Teaching Physician Billing Compliance

Effective Date: March 27, 2012

Office of Origin: UCSF Clinical Enterprise Compliance Program

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I. Purpose

These Policies and Procedures are intended to clarify the Medicare requirements for Teaching Physician (TP) services and billing and to state UCSF policies designed to promote compliance with these requirements. The policies and procedures set forth in this document are based upon the interpretation of the applicable regulations, advice of legal counsel, and determinations by the Compliance Officer. These policies and procedures are in response to the Medicare regulations which replaced IL 372 and became effective July 1996.

Unless otherwise specifically provided, these policies and procedures apply with respect to all Teaching Physician services for which a claim is to be submitted by or on behalf of the UCSF School of Medicine, any subdivision of the University, or any physician for a service furnished in his or her capacity as a University faculty member (including full-time, part-time, Income Limitation Plan[ILP], and any other physicians who are members of any University compensation plan), and any physicians for whose services the University or related entities may bill or receive any economic benefit (*e.g.*, certain voluntary faculty). The only exceptions to these policies and procedures shall be set forth in Departmental Appendices, which set forth department-specific policies, interpretations, definitions, and procedures. Nothing in any Departmental Appendix shall be construed to excuse compliance with these UCSF Policies and Procedures for Teaching Physician Billing Compliance.

Further, nothing in this document shall be construed to eliminate the necessity of complying with specific practice and documentation requirements imposed by particular payors (including Medi-Cal).

These Policies and Procedures address the requirements for Teaching Physician services, but are not intended to provide an exhaustive statement and explanation of all regulatory requirements applicable to physician services, and shall not be construed to excuse failure to comply with any other regulatory requirements.

The general question addressed by these Policies and Procedures is not: "When can a Teaching Physician bill for professional services furnished by a resident?" Rather, the question is: "When has a Teaching Physician furnished a professional service that is discretely billable?"

The focus of analysis regarding Teaching Physician involvement in patient care and documentation must be on the Teaching Physician. In applying the Medicare Teaching Physician regulations it is important to remember that physician services in institutional settings generally must (1) be "personally furnished for an individual beneficiary by the physician;" (2) "contribute directly to the diagnosis or treatment of an individual beneficiary;" and (3) "ordinarily require performance by a physician."

At UCSF, the policies and procedures set forth in this document are applicable not only to Medicare patients, but to all patients, regardless of payor source, except when specific billing requirements of a particular payor may differ.

II. Definitions

a. Definition of "Teaching Physician"

- Teaching Physician means a physician (other than a resident) who involves residents in the care of his or her patients.

- Fully licensed physicians who are <u>not</u> participating in a graduate medical education program recognized by the ACGME or ABMS may be considered Teaching Physicians.

- Regardless of the designation "fellow" or "clinical instructor" an individual enrolled in an approved GME program as defined below may not be considered a Teaching Physician.

b. Definition of "Resident"

- Determining whether a medical trainee is considered a "resident" for purposes of these Teaching Physician policies and procedures is essential to determining whether claims may be submitted *by* or *on behalf of* the trainee, or whether a Teaching Physician must establish and document sufficient personal participation in the care of the patient to permit billing by the Teaching Physician for services in which the trainee was involved.

- The term "resident" means one of the following:

  - An individual who participates in an **approved GME** program, including programs in osteopathy, dentistry, and podiatry.

  - A physician who is **not in an approved GME** program, but who **is** authorized to practice only in a hospital (*e.g.,* temporary or restricted licenses, unlicensed graduates of foreign medical schools).

- Approved graduate medical education (GME) program means (1) a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatric Medicine Education of the American Podiatric Medical Association, (2) certificate programs in specialties and subspecialties recognized by the American Board of Medical Specialties (ABMS), or (3) programs that may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either The Directory of Graduate Medical Education Programs (AMA), or The Annual Report and Reference Handbook (ABMS).

- The term "resident" includes "interns" and "fellows" in **approved GME** programs. The term "fellow" has no distinct meaning and has no impact upon whether a trainee is considered to be a "resident" for purposes of these policies and procedures.

