# GRADUATE MEDICAL EDUCATION: INSIGHTS ABOUT THE 2020 IPPS PROPOSED RULE AND MEDICAL RECORD DOCUMENTATION

The Centers for Medicare & Medicaid Services (“CMS”) recently made several announcements regarding graduate medical education (“GME”). This article discusses three matters that are particularly significant for teaching hospitals, teaching physicians and other GME stakeholders. First, CMS issued its inpatient prospective payment system (“IPPS”) proposed rule (“Proposed Rule”) for fiscal year 2020 and announced the initiation of a new round of GME slot redistribution. Second, in the Proposed Rule, CMS proposes to reinstate the option for a critical access hospital ("CAH") that trains residents to be considered a non-provider setting for an IPPS teaching hospital, allowing the IPPS hospital to claim resident time spent training at the CAH.

Finally, a separate CMS publication (Transmittal 4283, also summarized in MLN Matter MM11171) provides clarification to the Medicare Claims Processing Manual (“Manual”) regarding the documentation policy for teaching physicians, residents and students related to evaluation and management (“E/M”) services.

## GME SLOT REDISTRIBUTION AFTER A TEACHING HOSPITAL CLOSURE

In the Proposed Rule, CMS announced Round 14 of the application and selection process for slot redistribution. Due to the closure of Good Samaritan Hospital in Dayton, Ohio, CMS will redistribute 62.60 Indirect Medical Education ("IME") slots and 62.03 Direct Graduate Medical Education ("DGME") slots. Of the IME slots, 7.00 will be reimbursed at half of the normal rate since they are from a section 422 cap increase. Of the DGME slots, 3.14 are from a section 422 cap increase and will be reimbursed at a national average per resident amount.

Hospitals that wish to acquire these available IME and/or DGME slots must ensure that CMS receives an application no later than July 22, 2019. Additional information about the application may be found at the CMS DGME website.

## IPPS HOSPITALS MAY CLAIM GME COSTS FOR RESIDENTS AT “NON-PROVIDER SETTING” CAHS

The Proposed Rule permits full-time equivalent ("FTE") resident time in approved GME programs training at a CAH to be counted as time at a “non-provider setting” on IPPS teaching hospitals’ cost reports, effective October 1, 2019, so long as the IPPS hospital incurs 100 percent of the resident salary and benefits costs during that time at the CAH. The other option is to have the CAH pay for resident salaries and benefits at the CAH and the CAH would then receive 101 percent of its Medicare portion of those direct GME costs. Prior to 2014, a CAH providing training to residents could participate in Medicare GME funding in one of these two ways:

- Seeking payment for 101 percent of reasonable Medicare costs of GME incurred by the CAH; or
- Participating as a non-hospital setting for an IPPS teaching hospital, where the IPPS teaching hospital would claim the FTE resident time on its cost report.

CMS eliminated the option for CAHs to participate as non-hospital settings through its 2014 IPPS final rule. During that time, CAHs were not considered “non-provider settings” and IPPS teaching hospitals could not claim time residents spent training at CAHs on cost reports even if the IPPS hospital incurred costs from paying residents’ stipends and benefits. This rule also applied to provider-based departments of CAHs. It is currently unclear how CMS handled CAH provider-based entities under these 2014 changes.

The Proposed Rule was developed out of a concern that not classifying CAHs as “non-provider settings” created barriers to training residents in rural areas. In furtherance of CMS’s stated goal of supporting resident training in rural and underserved areas, CMS reversed course. The Proposed Rule reverses the 2014 policy change by proposing to again allow IPPS teaching hospitals to include resident training time at CAHs on cost reports, provided that the CAH and the IPPS hospital fulfill the non-provider setting requirements at 42 C.F.R. §§ 412.105(f)(1)(ii)(E) and 413.78(g). The deadline to submit comments regarding the Proposed Rule is June 24, 2019. CAHs and other GME stakeholders who agree with this policy change are encouraged to submit comments.

## CLARIFICATION OF DOCUMENTATION POLICY

In Transmittal 4283, CMS clarified the language in the Manual (Chapter 12, Section 100.1.1) about the E/M services documentation policy for

residents and teaching physicians. These revisions underscore that medical records must show that the teaching physician performed the E/M service or was physically present during the key portions performed by the resident. The revised language notes, however, that the teaching physician's presence may be demonstrated "by the notes in the medical records made by physicians, residents or nurses." Notably, students were not included as personnel able to document the physical presence of a teaching physician. In addition, the clarifications specify that any contribution and participation of students to the performance of a billable service must be performed in the physical presence of a teaching physician or physical presence of a resident to satisfy billing requirements. Transmittal 4283 has an implementation date of July 29, 2019.

The aforementioned revision follows and continues changes to the same section in Transmittal 4068 (implemented March 5, 2018), where CMS modified the language to state that a teaching physician "must verify" all student documentation "in the medical record." It also required that the teaching physician "personally" perform the physical exam and medical decision making "but may verify any student documentation" in a medical record "rather than re-documenting this work."

Before these changes, these Manual sections included a lengthy discussion of combined resident and teaching physician entries, sample scenarios of minimally acceptable documentation by teaching physicians and examples of unacceptable documentation. However, the Manual after the changes discussed above will no longer include any example discussions. While the elimination of the examples and sample lists of unacceptable documentation seemingly removes helpful guidance, it may also suggest an easing of the documentation requirements for teaching physicians. If that is the case, it is surely welcome. However, teaching physicians must still be assured that the documents present in the record support what is needed for physician billing. Notably, based on the new language in the Manual, documents created by students may not be used to evidence teaching physician presence in the encounter or procedure.

**PRACTICAL TAKEAWAYS AND RECOMMENDATIONS**

As noted above, any comments to the Proposed Rule must be received by CMS no later than June 24, 2019. Teaching hospitals in and around Dayton, Ohio and elsewhere (since geography is only one criteria used by CMS for ranking) should consider whether any potential benefit might be achieved by adding additional GME FTE slots and whether an application should be submitted. Teaching hospitals providing training at CAHs and other GME stakeholders should monitor the proposed policy related to CAH participation as non-provider settings and should assess CAHs fulfillment of the necessary requirements for reimbursement to ensure reimbursement.

Separately, CMS's changes to the Manual change the documentation requirements for teaching physician billing. While the changes arguably shift the burden in favor of teaching physicians in satisfying billing requirements, teaching physicians and their teaching physician groups should still make conscious efforts to ensure that they comply with all documentation requirements to receive reimbursement for such services. Teaching hospitals and teaching physician groups should ensure that teaching physicians and students receive appropriate training about proper documentation.

If you have any questions or would like additional information about this topic, please contact:

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