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Medical Residency Programs:

Compliance, Coding Education and Program Success

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About the Authors

Erika Fisch, CCS, CPC | Senior Auditor

Erika Fisch has over 11 years of experience working in an integrated health system, providing various audits and education to clinicians. Skilled at teaching E/M to clinicians, coders, and administrative staff, she has worked with several departments on system-wide projects that ultimately affected coding and reimbursement for the health system, including consulting on implementing new services, rolling out RN-led Medicare Annual Wellness visits, and giving feedback on write-off data. Erika is experienced in many areas of inpatient professional coding and outpatient professional coding. She has provided quarterly benchmark reporting to clinicians and administrative staff, from which audits and education services were often conducted.

Holly Hansen, CPC, CPMA | Senior Auditor

Holly Hansen is a senior associate with over 23 years of experience in healthcare. Her experience includes the full revenue cycle, from registration to payment. For the past seven years, she has been exclusively auditing and educating clinicians and coders in a variety of specialties, including Oncology, Palliative, Endocrinology, and Dental. She has spent years consulting with Primary Care departments on the Medicare Annual Wellness (MAW) visit and initiatives such as the RN-led MAW to ensure compliance, consistent billing practices, Hierarchical Condition Category (HCC) capture, and revenue.

Holly has been involved in speaking and contributing to her local AAPC chapter for the past several years. She has delivered presentations at meetings on topics such as CPT and ICD-10 updates as well as presenting to large physician groups on acute visits with a wellness.

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Executive Summary

Medical residency programs are the cornerstone of physician workforce development in the United States, bridging the gap between academic training and independent clinical practice, all while managing substantial compliance and operational demands. Hospitals and health systems operating teaching programs face real risks when documentation and attestation practices fall short.

At the same time, a well-run residency program is a genuine financial asset, producing physicians who are prepared not just clinically, but as effective, compliant billers from day one. This white paper addresses the compliance and operational considerations central to high-performing medical residency programs, including:

- **The roles and responsibilities** of everyone involved in a teaching program
- **Attestation rules** for teaching physicians across service types
- **Documentation and compliance** red flags auditors look for
- **How to evaluate the effectiveness** of a coding education program

Organizations that get this right build programs that prepare physicians effectively while remaining resilient under regulatory scrutiny. Acuvance Coker's coding experts and audit team partner with teaching institutions to help programs succeed across these dimensions.

The Challenges and Purpose of Residency Programs

Medical residency programs, or teaching programs, are the next step for physicians graduating medical school. These programs train new doctors in their chosen specialty and bridge the gap between academic training and real-world applications that will prepare them for independent practice. The purpose of residency programs is to provide physicians with supervised hands-on training in real clinical settings. This allows the residents to develop the skills they will need for practicing independently as well as test out the knowledge learned in medical school in an environment safe for patients and providers alike. The years of resident training prepare the new physicians for the workforce by meeting licensure requirements, specialization training, patient communication, and emergency response.

For program directors, compliance teams, and revenue cycle leaders, residency programs present compliance and operational complexities that must be managed thoughtfully. The Centers for Medicare and Medicaid Services (CMS) establishes requirements for how teaching physician services must be documented, supervised, and billed. These rules are not optional. They are conditions for reimbursement. When documentation and supervision standards are not met, the consequences can be substantial: audit findings, claim denials, revenue cycle disruptions, repayment demands, and, in serious cases, False Claims Act exposure.

Residency programs have enormous upside; a strong program will prepare the residents to be financial assets to their chosen organization by teaching clinical skills alongside appropriate coding and billing practices. Managing this balance represents a core challenge (and opportunity) for high-performing residency programs. Training competent physicians while ensuring compliance and financial accountability is the hallmark of a strong residency program.

Roles in a Residency Program

As defined by the Centers for Medicare & Medicaid Services (CMS), a residency program involves a defined set of roles, each with distinct responsibilities, privileges, and limitations. Everyone associated with the program, from the program director to billing and coding staff, must understand these distinctions.

Teaching Physician (Attending)

A teaching physician, also called an attending or supervising physician, is an experienced physician on staff who supervises and trains residents within the program. Both medical doctors (MDs) and osteopathic medicine doctors (DOs) can be teaching physicians.

Intern

An intern is a resident in their first year of training who provides patient care under the supervision of senior residents (depending on program rules) and teaching physicians.