- The fact that an individual hospital does not choose to include an eligible individual in its full-time equivalency count of residents does not change that individual's status as a resident in an approved GME program.
- Physician trainees ("residents", "interns", or "fellows") who are **not in an approved GME program** and **are not authorized** to practice only in a hospital (*e.g.,* temporary or restricted licenses, unlicensed graduates of foreign medical schools) and **do not have** an approved UCSF Office of Graduate Medical Education (OGME) exception are not considered "residents" subject to these teaching physician guidelines.

c. Definition of "Minor" Procedure

- Procedures that take only a few minutes to complete, *e.g.,* simple suture, and involve relatively little decision making once the need for the operation is determined.
- Procedures that typically require more than five (5) minutes to complete are considered major procedures for purposes of these policies and procedures. In this matter, USCF is adhering to Medicare's determination as described in the Medicare Claims Processing Manual (Publication 100-04, Chapter 12, Section 40: "*Codes with "090" in Field 16 are major surgeries. Codes with "000" or "010" are minor surgical procedures*").

III. Policy

1. Use of Medical Students

1.1 A medical student is never considered to be a resident.

1.2 Notwithstanding potentially greater leeway allowed by the Medicare Carriers Manual instructions, any contribution of a medical student to the performance of a service billable by a Teaching Physician must be disregarded for the purposes of documenting and billing the Teaching Physician's services.

1.3 Neither a Teaching Physician nor a resident may rely on any aspect of a service performed by a medical student.

1.4 Students may document services in the medical record, however the Teaching Physician may not refer to a student's documentation of physical findings or medical decision making in his or her personal note. If the medical student documents E&M services, the Teaching Physician must verify and re-document all requirements for a billable service, including personal performance and documentation of the physical examination and medical decision making.

2. Use of Moonlighting Residents/Fellows

2.1 Moonlighting services provided by a resident in an **approved GME** program **may not** be billed under the Medicare physician fee schedule **as independent professional services. Please note this section addresses professional fee billing only. For further information on this topic, please contact the Graduate Medical Education office at:** http://www.medschool.ucsf.edu/gme/

2.2 “Internal moonlighting” is defined as extra work for extra pay performed at a site that participates in the resident’s training Program. This activity must be supervised by faculty and is not to exceed the level of clinical activity currently approved for the trainee. While performing internal moonlighting services, residents are not to perform as independent practitioners *and may not bill for their professional services*. ACGME fellows may function independently pending appropriate credentialing and prior approval. Internal moonlighting hours must be documented, and the must comply with the written policies regarding Duty Hours as per the training Program, UCSF, and ACGME.

2.3 “External moonlighting” is defined as work for pay performed at a site that does not participate in the resident’s training Program. External moonlighting hours must be documented (including days, hours, location, and brief description of type of service(s) provided) in order to comply with Medicare reimbursement requirements for GME. For external moonlighting, the trainee is not covered under the University’s professional liability insurance Program as the activity is outside the scope of University employment. The trainee is responsible for his/her own professional liability coverage (either independently or through the entity for which the trainee is moonlighting), DEA licensure, Medicare (or other governmental) provider number and billing training, and licensure requirements by the California Medical Board and any other requirements for clinical privileging at the employment site.

2.4 ACGME fellows may moonlight at a UCSF School of Medicine facility if it is outside the area of training for that fellowship and if it is not in an inpatient setting (per Medicare rules). A “Professional Services Agreement for Moonlighting by ACGME Clinical Fellows” form must be completed and signed prior to moonlighting at a UCSF facility by an ACGME fellow. This would be considered internal moonlighting because it is at a site used by the training program *and therefore, the physician services provided may not be billed by the fellow.* Note: If the ACGME fellow is working within his/her training program, not exceeding his/her approved clinical level of activity and is supervised by faculty, the “Internal Moonlighting Form for Residents” should be used.

2.5 No bill may be submitted for Teaching Physician services associated with moonlighting residents.

3. Evaluation and Management Services

3.1 Evaluation and Management (E&M) services include (but are not limited to) initial hospital care, emergency department visits, new patient office visits, consultations, subsequent hospital care, established patient office visits, and certain other services such as psychiatric evaluations and preventive medicine services.

3.2 Medicare Requirements: The selection of the appropriate level of E&M service is based on the guidelines set forth in either the 1995 or 1997 “Documentation Guidelines for Evaluation and Management Services,” which were developed by the American Medical Association (AMA) and CMS and published by the AMA. The decision regarding which set of guidelines is clinically appropriate and will result in achieving the highest level of reportable service may be made at the department level and documented in the Department Appendices to this policy.

