents E/M services, the attending must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.
2. General medical observation
3. External ophthalmic examination
4. Ophthalmoscopic examination
5. Gross assessment of visual fields
6. Sensorimotor assessment
7. Diagnosis
8. Treatment

Optional features of a Medicare compliant examination include:

1. Biomicroscopy
2. Dilated ophthalmoscopic examination
3. Tonometry

Compliance Protocol for Health Record

NEE's interpretation of Medicare rules for a comprehensive eye exam does allow for the involvement of optometry students in portions of the exam. However, to be Medicare compliant, the attending doctor is required to personally perform and document the essential parts of the examination listed above, except for the review of systems and/or past family/social history which may be documented by students.

Furthermore, the diagnosis and treatment plan must be supported by procedures actually performed by the attending doctor. (For example, a diagnosis such as glaucoma would require tonometry - in most cases - and thus tonometry would have to be performed and documented personally by the attending doctor.

It must be clear from a record audit that the diagnosis, treatment, and management were derived solely based on the attending doctor's examination. The attending doctor must be able to advocate the position that the student's findings were not considered in making decisions.

Additionally, NEE's teaching compliance protocol states that the history of present illness, diagnosis, and treatment are essential exam components and thus the accompanying documentation of these essential elements are to be completed by the attending doctor, either by handwritten notes, through dictation and typed record, or via computer generated and typed method.

The NEE Medicare compliance protocol does not require that the attending doctor to repeat non-essential elements of the exam or elements that are not covered by Medicare, such as refraction.

Electronic Health Record (EHR)

Optometry students may document their examination in the electronic record only in the section designated for student entry. The attending doctor must personally perform the essential elements of the eye exam and clearly document notes in the EHR.

Written/Paper Health Record

The NEE comprehensive eye exam form has a column for the attending doctor to document essential elements. The form also has space for exam procedures such as biomicroscopy and other elements of an exam that would be repeated by the attending doctor as a matter of course.

The section for the student's assessment and plan are placed on a separate sheet at the end of the exam form, after the attending doctor's assessment and plan. This is to assure compliance with Medicare guidelines and the independence of the attending doctor's conclusions from those of the student**.**

