Certified nurse-midwives are teaching obstetrics and gynecology residents and medical students in major academic institutions across the United States. In these instances, the ability to appropriately document services rendered to support a billable service is paramount. This article explains the difference in requirements for midwives’ documentation when working with residents compared with documentation required of an attending obstetrician-gynecologist. It also reviews the teaching physician guidelines developed by the Centers for Medicare and Medicaid Services (CMS) as well as current evaluation and management documentation requirements. Several examples of documentation are provided, as are suggestions for enhancement and simplification of the guidelines to include midwives. An important point to remember is that the CMS rules do not prohibit a certified nurse-midwife from teaching a resident. J Midwifery Womens Health 2009;54:282–286 © 2009 by the American College of Nurse-Midwives.

Keywords: documentation, Medicaid, medical, midwifery, obstetrics, residency

Many factors in the current delivery of obstetric services in the United States have led to the use of certified nurse-midwives/certified midwives in new and expanded roles that are necessary for the success of obstetric departments in large academic institutions. In many institutions, midwives are currently teaching obstetrics and gynecology residents and medical students in labor and delivery units, triage settings, and in outpatient clinics.1–5

When midwives provide care for women with residents and medical students, they must adhere to prescribed regulations for billing for these services. This article reviews ways in which midwives in academic settings can comply with current regulations related to documentation and coding in the provision of ambulatory and inpatient services when working with residents and/or medical students. Examples are provided of appropriate documentation for antepartum global services, evaluation and management (E&M) services (e.g., outpatient and inpatient procedures, sick visits or labor, and delivery triage), and inpatient services such as admission histories and physical examinations.

BACKGROUND: CENTERS FOR MEDICARE AND MEDICAID SERVICES REGULATIONS

Traditionally, obstetrician-gynecologists and/or maternal-fetal medicine specialists have served as attending providers for medical students and residents. More recently, midwives have been called upon to supervise them as well.5–8 Some of the factors that have precipitated the evolution of the midwifery role to include teaching residents and medical students are rising health care costs, declining reimbursements from third-party payers, and the 80-hour work week rule for residents, which in turn demands more work from attending providers.9

The stringent enforcement of the rules of the Centers for Medicare and Medicaid Services (CMS) regarding teaching physicians and documentation requirements for billing for services provided in an academic institution have also added to the time demands on attending providers.

The CMS regulations are intended to specify when it is appropriate to bill under Medicare if a physician is serving in both the role of a clinical preceptor and as a provider of services to Medicare beneficiaries. Current federal law provides Medicare subsidies to teaching facilities to provide physician residency training in the form of graduate medical education (GME) dollars. These funds are for direct expenditures such as the residents’ actual stipend (salary) and indirect expenditures such as institutional expenses incurred by the teaching facility (e.g., faculty/staff subsidies). Teaching rules of CMS clearly define a teaching physician:

“… a physician, other than an intern or resident, who involves residents in the care of his or her patients. Generally, the teaching physician must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the Medicare Physician Fee Schedule (MPFS).”10

If the physician is precepting a resident and primarily teaching while the resident is providing key portions of the service, then the physician may not bill Medicare for his or her services or the services rendered by the
residents. This is because, according to CMS rules, the physician is being compensated for his or her teaching time through the GME payments that are paid to the teaching institution. The physician’s salary is supplemented for his or her preceptor work by the institution. The resident’s services are also being paid by GME funds. Therefore, billing Medicare for work performed by a resident physician would essentially be a second bill for the same service, or double dipping. Of note, there can be no confusion that the teaching physician rules apply to physicians only.10,11

So, here is the dilemma: midwives can serve as attending providers and bill for services but how must those services be documented to comply with CMS guidelines? The teaching physician rules state:

“Services can be paid under the Medicare Physician Fee Schedule if performed by a physician who is not a resident, is furnished by a resident when a teaching physician is physically present during the critical or key portions of the service, or furnished by residents under a primary care exception within an approved Graduate Medical Education program.”10

Institutional compliance officers provide analysis and guidance, interpreting CMS rules as they apply to specific cases. Compliance officers are able to guide providers on appropriate documentation for work done to support a billable service. These officers function to assist providers in appropriate documentation, coding and billing, not to admonish those who are not compliant. Of note, some of the documentation examples provided in this article are compliant according to Vanderbilt University Medical Center’s compliance review; however, other institutions may interpret the CMS rules differently and advise providers differently.

When attending physicians bill for an E&M procedure (by using the appropriate code from the American Medical Association’s Current Procedural Terminology,12 code book) they must personally document their own participation in the service.13 They must also document that they were present for the key or critical portions of the service that was provided by the resident. The combined entries of the resident and the teaching physician are sufficient documentation for billing these services. This is referred to as the physicians “attestation” to the resident’s note (Table 1).