3.2.1 Both Medicare and Medi-Cal require that the teaching physician perform some medical service. Medi-Cal requires “direct service,” while Medicare requires “personal service”. Direct service for Medi-Cal billing is service by the TP that is more than passive supervision, but may be carried out by the resident and is intended to benefit the patient’s condition. The criteria is active faculty participation in the patient’s care (e.g., contributing to the plan of treatment), not passive teaching supervision alone.

3.3 If a teaching physician documents that he/she was present and participated in the E&M service, the level of service may be selected based on the extent of history and/or examination and/or complexity of the medical decision-making that was medically necessary. The teaching physician’s personal entry/attestation statement along with the resident’s entry will be combined to determine the level of service. The teaching physician’s entry/attestation statement includes references to notes which were previously entered in the medical record by the resident. Teaching physicians must personally document at least the following:

3.3.1 That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and

3.3.2 Their participation in the management of the patient.

3.4 The key or critical portion of an E&M service is that part of the service that the Teaching physician determines is (are) a critical or key portion.

3.5 For time-based codes, the Teaching Physician must be present for the entire period of time for which the claim is made. Time spent by the resident in the absence of the Teaching Physician may not be counted.

4. Teaching Physician E&M Examinations Subsequent to Resident Examinations

4.1 The Teaching Physician's service to the patient need not occur simultaneously with services furnished by a resident. The Teaching Physician's personal service to the patient may occur subsequent to services furnished by a resident without precluding billing or reducing the level of service that may be billed by a Teaching Physician provided certain medical record documentation requirements are satisfied.

4.2 Under these circumstances, to assure appropriate patient care and the Teaching Physician's involvement in the medical decision making for the patient, residents providing inpatient services should be instructed to contact the Teaching Physician by telephone promptly following their examination of the patient to discuss the resident's assessment and plan of care for the patient. The resident should document the telephone conversation in the medical record.

4.3 Teaching Physicians shall personally see the patient within a reasonable time based on clinical considerations and shall personally perform and document those services considered to be key or critical and which document the TP’s direct involvement in the management of the patient. The TP’s note may reference the resident’s note.

4.3.1 When providing inpatient services, in no event may a resident's work-up be considered in coding a claim if the Teaching Physician's examination of the patient occurs more than 24 hours after the resident's examination.

4.3.2 When providing services in the outpatient setting, for a resident's work-up to be considered in coding a claim, the Teaching Physician's examination of the patient must occur on the same day and as soon as clinically possible after the resident's examination.

4.4 Teaching Physician inpatient services shall be billed on the date the Teaching Physician personally examines the patient, even if the resident's examination occurred on the preceding calendar day. Billing and coverage rules, which generally prohibit billing multiple services for a patient on the same day, *e.g.,* subsequent hospital visit on the same day as initial hospital care, also apply under these circumstances.

5. Content of Teaching Physician's Medical Record Notes/Entries

5.1 "Seen, examined, agreed" is **not** sufficient documentation for E&M services.

5.2 When a Teaching Physician provides an E&M service to a patient **without** the assistance or involvement of a resident the Teaching Physician must prepare a complete note substantiating the level of E&M services provided and medically necessary for the patient.

5.3 When a Teaching Physician is physically present with a resident during the key or critical portions of the service and the resident prepares a note for the service:

5.3.1 The Teaching Physician's personal note/attestation statement must consist of comments making reference to and confirming or revising the resident's findings and entries. At a minimum the note should establish physical presence of the TP during the key or critical portions of the service and the combined entries in the medical record by the TP and resident must support the level of E/M service billed as well as the medical necessity for the services provided.

6. Selecting the Level of CPT-4 Coding for the Service

6.1 Level of service must be determined based upon the Code descriptions in the current CPT-4 (published by the AMA) and the "Documentation Guidelines for Evaluation and Management Services" published by the AMA and CMS.

6.2 If a resident has prepared a note for the service and the Teaching Physician's note makes reference to the resident's note, the level of service may be established based upon the combination of medical record entries.

7. Surgical Procedures

7.1 The practice and documentation requirements for procedures vary depending upon the type of procedure (*e.g.*, major, minor, endoscopic) and whether the Teaching Physician is present for the entire procedure or only for the key and critical portion(s) of the procedure. Two levels of Teaching Physician involvement need to be considered in connection with procedures: (1) physical presence and (2) "immediate availability" (required throughout the entire procedure).

7.2 For Major Procedures, the Teaching Physician must be: (1) "Present during all critical and key portions of the procedure," and (2) "Immediately available to furnish services during the entire service or procedure."