Exhibit 2
Example of EHR

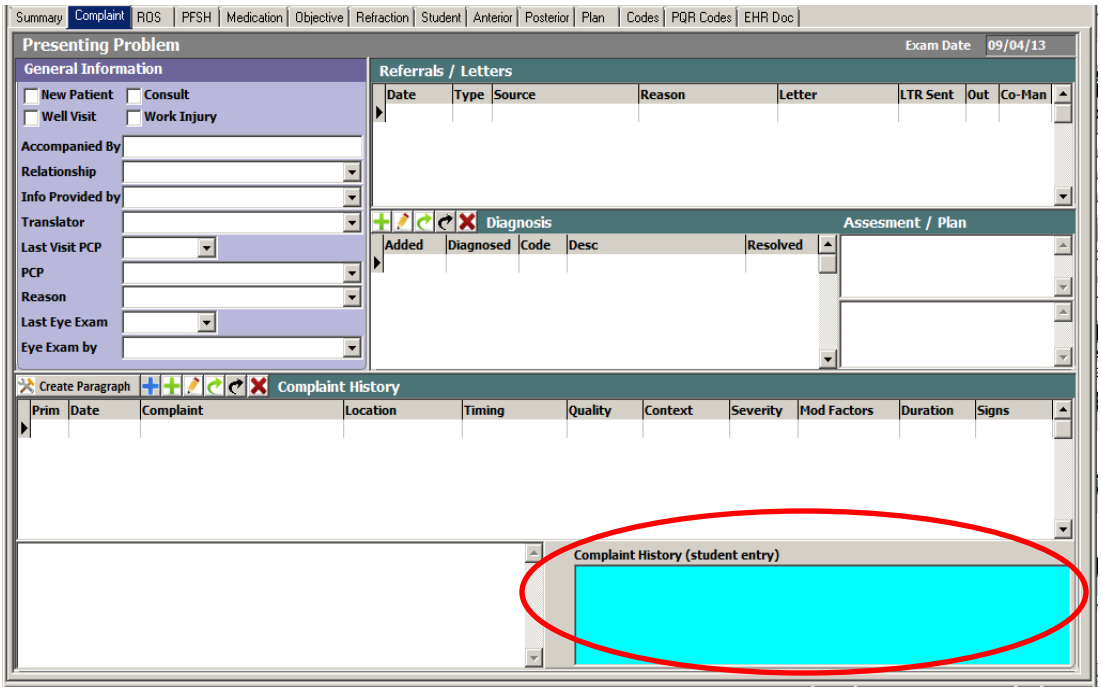

Figure 1: History of Present Illness box for student entry

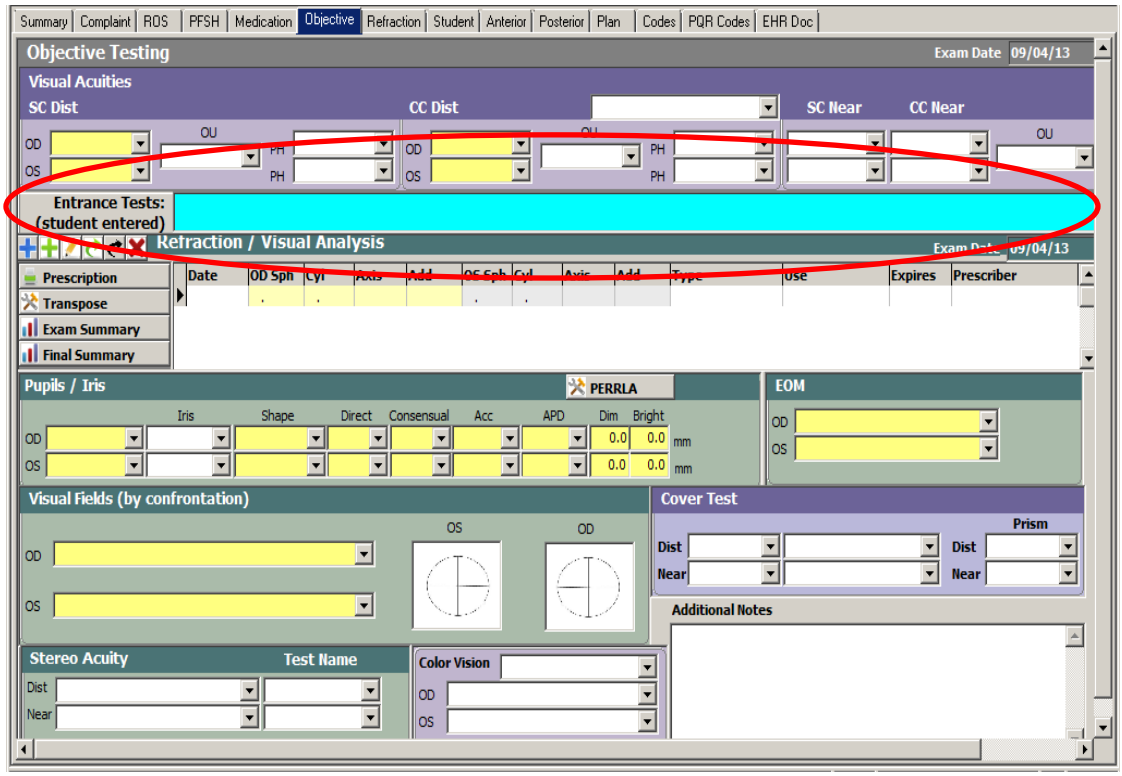