Resident

A resident is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary (FI). Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full-time equivalency count of residents.

Chief Resident

In non-surgical programs, a chief resident stays on for an additional year as chief. In that additional year, the chief resident acts as an attending within their specialty, allowing them to supervise residents. In a surgical program, the last year of the residency program is the chief resident.

Fellow

A fellow is a resident in a post-graduate training program who is continuing in the program to obtain expertise in a more specialized area of their choosing. For Medicare reimbursement purposes, there is no difference between a fellow and a resident. Fellows may "moonlight," or work additional hours providing care outside of their fellowship training specialty. For example, a bariatric surgery fellow may moonlight by working additional hours in an internal medicine clinic. In providing internal medicine services, the fellow is treated the same as an attending physician.

Student

A student participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. Students are never considered interns or residents. Medicare does not pay for any service furnished by a student. Students may document in the medical record only if a non-resident physician reviews and verifies all student entries and personally signs the documentation. The non-resident physician must also perform or reperform the exam and all medical decision-making services. It is appropriate to verify student documentation in the record rather than redocument.

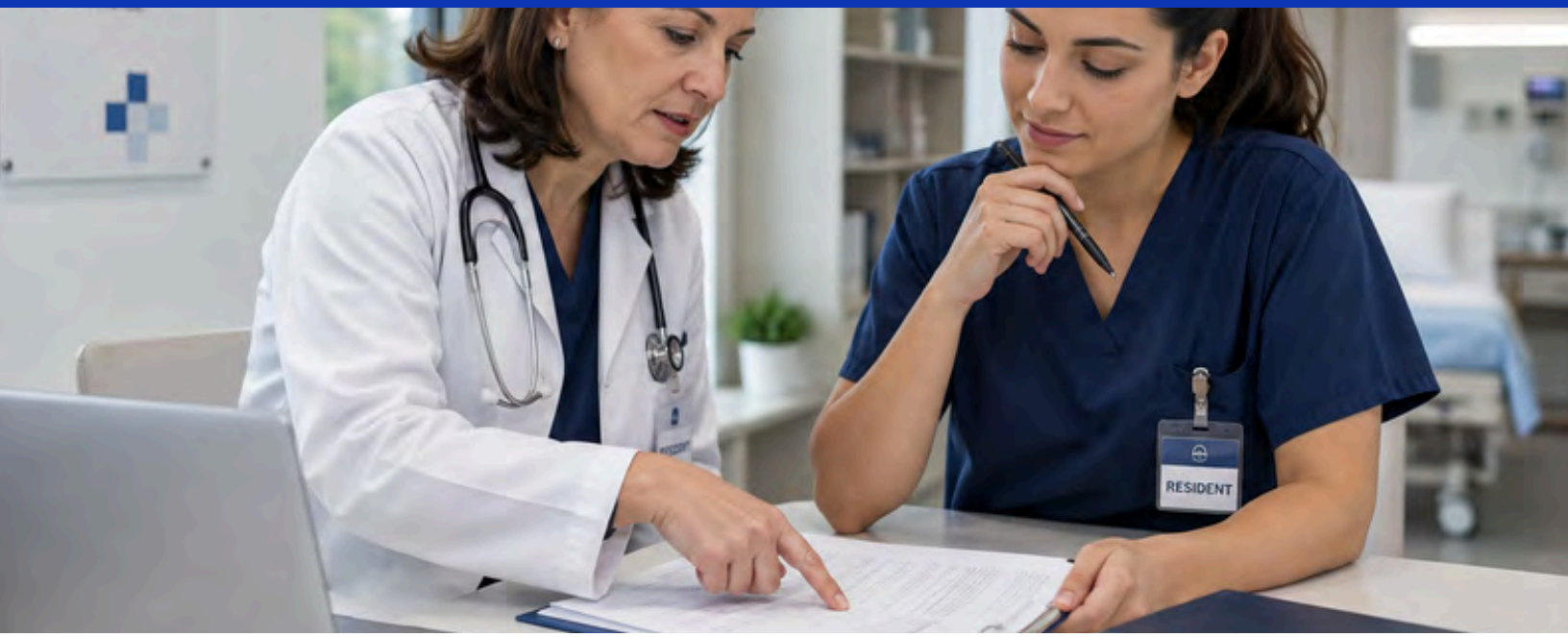
Attestation Rules and Requirements

Participants in a residency program require supervision when providing services. This supervision is documented through an attestation, or a statement made by the teaching physician (TP) certifying proper supervision of a resident. This statement may be documented by another individual, but it must be reviewed and signed by the supervising physician.