7.2.1 To be considered "present", the Teaching Physician must be in the operating room (and be listed as a surgeon in the operating room record).

7.2.2 Physicians have flexibility in defining the key and critical portions of particular procedures. Generally, Teaching Physician presence is not required during opening and closing of the surgical field. For some procedures, however, the closing may actually be the key portion of the procedure, e.g., plastic and reconstructive surgeries. For such procedures, the Teaching Physician must be present for the closing.

7.2.3 For Minor Procedures and Endoscopic Procedures the teaching surgeon must be present in the operating room or procedure room for the entire procedure.

8. Documentation for Minor Procedures

8.1 The fact that the physician was present throughout the entire procedure must be documented in the medical record.

9. "Immediate Availability" for Procedures

9.1 The Teaching Physician must be "immediately available" to furnish services during the entire procedure (including opening and closing) unless he or she has arranged for a "designated physician" to be immediately available to intervene in the original case, should the need arise.

9.2 Immediate availability is not defined in terms of geographic location vis-a-vis the operating room. Immediate availability must be interpreted in a common sense manner, focusing upon the Teaching Physician's ability to return to the procedure and intervene immediately if necessary.

9.3 To be considered "immediately available" The Teaching Physician must not be involved in another activity from which he or she cannot immediately return.

9.4 At UCSF hospitals, Teaching Physicians will be considered immediately available if they are within the hospital and available by page and, able to be present in the operating room within five to ten minutes. Please check specific Departmental Appendices for specific interpretations and definitions of immediate availability.

10. Overlapping Procedures

10.1 Medicare Teaching Physician rules also permit a Teaching Physician to satisfy the "immediate availability" requirement by designating another Teaching Physician to be "immediately available" with respect to one procedure while the

surgeon begins to take part in a second procedure or another activity that would render the surgeon not available with respect to the first procedure.

10.2 If the Teaching Physician wishes to become involved in an overlapping procedure:

10.2.1 The Teaching Physician must remain physically present during a first procedure until all of the key portions of that procedure have been completed.

10.2.2 The Teaching Physician shall designate another Teaching Physician to be immediately available with respect to the first procedure when the Teaching Physician becomes involved in the second procedure.

a. The designated physician may not be a "resident," as defined in these policies and procedures, but must be a qualified, fully licensed physician.

b. The designated physician must not be involved in any other service or activity that would prevent him or her from intervening immediately in the surgical procedure, if necessary.

c. The same physician cannot serve as the designated physician for more than one procedure at a time.

11. Documentation for Major Surgical Procedures

11.1 When the Teaching Physician is present throughout the entire procedure, Medicare guidelines state that "The presence of a Teaching Physician during procedures may be demonstrated by the notes in the medical record made by the physician, resident or nurse".

11.2 If the Teaching Physician is not present for the entire procedure (including during opening and closing):

11.2.1 The Teaching Physician must personally document the key portion of the procedure for which he or she was present; and

11.2.2 The identity of any physician designated to cover the immediate availability requirement for the procedure must be documented.

11.3 The Teaching Physician's note should be a clinically relevant entry describing the portions of the procedure during which the Teaching Physician was present.

11.4 The operative report may be prepared by the Teaching Physician or a resident. Whoever dictates the operative report shall sign it. A Teaching Physician may cosign an operative report dictated by a resident, but this does not eliminate the need for a separate personal entry by the Teaching Physician (unless the Teaching Physician was present for the entire procedure and this is documented in the medical record). The Teaching Physician is responsible for ensuring proper documentation of the Teaching Physician’s presence is contained in the resident’s note. If such documentation is absent, the Teaching

Physician must personally document the Teaching Physician's presence and participation in the service.

12. Pre-Operative and Post-Operative Services

12.1 The Teaching Physician must be responsible for the preoperative, operative, and post-operative care.

12.2 Preoperative Examination

12.2.1 The Teaching Physician must be present for the preoperative examination whenever the preoperative examination is considered by the Teaching Physician to be a key or critical portion of the global surgical service.

12.2.2 Even when the Teaching Physician does not consider preoperative examination to be a key or critical portion of the service, the medical record must reflect that a pre-op examination was conducted. Thus, it is appropriate for the Teaching Physician to indicate that he or she reviewed the resident's pre-op examination prior to the surgery by co-signing the resident's pre-op examination note.

12.3 Postoperative Visits

12.3.1 The Teaching Physician need not be present for all postoperative visits, but must determine which post-operative visits are considered "key" and thus require the Teaching Physician's presence.