Figure 2: Entrance tests box for student entry

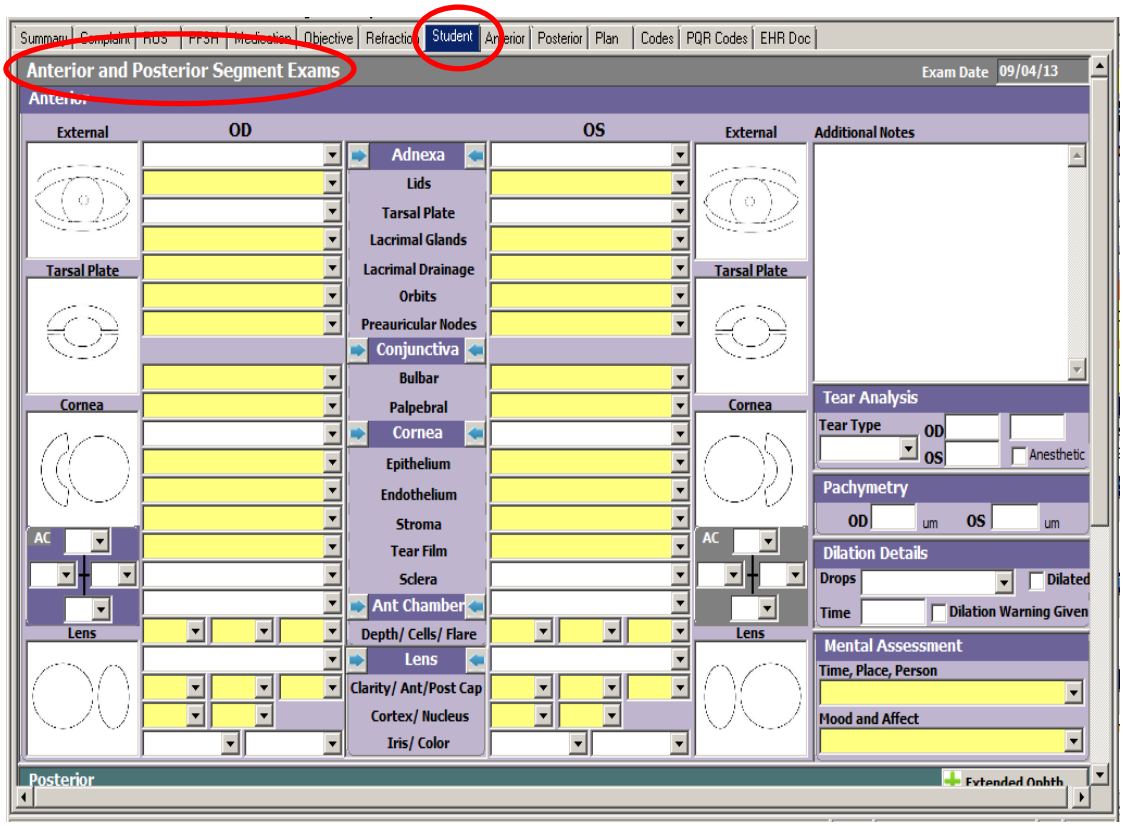

Figure 3: Student tab for anterior segment and posterior segment entries.