The attestation must demonstrate the TP was present for the key and critical portions of the resident service and how the TP participated in patient management. "Key and critical" is defined by CMS as "that part (or parts) of a service that the TP determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable."

Because residents are physicians in training, only a licensed physician (MD/DO) may supervise and attest to a resident's services. Other clinical providers, such as a midwife, physician's assistant, nurse practitioner, licensed social worker, clinical psychologist, or clinical nurse specialist may not supervise or attest to a resident's work.

Different types of services require different types of attestations. An appropriate attestation for an evaluation and management ("E/M") service will not be appropriate for a procedural service, and vice versa.



1 Evaluation and Management (E/M) Services

An attestation for an E/M service must state that either the TP performed the service or was present during the key and critical portions of the service with the resident. It must also address the TP's participation in patient management.

2 Surgical Services

A surgical attestation refers to any procedure, not just a surgical procedure, in the operating room. For example, joint injection, laceration repair, IUD insertion, and casting/fracture care all fall under this category. Attestation requirements differ based on whether the procedure is classified as major or minor.

Major:

A procedure requiring more than a few (over five) minutes and continued medical decision-making during the procedure. The TP must state they were present for the key and critical portions of the service and must be immediately available to furnish care during the procedure.

Minor:

A procedure of a few minutes (five minutes or less) requiring relatively little decision-making once the procedure need is determined. The TP must be present for the entire procedure.

If a procedure is in question as to whether it is major or minor, the teaching physician makes the final determination.

3 Endoscopic Procedures

An attestation for an endoscopic procedure performed by a resident in the presence of the TP must include that the TP was present during the entire viewing, from the time of endoscope insertion to removal. Viewing the entire procedure via monitor from a separate room does not meet the presence requirement.

4 Diagnostic Radiology

Interpretations of diagnostic radiology or other diagnostic tests are only reimbursable when a physician other than a resident performs them.

5 Anesthesia Services

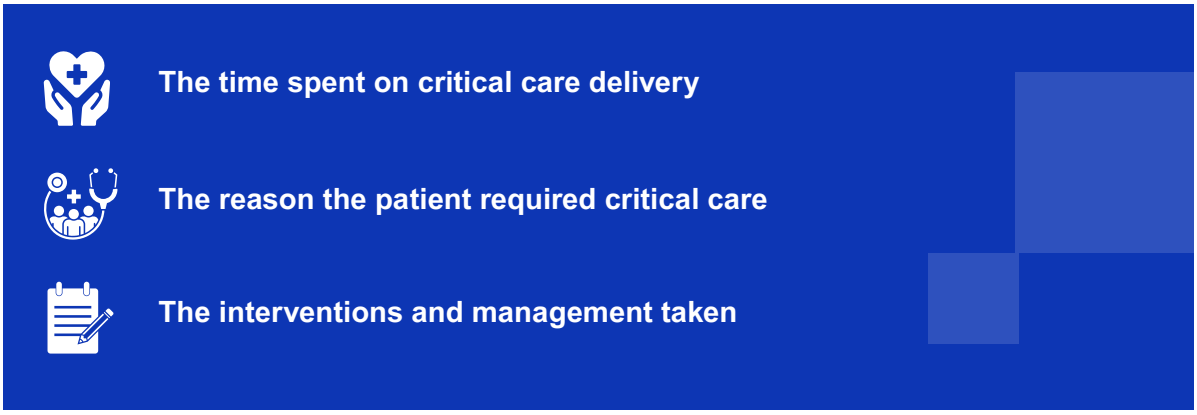
A teaching attestation for anesthesia must include that the teaching anesthesiologist who started the case stayed with the resident during critical or key service and procedure parts. The attestation must also note that another teaching anesthesiologist was immediately available if needed.

6 Time-Based Services

Several procedure codes utilize time to determine when a code can be a billable service. These codes include, but are not limited to, individual psychotherapy, hospital discharge day management, critical care, and prolonged services. For services billed based on time, only the total time contributed by the TP can be used to report the service. Time spent in the absence of the TP cannot be used towards the service.

