

## Taking Exception to the Primary Care Exception Rule

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There are many milestones in the medical profession. For some, the white coat ceremony during medical school represents the first time when trainees envision themselves as a “real doctor.” This common ritual offers a symbolic start to a clinical career, but few would suggest that students are ready for independent practice. Immense growth occurs in the years after graduation, and life-long learning remains a cornerstone of our vocation. Yet, somewhere along the way, trainees must learn to practice independently in order to successfully enter the workforce. For many young doctors across the country, the transition to semi-independent practice occurs after completing the first six months of internship.

For many interns, the six-month mark is of little significance. Some thrive as they become more confident in their clinical skills, but other trainees struggle around this time of year. The days get shorter, the nights colder, and, for some learners, sleep deprivation, exhaustion, and the beginnings of burnout may start to take hold. On the other hand, most interns by this time become familiar with their clinical workflows and learn how to function as an essential junior member of the care team. Depending on the structure of the training program, the six-month intern may become increasingly familiar with the patients in his/her ambulatory practice and start to develop clinical efficiency in that setting. To be sure, some exceptional six-month interns may have already achieved “aspirational” competence more consistent with a senior colleague, but others will perform far lower on the bell curve. Everyone has his/her

unique strengths, weaknesses, and interests; seasoned faculty will recognize that competence is an evolutionary process that inconsistently develops among trainees and varies for an individual from task to task. And yet, the Centers for Medicare and Medicaid Services (CMS) billing rule, commonly known as the Primary Care Exception Rule (PCER), allows the six-month intern in some training programs to practice under only indirect supervision in his/her ambulatory clinic. Colleagues and I explore this apparent quandary in a recent article published in *Academic Medicine*.<sup>1</sup>

Traditionally, CMS requires teaching physicians to be physically present in the examination room for the portion of the care for which they invoice. The “physical presence” requirement has long been the gold standard of outpatient care delivery, and it arguably best meets both the billing *and* educational needs of the visit; CMS only pays for care from a “real” doctor in practice (the teaching attending), and preceptors can directly supervise and provide real-time feedback to their trainees. However, it can be inefficient in busy primary care teaching clinics where residents form long lines to wait for the next available preceptor. Recruiting additional teaching physicians to ensure adequate staffing is expensive, and residency programs historically argued that the physical presence requirement also stymied residents’ progress toward independent practice. Under protest from residency programs in family medicine, internal medicine, obstetrics-gynecology, and psychiatry, CMS ultimately yielded and created the PCER.<sup>2</sup>

The PCER allows certain qualifying programs to bill for indirect teaching services as long as the trainee has completed six months or more of his/her residency training.<sup>3</sup> In addition to the time requirement, faculty may not supervise more than four residents at a time, must be immediately available if needed, and may not have other concurrent responsibilities. Other requirements include ensuring that services are appropriate, assuming primary responsibility for the care provided by the resident, reviewing the case with the resident during or immediately after each visit, and documenting the extent of his/her involvement in the care. Under the PCER, billable evaluation and management services are limited—teaching physicians can use only low to midlevel codes for both new and established patients (i.e., 99201–99203 and 99211–99213).

Conspicuously absent, however, is a mandate to evaluate residents for minimal competence *before* utilizing the PCER. Appropriately, CMS makes no mention of what specific knowledge, skills, or attitudes a trainee must master—this is a responsibility of the graduate medical education (GME) community, as the PCER is merely a billing rule. However, CMS does not require training programs to evaluate their residents at all, and individual residency programs may—at their sole discretion—choose to implement the PCER without any standards of quality or resident competence. Undoubtedly, the vast majority of programs do their utmost to promote high-quality medical education and patient care, but some resi-

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gency programs report using the PCER “always,” including 31% of respondents to the 2016 SGIM Medical Resident Clinic Director Interest Group (MRCDIG) annual survey.<sup>4</sup> It is unclear whether these programs all have an internal vetting system to evaluate residents for various areas of competence before allowing them to see patients with only indirect supervision in the clinic, but it is unlikely. Furthermore, even if every program did internally vet their trainees, the GME community has not agreed on a uniform set of standards, perhaps because this has never been required.

This type of assessment is important to ensure that we are providing the highest quality care to our patients. Without joining the resident in the exam room, the trainee becomes our eyes, ears, hands, and voice as he/she assesses patients and implements care plans on our behalf. We must trust that his/her history-taking is accurate and appropriately targeted, that physical findings are properly obtained, that synthesis, organization, and presentation of data are done effectively, and that our care plans are implemented with empathy and without error. As our proxies, we are responsible for their actions and must be confident that our trust in a trainee is deserved. To do so, the GME community needs to develop and insist on careful review of residents before we allow them to provide care using the PCER. Thankfully, an evaluation rubric based on earned trust already exists as part of the Accreditation Council for Graduate Medical Education (ACGME) Milestone Project where established Milestones and Entrustable Professional Activities (EPAs) provide guidance.<sup>5-7</sup> These resources represent a good starting point to address this challenge, however, I believe that a new standard should be developed in a systematic way with consistent metrics across training programs.

To be clear, the PCER is a billing tool that is a great benefit to our busy workflows and—when used properly—can help to guide our trainees toward independent practice. But, we must also protect our patients by ensuring that a given resident can safely function in the clinic under indirect supervision. To this end, I recommend that CMS modify the PCER to require programs to perform a standardized assessment prior to allowing interns to practice under PCER. However, CMS must *not* dictate how or when that assessment occurs; those standards must come from the GME community. It is also important that CMS refrain from developing a cumbersome reporting system for tracking these assessments; this would negate many of the efficiencies gained by the PCER. Instead, teaching programs could be required to maintain internal documentation, in a fashion similar to other record keeping requirements from the ACGME.

As is often the case, financial pressures are powerful motivators for change and a modification of the CMS billing rule would undoubtedly inspire action by the GME community. Until then, the SGIM brain trust should collaborate with the Alliance for Academic Internal Medicine (AAIM) and the ACGME to address this challenge and proactively engage with CMS to influence change rather than remain the passive recipient of regulations with which we may not agree. Many member SGIM residency programs are already leading the way in this effort and the rest of us can learn from their labors. Perhaps this collaborative effort should be our next milestone.

### References

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