12.3.2 If the global surgery period extends beyond the discharge, CPT-4 coding modifiers for less than the global package apply.

12.3.3 The Teaching Physician shall prepare a personal note for each key post-surgical follow-up visit for which he or she was present. The physician's note for post-surgical follow-up visits need not satisfy the criteria for an E&M service, but must be a clinically relevant entry in the medical record. This may be a brief note, but "Seen, examined, agreed" or similar entries are not sufficient.

12.3.4 If surgical services have been performed by a resident without Teaching Physician presence, the Teaching Physician may bill for follow-up visits with appropriate coding modifiers.

13. Endoscopic Procedures

13.1 For diagnostic procedures using an endoscope, the Teaching Physician must be present during the entire viewing. For Medi-Cal patients, endoscopic procedures must be performed by the Teaching Physician.

13.1.1 The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope

13.1.2 Viewing through a monitor in another room is not sufficient.

13.2 "Endoscopic operations" (*i.e.*, therapeutic services performed through an endoscope) are subject to the general rules for surgical procedures.

14. Other Complex or High-Risk Procedures

14.1 Other Complex and High-Risk Procedures include procedures for which national Medicare policy, local Carrier policy, or CPT-4 code description indicates that personal (in person) supervision by a physician is required.

14.1.1 Complex or high-risk procedures include, but are not limited to:

Interventional radiologic and cardiologic supervision and interpretation codes; Cardiac catheterization; Cardiovascular stress tests: Transesophageal Echocardiography.

14.2 Key/Critical Portion of Other Complex and High-Risk Procedures

14.2.1 When the CPT-4 procedure code description for a Complex and/or High-Risk service includes the term "supervision", the Teaching Physician **shall be present for the entire service defined by that CPT-4 code. For these codes no distinct key/critical portions are recognized.**

14.2.2 When a department has determined that an Other Complex or High-Risk Procedure has separately identifiable key/critical portions, that department shall submit those procedures for inclusion in the Departmental Appendix to these Policies and Procedures.

14.3 The Teaching Physician billing for an Other Complex or High Risk Procedure shall be present for all of the key/critical portions of the procedure.

14.3.1 If the Teaching Physician's department has determined that there are distinct key/critical portion(s) for a particular Other Complex or High-Risk procedure:

a. The Teaching Physician must be present during the key and Critical portion(s) of the procedure and must personally document services provided.

b. The Teaching Physician must be immediately available throughout the entire procedure to intervene or confer with the resident if necessary.

14.3.2 If the Teaching Physician's department has not identified a key portion with respect to an Other Complex or High Risk procedure:

a. The Teaching Physician must be present in the room in which the procedure is furnished throughout the entire procedure.

b. The Teaching Physician's presence throughout the procedure must be documented in the procedure note.

15. Diagnostic Interpretation Services

15.1 These rules apply to interpretations of all forms of diagnostic tests (professional component services), regardless of whether the results are presented as an image, numeric calculation, a slide, strip, or any other modality. To the extent a service involves a procedure instead of an interpretation only, the rules governing procedures (please see above) must be followed.

15.2 All diagnostic interpretations shall be performed by or reviewed with the Teaching Physician.

15.3 To bill based on review of a resident's interpretation, the Teaching Physician must review both the test and the resident's interpretation report.

15.4 Documentation for Diagnostic Interpretation Services

15.4.1 Documentation must indicate that the Teaching Physician personally performed the interpretation or reviewed both the test/image and the resident's interpretation.

15.4.2 If the Teaching Physician personally performs the interpretation before the results are transmitted (whether orally or in writing) for use in the treatment of the patient:

a. The Teaching Physician may personally prepare the report and sign it for the medical record, or

b. If the resident prepares the report, the Teaching Physician must indicate in a personal note/attestation entry signed by the Teaching Physician that he or she has reviewed the test, the resident's report (whether notes, dictations, or preliminary interpretations), and has performed all necessary edits before signing the final report.

15.4.3 If the Teaching Physician has not personally performed the interpretation of a test before the results are transmitted (whether orally or in writing) for use in the treatment of the patient, the Teaching Physician must enter a signed personal note in the medical record indicating that the Teaching Physician has reviewed the test, any resident created report (whether notes, dictations, or preliminary interpretations), and has performed all necessary edits before signing the final report.