7 Critical Care Services

Critical care services need to be clearly documented by the TP to be acceptable for billing purposes. While the medical record can reflect a combined effort between the resident and TP, there are specific requirements the TP attestation must meet, given the increased complexity of critical care services. The attestation must indicate:



As with any other time-based service, only the time spent by the TP may be counted toward the total critical care time.

8 Primary Care Exception

The rules for the primary care exception (PCE), including attestations, are different from other areas of a medical residency program. For this reason, all things to do with PCE are discussed in a separate section below.

PCE Attestation Rules and Requirements

The primary care exception (PCE) allows, in certain teaching hospital primary care centers, teaching physicians (TPs) to bill certain services provided by residents independently, without a TP present. The TP must still review the care with the resident.

Service Eligibility and Scope

The exception applies to low and mid-level evaluation and management (E/M) services (99202–99203, 99211–99213) and specific preventive services. Only medical decision making (MDM) may be used to calculate the E/M level under PCE.

For PCE to apply, services must be provided in a center located in a hospital outpatient department or another ambulatory care entity where the time spent by residents in patient care activities is included in determining a teaching hospital's direct graduate medical education (DGME) payments.

Resident Eligibility and Supervision Requirements

While any resident can work in a PCE department, a resident must first complete more than six months in the approved residency program before providing billable patient care without a TP's physical presence.

TPs working in a PCE setting must:

- Supervise no more than four residents at a time
- Remain immediately available, with resident supervision as their sole responsibility
- Retain primary medical responsibility for the patients residents see
- Ensure all care is reasonable and medically necessary
- Review resident care during, or immediately after, each visit, including medical history, diagnosis, physical exam findings, and treatment plan

PCE Attestation Rules

Two different attestation standards apply under the PCE, depending on how long the resident has been in the program:

Six months or less in the program:

Standard resident attestation rules apply. The resident may not see a patient without the presence of a TP. The TP attestation must include that either the TP performed the service or was present during the key and critical portions of the service. The attestation must also include the TP's participation in patient management.

More than six months in the program:

The resident may see patients without the TP in the room. The TP attestation must include the extent of the TP's involvement in patient services, direction, and review.

Procedural attestations in PCE settings follow the same procedural guidelines as non-PCE attestations for procedures, regardless of the resident's time in the program.

Documentation and Compliance Concerns

Understanding where programs most commonly fall short is the first step toward protecting yours. Because poor documentation and compliance have negative side effects for an organization, it is crucial that any resident training program adheres to strict documentation and compliance standards to ensure the program's success. With a strong knowledge base and good training, a successful program is entirely possible. Below are common potential red flags and areas of concern for auditors.

Areas of Concern for Auditors

Concern	Risks	Mitigation
Templated Attestations	• Generic statements may not reflect the reality of the situation • Lack of specific verbiage describing the physician's involvement can create concerns • Cloned attestations fail to indicate individual involvement in the specific patient's care	Create customizable teaching physician attestation templates that encourage flexible language rather than a single-use statement.
Timing Inconsistencies	• Attestations can be added after the note is signed • Late attestations can suggest that the TP was not involved in the patient's care • Multiple people can be involved in the care of the patient when shifts change	Require TPs to complete their attestation on the same day as the resident documentation.
Missing or Incomplete Attestations	• Notes can have inadequate verbiage, such as "seen and agree" or a simple cosignature • Attestations can have partial information without indicating the TP's specific involvement	Provide education to all necessary parties regarding required components. Use a structured, editable template to prompt for each of the required elements.
EHR Workflow Design Issues	• Use of pre-filled or templated language when appropriate • Improper designation of provider roles within the EHR • Claims submission before TP signature or verification of appropriate level of TP presence	Leverage the EHR to ensure entries are signed and dated. Set rules in place to ensure that encounters cannot be closed until the TP attestation is entered.

EHR Considerations

Electronic health records (EHRs) offer a wide range of benefits to healthcare organizations but can introduce compliance risk in teaching environments when documentation does not meet CMS minimum requirements. Attestation templates that are incomplete, auto-populated without review, or copied from prior encounters increase this risk and can lead to claim denials, overpayments, or even legal ramifications.

Inpatient Complexity

Inpatient care is provided around the clock and is not as neatly outlined as a clinic day. The complexity of managing multiple notes, encounters, and care providers increases the risk of documentation gaps. Teams operating in inpatient settings must understand the rules for inpatient professional coding in addition to teaching physician guidelines

Moonlighting

Physicians who moonlight can create potential areas for audit concerns. These providers can be billed as full physicians in their primary specialty but are considered residents in their fellowship department.