Note that the physician attestation is a reference to the resident’s documentation, a review of pertinent facts, and agreement with the plan of care. The teaching physician is able to attest a resident’s note in this fashion without repeating or redoing the physical examination. If a midwife admitted this woman with the resident, the midwife’s documentation would need to include a new history of present illness (HPI), physical examination, assessment, and plan. These must all have been performed by the midwife to support a billable service. The midwife may refer to the resident’s past medical, surgical, family, and social histories as well as existing lab work, and allergy or medication lists in the written or typed note.

**EVALUATION AND MANAGEMENT DOCUMENTATION**

Midwives are excluded from the teaching physician language and therefore must document services rendered to support a billable service by following the 1997 Documentation Guidelines for Evaluation and Management Services.13 The documentation of each patient encounter should include 1) the reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results; 2) assessment, clinical impression, or diagnosis; 3) plan for care; and 4) date and legible identity of the observer.

The following seven components are used in defining the levels of E&M services: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time. The first three of these components (history, examination, and medical decision making) are the key components in selecting the level of E&M services.

The levels of E&M service consider four types of history: problem focused, expanded problem focused, detailed, and comprehensive. In addition, each of these types of history includes some or all of the following: chief complaint, HPI, review of systems, and past, family, and/or social history.

The HPI is a chronologic description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present (quality, timing, context, location, duration, severity, modifying factors, associated signs, and symptoms). It may be brief or extended. A review of systems is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. The past, family, and/or social history consists of a review of three areas: 1) past history (the patient’s past experiences with illnesses, operations, injuries, and treatments), 2) family history (a review of medical events in the patient’s family, including diseases that may be hereditary or place the patient at risk), and 3) social history.
Attestation by Jane Doe, M.D. on 2008/06/25 02:24

ROS: past medical, family, social history were reviewed and confirmed with the patient. 24-year-old G1 at 20 6/7 weeks status post cerclage placement on 6/12 who complains of loss of fluid. I examined the patient and confirmed the examination by the physician below.

Abdomen nontender, FHTs 160. Rupture confirmed per Dr. Jones’ exam. I have reviewed the chart, tests, and labs. I have discussed the differential diagnosis, workup, and treatment plan with the physician below and approved the plan. Patient and husband counseled re: dismal prognosis for achieving fetal viability, pulmonary hypoplasia, risk for intrauterine infection, etc. Offered choice of expectant management vs. clipping cerclage vs. clipping cerclage plus induction; after discussion with husband, patient chooses to have cerclage clipped and await spontaneous labor.

End of Attestation

FHT = fetal heart tones; ROS = review of systems.

*This note would follow a full history and physical documented by the resident physician.

(substance use, education, marital status, sexual history, abuse history).

Another key determinate when choosing an E&M code is the amount of physical examination that is performed. There are four levels of physical examination that correspond to the four types of history: 1) problem focused, a limited examination of the affected body area or organ system; 2) expanded problem focused, a limited examination of the affected body area or organ system and any other symptomatic or related body areas or organ systems; 3) detailed, an extended examination of the affected body area or organ system and any other symptomatic or related body areas or organ systems; and 4) comprehensive, a general multisystem examination or complete examination of a single organ system and other symptomatic or related body areas or organ systems. General multisystem examinations may be done by any provider regardless of specialty. There are also provisions for detailed single organ system examinations and specific documentation guidelines for each level of E&M service.

The final key element of E&M coding considers four levels of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by 1) the number of possible diagnoses and/or the number of management options that must be considered; 2) the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and 3) the risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the presenting problems of the patient, the diagnostic procedures, and/or the possible management options.

### Table 1. Attending Physician’s Attestation of Resident Physician’s Documentation

**Table 1. Attending Physician’s Attestation of Resident Physician’s Documentation**

<table>
<thead>
<tr>
<th>Attestation by Jane Doe, M.D. on 2008/06/25 02:24</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROS: past medical, family, social history were reviewed and confirmed with the patient. 24-year-old G1 at 20 6/7 weeks status postcerclage placement on 6/12 who complains of loss of fluid. I examined the patient and confirmed the examination by the physician below.</td>
</tr>
<tr>
<td>Abdomen nontender, FHTs 160. Rupture confirmed per Dr. Jones’ exam. I have reviewed the chart, tests, and labs. I have discussed the differential diagnosis, workup, and treatment plan with the physician below and approved the plan. Patient and husband counseled re: dismal prognosis for achieving fetal viability, pulmonary hypoplasia, risk for intrauterine infection, etc. Offered choice of expectant management vs. clipping cerclage vs. clipping cerclage plus induction; after discussion with husband, patient chooses to have cerclage clipped and await spontaneous labor.</td>
</tr>
<tr>
<td>End of Attestation</td>
</tr>
</tbody>
</table>

FHT = fetal heart tones; ROS = review of systems.