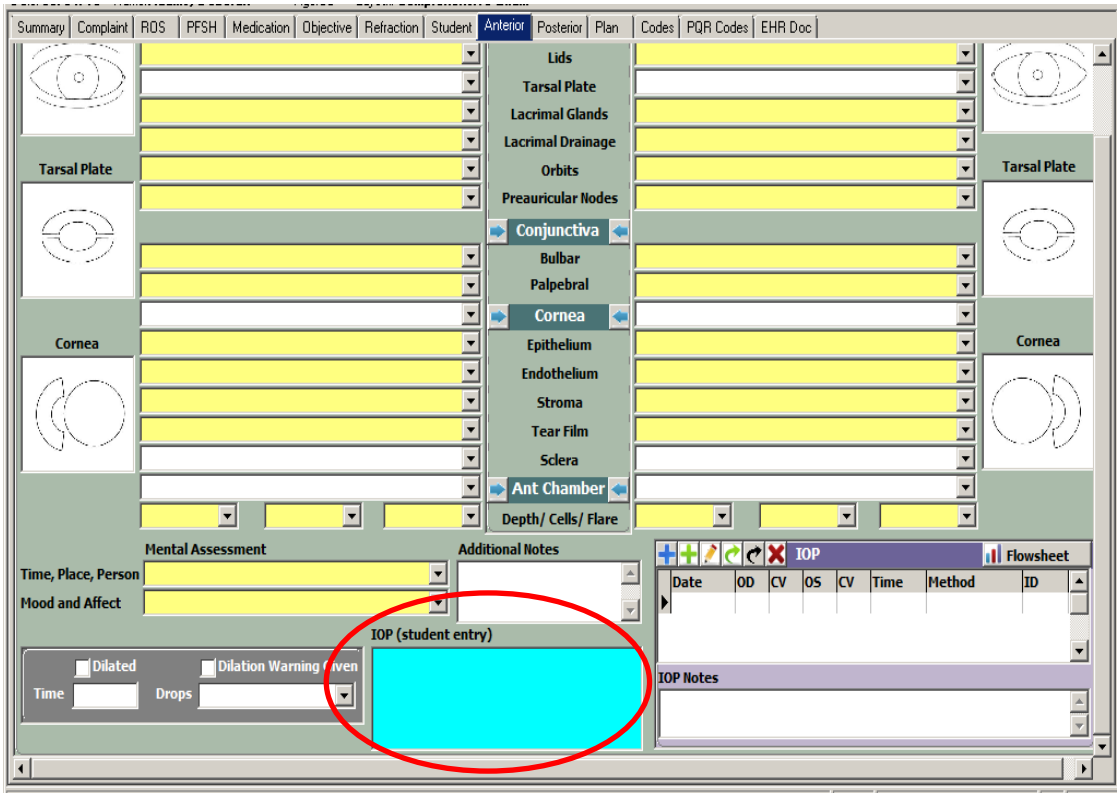

Figure 4: IOP box for student entry

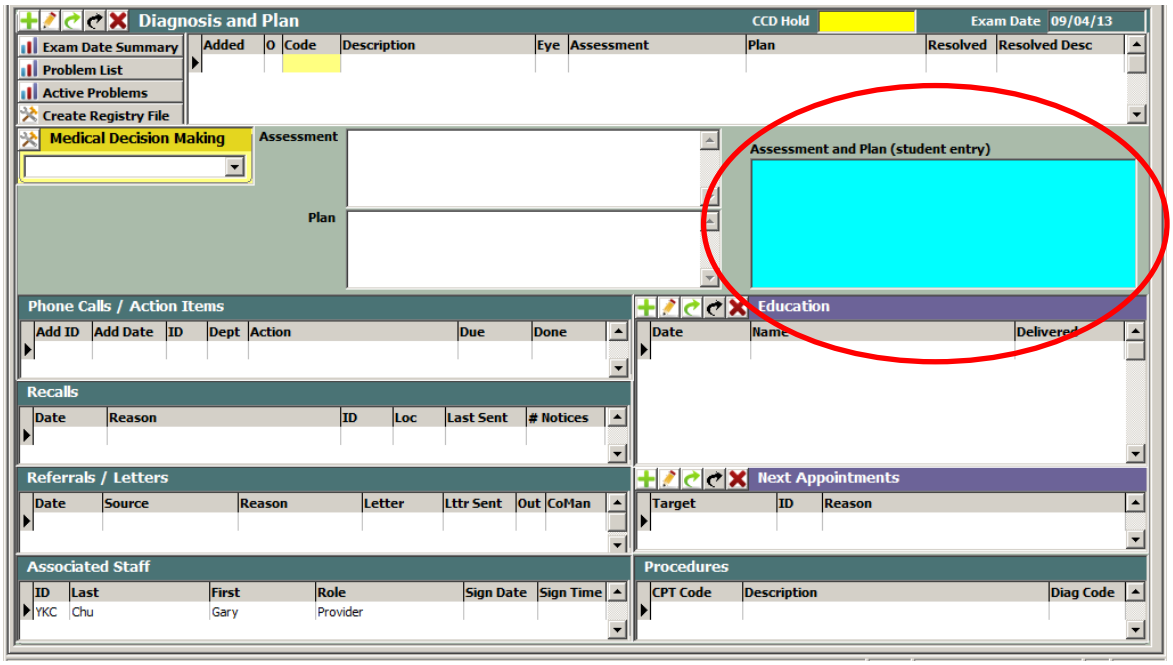

Figure 5: Assessment and Plan box for student entry.