Upcoding & Downcoding in PCE

In PCE-eligible settings, specific scenarios can be billed without teaching physician (TP) involvement. The service provided determines the code, not the presence or absence of the TP. For example, a visit for a patient with two stable chronic conditions resulting in a prescription should be coded as 99214, regardless of whether the TP was present. It would not be appropriate nor compliant to code this as a 99213 simply because the TP did not see the patient.

Evaluating the Effectiveness of Your Coding Education Program

Residents who understand coding and billing are a financial asset to any organization they join. Yet coding education is often treated as an afterthought in residency programs—relegated to a single orientation session or a stack of reference materials that residents rarely consult.

Strong programs recognize that coding education must be structured, layered, and ongoing, and often rely on dedicated coding or provider education departments to support this effort. Without this support, teaching physicians stretched across clinical and coding responsibilities may struggle to provide consistent guidance, and the program's compliance posture can suffer.

Building a Strong Foundation

However an organization decides to integrate coding education into its residency program, evaluating its effectiveness at regular intervals and through multiple methods is essential. This keeps the program strong and compliance on track.

If a separate department is leading coding education and evaluation, its lead educator should establish good rapport and strong communication with both the chief resident and the teaching physicians (TPs) heading the PCE program.

A few core elements at the outset will help ground the coding education program with a solid foundation.

Orientation: The First 90 Days

Every incoming cohort of residents should receive a structured orientation to coding and billing within their first 90 days. This should include:

- A didactic session to introduce coding and billing basics
- Clear guidance on who to contact for coding or billing questions and how
- Quick reference sheets for the most common coding scenarios, small enough to keep at a desk or in a pocket

Ongoing Education for All Residents

Orientation alone is not enough. Coding education should continue throughout all years of the program, reaching first-, second-, and third-year residents alike. A combination of in-person sessions and supplementary channels works best, and no program relying solely on emails or electronic communication will be successful. In-person interaction is irreplaceable because it allows real-time questions and dynamic discussions with peers, attendings, and coding experts.

Effective Ongoing Methods

Didactic Sessions

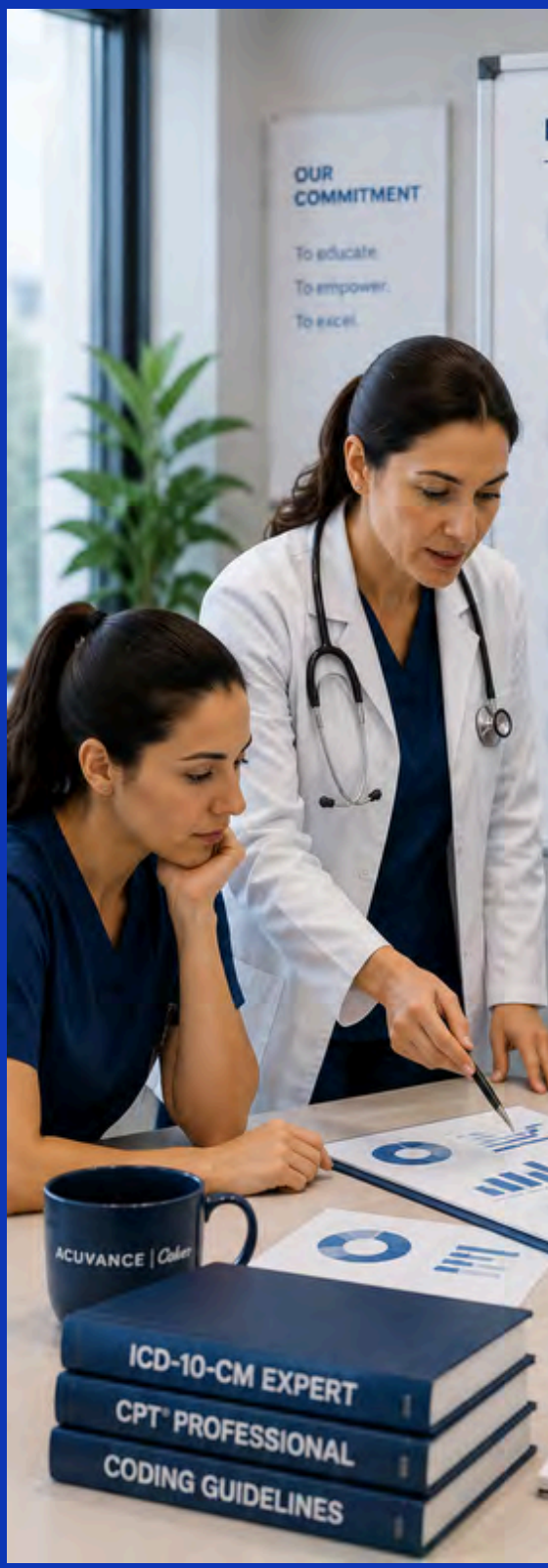
Twice-yearly coding education refresher sessions are strongly encouraged. These are often incorporated into residents' yearly seminar schedule in coordination with the residency program directors. A large-group format with a structured presentation and Q&A is most effective.