*This note would follow a full history and physical documented by the resident physician.

### Table 2. Midwife’s Documentation of Spontaneous Vaginal Delivery with Resident Physician

**Table 2. Midwife’s Documentation of Spontaneous Vaginal Delivery with Resident Physician**

Amended by Brown, Sue on 2008/07/01 at 23:55 as follows:

I was gowned and gloved and together with Dr. Johnson delivered a viable male infant over intact perineum under epidural anesthesia. Approximate 1 minute shoulder dystocia was relieved with McRoberts’ maneuver and suprapubic pressure. Cord was double clamped and cut and cord blood was collected. Spontaneous delivery of intact placenta with 3-vessel cord via Shultz’ mechanism. Fundal massage applied. Pitocin to IV. Fundus firm below the umbilicus. Scant vaginal bleeding. No lacerations noted. Weight 8 lbs 12 oz. Apgar 8/9. Estimated blood loss 300 cc.

*This would follow a complete delivery note by the resident physician, often utilizing forms or templates according to institutional requirement.

In the case where counseling and/or coordination of care dominates more than 50% of the provider/patient and/or family encounter (face-to-face time in the office, other, or outpatient setting, floor/unit time in the hospital or nursing facility), time determines the level of E&M service that is coded. For a detailed explanation of documentation requirements, the reader is referred to the *1997 Documentation Guidelines for Evaluation and Management Services.*

Per the E&M guidelines, the billing provider must perform medically necessary personal services. Therefore, the midwife must document hands-on performance of a service to bill for that service. That means that unlike physicians, when working with residents midwives can only bill for services performed by the midwife. This can be challenging but not impossible. Being gloved for a delivery and “participating actively” in the procedure is necessary to comply with billing guidelines (Table 2).

In the documentation of these services, it is imperative to chart a new HPI, physical examination, and medical decision making (or assessment and plan). The history portions of a note (past medical, obstetric, gynecologic, surgical, social, medications, and allergies) may be referred to or be reused.

These guidelines apply to any and all E&M services, including problem visits seen in the office/clinic (e.g., bleeding in early pregnancy, urinary tract infections, upper respiratory infections), triage or inpatient visits (e.g., threatened preterm labor, dehydration, and medical problems such as pyelonephritis or gastroenteritis), procedures such as intrauterine device or Implanon insertions in the office, deliveries, and routine gynecologic exams. Tables 3 and 4 have examples of notes a midwife might write when precepting a resident in the outpatient department and in a hospital triage setting.

In the documentation provided in Tables 2, 3, and 4, it is clear that the midwife was actively involved in the delivery of the service. The midwife’s documentation alone supports the level of service coded and submitted for billing purposes.

### Outpatient Global Services

Outpatient global services, which include routine prenatal and postpartum visits, may be documented differently.
Midwives working in an academic institution face many challenges when billing for services while working with residents and medical students. An important point to remember is that the CMS rules do not prohibit a midwife or nurse practitioner from teaching a resident. The regulations were not constructed for that purpose and were not intended for teaching physician billing.'

**IMPLICATIONS FOR PRACTICE**

Midwives working in an academic institution face many challenges when billing for services while working with residents and medical students. An important point to remember is that the CMS rules do not prohibit a midwife or nurse practitioner from teaching a resident. The regulations were not constructed for that purpose and were not intended for teaching physician billing.'
intended to establish who may precept residents. That is clearly left to the discretion of the individual residency programs. The regulation clarifies the distinction between a physician billing for performing “key portions” of the care he or she provides to a Medicare patient versus billing for his or her teaching/preceptor services, which are already paid for through GME monies.

Many compliance offices have suggested that midwives or nurse practitioners should not teach residents or serve as attending providers. This is often the result of inadvertent misinterpretation of CMS guidelines. Often, a meeting with compliance officers can and will achieve a mutually agreeable resolution to misunderstandings in this area.

Teaching rules of CMS need a clear, speedy revision that specifically includes guidelines for midwives and other advanced practice nurses who teach residents and medical students. The language is confusing and often cumbersome to midwives, whose clear mission is to provide evidence-based education to women’s health care learners, ease the burden of departments who have seen reimbursements decline simultaneously with increasing time demands on attending providers, and to bill and be paid for services rendered. Equality in reimbursement for services has been a longstanding issue for midwives and is a problematic in large academic centers as it is in community hospitals. Legislative changes in these areas are crucial to the viability of midwives in the academic arena.

REFERENCES


