



Primary Care Exception Rule: Just the Facts

Lara Smith CPC, CMEC | REGIONAL AUDIT DIRECTOR



Primary Care Exception Attestation Checklist

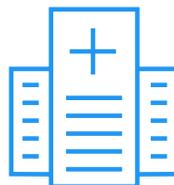
Understanding Primary Care Exception

The CMS defines Primary Care Exception:

“An exception within an approved GME Program that applies to limited situations where the resident is the primary caregiver and the faculty physician sees the patient only in a consultative role (that is, those residency programs with requirements that are incompatible with a physical presence requirement). In such Programs, it’s beneficial for the resident to see patients without supervision to learn medical decision making.”

In the primary care setting, it’s possible to report low to mid-range E/M services performed by a resident without direct teaching physician supervision. However, this doesn’t mean that the teaching physician is uninvolved. Since the service is reported under the teaching physician’s name, he/she still has to ensure the services rendered are appropriate and medically necessary. However, when done correctly, this exception to the teaching rule could translate to more patients treated than in a typical residency program and also a better learning experience for those residents.

There isn’t an application process or pre-approval in order to start operating under the primary care exception. However, a primary care center must attest in writing that all of the following conditions are met:





Primary Care Exception Attestation Checklist:

- The services were furnished in a primary care center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct Graduate Medical Education (DGME) payments to a teaching hospital.
 - Typically, the residency programs that are likely to qualify for this exception are family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in cases where the program furnishes comprehensive care to the chronically mentally ill psychiatric patient (e.g., antibiotics are prescribed along with psychotropic medication management).
- The primary care center is considered the patient's primary location for healthcare services.

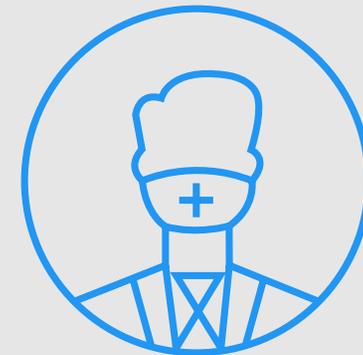
- Residents providing billable patient care without direct supervision must have completed at least 6 months of an approved residency program.
- The teaching physician (under whom the billing is reported) cannot supervise more than 4 residents at a time and must direct the care from such proximity as to constitute immediate availability.

The Teaching Physician Must:

- not have any other obligations during supervision of the residents (including supervising other personnel, e.g., non-physician practitioners),
- ensure the care furnished is reasonable and necessary,
- review the care furnished by the residents during or immediately after each visit, and
- document the extent of the participation in the review and

direction of the services furnished to each patient.

- Either the resident or the teaching physician (or a combination of both) can document the support of medically necessary services, but it is the teaching physician's responsibility to, at a minimum, document the review of the patient's medical history and diagnosis, the resident's findings on physical exam, and the treatment plan.





Types Of Services Residents Will Likely Perform And Level Of Risk

Residents in a primary care exception clinic would likely be seeing the same patients repeatedly over the time of their residency. As such, they would perform the following types of services:

- Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

Keeping in mind the first point, “Acute care for undifferentiated problems...,” the types of problems the resident is qualified to manage without a teaching physician’s direct presence will fall into the lower risk categories on the medical decision making table of risk.

Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
MINIMAL	One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	<ul style="list-style-type: none"> • Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep 	<ul style="list-style-type: none"> • Rest • Gargles • Elastic bandages • Superficial dressing
LOW	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain) 	<ul style="list-style-type: none"> • Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies 	<ul style="list-style-type: none"> • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational Therapy • IV fluids without additives

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>



Billing And Coding of Outpatient E/M Services

As a result, the highest level of service a resident can bill for outpatient E/M services is a 3 (99201-99203 and 99211-99213). Additionally, in recent years, CMS added the Initial Preventive Physical Examination, or IPPE (G0402), and both initial (G0438) and subsequent Annual Wellness Visits, or AWW (G0439), services to the list of allowed codes under PCE. Documentation for the IPPE and AWW services are very different from a “sick” visit billed with new or established patient visit codes, so be sure your providers know the requirements of both.

Primary Exception Rule: Important Qualifying Details To Consider:

- This is a Medicare concept, though some payers will follow Medicare’s lead. It’s important to exercise prudence by discovering which of your payers will allow this exception.
- Residents with less than 6 months in an approved GME program are not eligible. Teaching physicians would have to be physically present for the key or critical

portions of the services (see the CMS Claims Processing Manual, Chapter 12, Section 100 for detailed teaching physician guidelines).

- The GE modifier signifies to Medicare that the services were performed by a resident without the presence of a teaching physician under the primary care exception. This should be appended to the levels of service above when all of the requirements have been met.
- GC modifier is used when the service has been performed in part by a resident under the direction of a teaching physician (not primary care exception).
- This exception is not allowed in the inpatient hospital setting.

Conclusion

Remember, Primary Exception Rule is an exception within an approved GME Program that applies to some situations where a resident can act as the primary caregiver. While there isn’t an application process, the primary care center must attest in writing that all of a number of conditions are met. Residents will usually perform services in the medical decision making low risk categories like a stable chronic illness.

It’s crucial to remember that the service is reported under the teaching physician’s name, so he/she still has to ensure that the services rendered were appropriate and medically necessary. The benefit to this exception is that the rule could translate to more patients treated than in a typical residency program and it’s also a better learning experience for those residents regarding medical decision making.





AUTHOR BIO

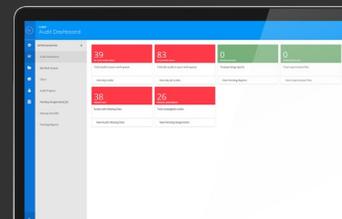
Lara Smith CPC, CEMC

Lara has over 10 years of experience in the healthcare billing and coding industry. She currently performs secondary audit reviews and provides education to clients in various parts of the country as a Regional Audit Director with Healthicity Audit Services. Lara has previously served as President and President-Elect in the Mooresville, NC chapter.

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