15.4.4 A countersignature on the resident's interpretation or dictation is not sufficient.

16. Special Rules for Obstetric Services

16.1 The Teaching Physician must be present for the delivery and for any other services requiring intervention by a physician.

16.2 Other specific general rules applicable to global maternity services must also be satisfied.

16.3 All delivery services are treated as major surgery procedures.

17. Special Rules for Anesthesia Services

17.1 Please see Departmental Appendix A

18. Special Rules for Dialysis Services

18.1 Physicians who elect to receive payment under the monthly capitation method need not comply with these Teaching Physician regulations with respect to services covered under the capitation payments.

18.2 Physicians who do not accept payment under the monthly capitation method must comply with the specific requirements for fee for service physician services in connection with dialysis services under applicable regulations.

19. Primary Care Exception for Certain Clinic Settings

19.1 The Departments of Medicine, OB/GYN, and Family and Community Medicine operate clinics in which some services will be furnished under the Primary Care Exception to the Teaching Physician presence requirement for certain E&M services. The Primary Care Exception does <u>not</u> apply to any other UCSF departments or divisions.

20. Medical Necessity Considerations and Resident Qualifications

20.1 CMS has indicated that it may seek to deny claims for Teaching Physician's services (as not reasonable and necessary) when a resident is considered fully qualified to furnish the services without supervision.

20.2 UCSF faculty physicians shall not bill, nor have bills submitted, for Teaching Physician services that are not considered by the Teaching Physician to be medically reasonable and necessary for the diagnosis and treatment of a patient.

21. Billing Modifiers for Medicare Claims

21.1 Unless one of the exceptions in section 24.2 applies, whenever a resident <u>has been involved in the care</u> of a Medicare patient, the "-GC" billing modifier must be attached to the CPT-4 code describing the service.

21.2 The only exceptions to use of the "-GC" modifier at UCSF are:

21.2.1 Services furnished in the Departments of Medicine, OB/GYN and Family and Community Medicine which satisfy the criteria for the Primary Care Exception to the Teaching Physician presence requirement. These services must be billed using modifier "-GE".

21.2.2 Services in which residents have not been involved. These services are to be billed without either of the Teaching Physician modifiers.

21.3 The Medicare Teaching Physician billing modifiers are mandatory but should not be used automatically. The modifiers represent certifications regarding the circumstances in which the services were furnished, and should be applied only to claims for which those specific circumstances were present. These modifiers do not affect the amount of payment received from Medicare.

21.4 The use of the -GC modifier certifies that the Teaching Physician was present during the key portions of the service.

21.5 The use of the -GE modifier certifies that the services was performed by a resident without the presence of a Teaching Physician, but under the primary care exception.

22. Department-Specific Policies and Procedures

Department-specific policies, definitions, and procedures are set forth in the following Departmental Appendices to these UCSF Policies and Procedures. Faculty members and personnel are responsible for compliance with these Departmental Appendices as well as these Policies and Procedures of general applicability.

Please note that this section will be updated as Department Policies are finalized

Appendix A	**Department of Anesthesia**
Appendix B	**Department of Dermatology**
Appendix C	**Department of Emergency Medicine**
Appendix D	**Department of Family and Community Medicine**
Appendix E	**Department of Surgery**
Appendix F	**Department of Neurosurgery**
Appendix G	**Department of Laboratory Medicine**
Appendix H	**Department of Medicine**
Appendix I	**Department of Neurology**
Appendix J	**Department of Obstetrics, Gynecology and Reproductive Medicine**
Appendix K	**Department of Ophthalmology**
Appendix L	**Department of Orthopaedic Surgery**
Appendix M	**Department of Otolaryngology-Head And Neck Surgery**
Appendix N	**Department of Pathology**
Appendix O	**Department of Pediatrics**
Appendix P	**Department of Physical Therapy and Rehabilitation**
Appendix Q	**Department of Psychiatry**
Appendix R	**Department of Radiation Oncology**
Appendix S	**Department of Radiology**
Appendix T	**Department of Urology**
Appendix U	**Osher Center for Integrative Medicine**
Appendix V	**Proctor Foundation**

IV. Responsibility

Any questions about the interpretation or application of these UCSF policies and procedures for Teaching Physician billing compliance or any Departmental Appendix should be directed to the Director of Compliance or the Chair of the Department.

Reports of instances of possible noncompliance may be made confidentially to the Director of Compliance, the Chair of the Department, or the UCSF Compliance Hot Line (415) 502-2810.