Example of Paper Chart

Patient's Name: _____

SS#: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: _____

Student: _____ Attending: _____

Insurance: _____

Date: _____

Subjective Data

Chief Complaint/Reason for Visit: _____

_____

_____

_____

☐ Contact Lens Services Today: Refer to CL form

History of Present Illness

Location:
Quality:
Severity:
Duration:
Timing:
Context:
Modifying factors:
Associated signs or symptoms:

Review of Symptoms

☐ Primary ROS taken today
☐ Reviewed ___ /___/___ ROS today:
Changes:_____

_____

Past, Family & Social History

Past: Ocular:
Medical:
Family: Ocular:
Medical:
Social/Occupational:
Medications:

Attending Notes

Chief Complaint/Reason for Visit: _____

_____

_____

_____

Objective Data

DVA SC CC CL
OD 20/___ PH 20/___
OS 20/___ PH 20/___
OU 20/___

Habitual Rx1
OD _____
OS _____
Add _____ Prism _____

Cover Test SC CC _____distance
SC CC _____near

Stereo SC CC _____
Method: _____

NPC _____ / _____

EOMs_____

NVA SC CC CL
OD 20/___
OS 20/___
OU 20/___

Habitual Rx2
OD _____
OS _____
Add _____ Prism _____

Color Vision SC CC _____ OD
Method: _____ _____ OS

Acc Amps SC CC
_____ OD
_____ OS

Pupils _____

FCFs_____ OD
_____ OS

Attending Notes

EOMs_____

Pupils _____

FCFs_____ OD
_____ OS

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REFRACTIVE TESTING

Keratometry	OD _____ / _____ @ _____ mires _____ OS _____ / _____ @ _____ mires _____	
Retinoscopy	OD _____ 20/ OS _____ 20/	
Subjective Refraction	OD _____ 20/ OS _____ 20/	
Binocular Balance	OD _____ 20/ OS _____ 20/	20/
Trial Frame	OD _____ 20/ OS _____ 20/ _____ add	20/

BINOCULAR TESTING

ADDITIONAL PROCEDURES

Attending Notes

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OCULAR HEALTH ASSESSMENT

OD BIOMICROSCOPY OS

lids/adnexa
Cornea
Conj/sclera
Iris
AC
Lens
Vitreous
angles

Additional Ocular Health Testing Procedures:

TONOMETRY ☐ GAT ☐ NCT ☐ Other _____
OD _____ OS _____ @ _____ AM / PM

OPHTHALMOSCOPY
Dilated? ☐ Yes ☐ No
With _____ gtt of _____

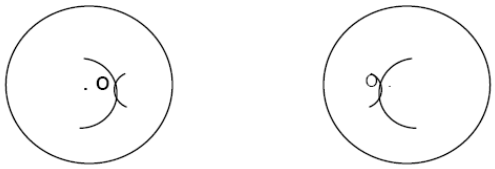
Dilation warning given? ☐ Yes ☐ No

FUNDUS EXAM
☐ Direct ☐ 78D ☐ 90D ☐ SF ☐ Indirect ☐ Other _____

Disk

cup/disk
margins
rims
a/v
macula
fovea
periphery

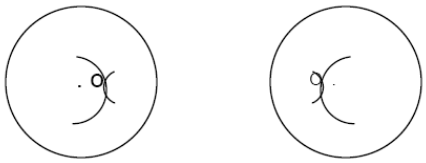
Disk



Attending Notes

lids/adnexa
Cornea
Conj/sclera
Iris
AC
Lens
Vitreous
angles

cup/disk
margins
rims
a/v
macula
fovea
periphery



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Additional Testing / Procedures

Attending Notes

Attending's Assessment and Treatment Plan

Assessment:

Plan:

Next recommended appointment: _____

Final Rx
OD _____ Add _____
OS _____ Add _____

This is to confirm that I met with this patient, reviewed reason(s) for visit and health history, reviewed and personally performed or repeated all clinical procedures if required by Medicare or other third party payors, verified the ocular health of the patient, determined the diagnosis and prescribed the above treatment.

Attending's Signature / Degree: _____ Date: _____

Student's Assessment and Recommended Treatment Plan

Assessment:

Plan:

Student's Signature: _____ **Date:** _____