Coding Updates

Annual or semi-annual coding updates serve two purposes: they keep residents current on the latest information, and they create a regular touchpoint between coding educators and residents. Even brief, well-targeted communications help reinforce the relationship between clinical work and documentation.

Queries and Feedback to Residents and Faculty

Queries and feedback for both attendings and residents will help them learn appropriate coding and billing and foster relationships with coding and education departments. Provider fatigue is real when it comes to emails and inboxes, so implementing an organized system for querying providers or sending feedback is highly encouraged to ensure the process is beneficial for all.



Routine Audit Program

Routine audits are one of the most important ways to evaluate the effectiveness of what residents are learning. Different methods for randomly selecting charges to audit are encouraged. Effective methods include:

- Quarterly audits of randomly selected encounters for each resident
- Using benchmark tools, such as Medicare's national averages, to select specific codes
- Quarterly reviews of randomly selected PCE-eligible visits
- Service-specific audits (e.g., Medicare Annual Wellness Visits or procedures) targeting high-risk or high-volume codes

What happens post-audit is important. The most successful audits result in a meeting with the resident to review their audited charts and discuss what is going well, where they are facing challenges, and what changes to make going forward.

Embed in Residency Clinic

This approach requires additional education staff outside the residency program who can support residents. Having a coding educator physically present on clinic days, available to answer questions in real-time, is a terrific relationship builder. Residents feel supported, and questions that might otherwise go unasked get answered the moment they arise.

Why a Successful Teaching Program Is Important

Compliance is the floor, not the ceiling. The best residency programs go beyond meeting regulations and strengthen both the institution and the broader community.

Community Benefit

Teaching physicians are responsible for training the next generation of doctors, which means a focus on up-to-date, evidence-based care. When this is combined with the team-based approach of a teaching setting, patients experience an elevated standard of care. The collaborative approach and regular review of cases increase accountability and, in turn, can support diagnostic accuracy and better patient care.

Residency programs also increase the number of available providers in an area, improving access to care, especially in underserved areas. Many programs extend their reach further through community outreach initiatives like screenings, wellness fairs, and school education efforts using the manpower of students and residents.

The indirect benefits are notable, too. Teaching institutions create demand for additional support staff, bolstering the economy with more clinical and support jobs. The continual influx of students, residents, and faculty also contributes to the local economy through housing, transportation, and other needs.

Academic Excellence and Leadership Development

Teaching institutions foster a culture of continuous learning, promote intrapersonal collaboration among colleagues, and create an environment where the next generation of physician leaders is shaped. A well-run teaching program helps uphold not only the prestige of academic medical centers but also helps attract top talent from across the world. Students and residents immersed in this environment can gain skills beyond the patient bedside—they can sharpen critical thinking, internalize ethical practice, and develop an enduring commitment to lifelong growth and excellence in medicine.

Maintaining Documentation Standards

In teaching environments, documentation is core to delivering safe, effective patient care. Beyond legal compliance, it reinforces patient safety measures, facilitates teaching concepts, and supports appropriate billing. In a teaching setting, it also demonstrates adherence to supervision requirements and teaching physician involvement with patient care. Falling short of these requirements can result in audits, penalties, or even loss of funding.

Documentation captures not only the clinical reasoning behind each encounter but also provides residents with ongoing learning opportunities. It fosters accountability across the care team and ensures consistent patient management. Running a successful physician training program requires dedication to meeting the many standards outlined by governing bodies, but the payoff is a structured, high-quality educational and clinical environment.

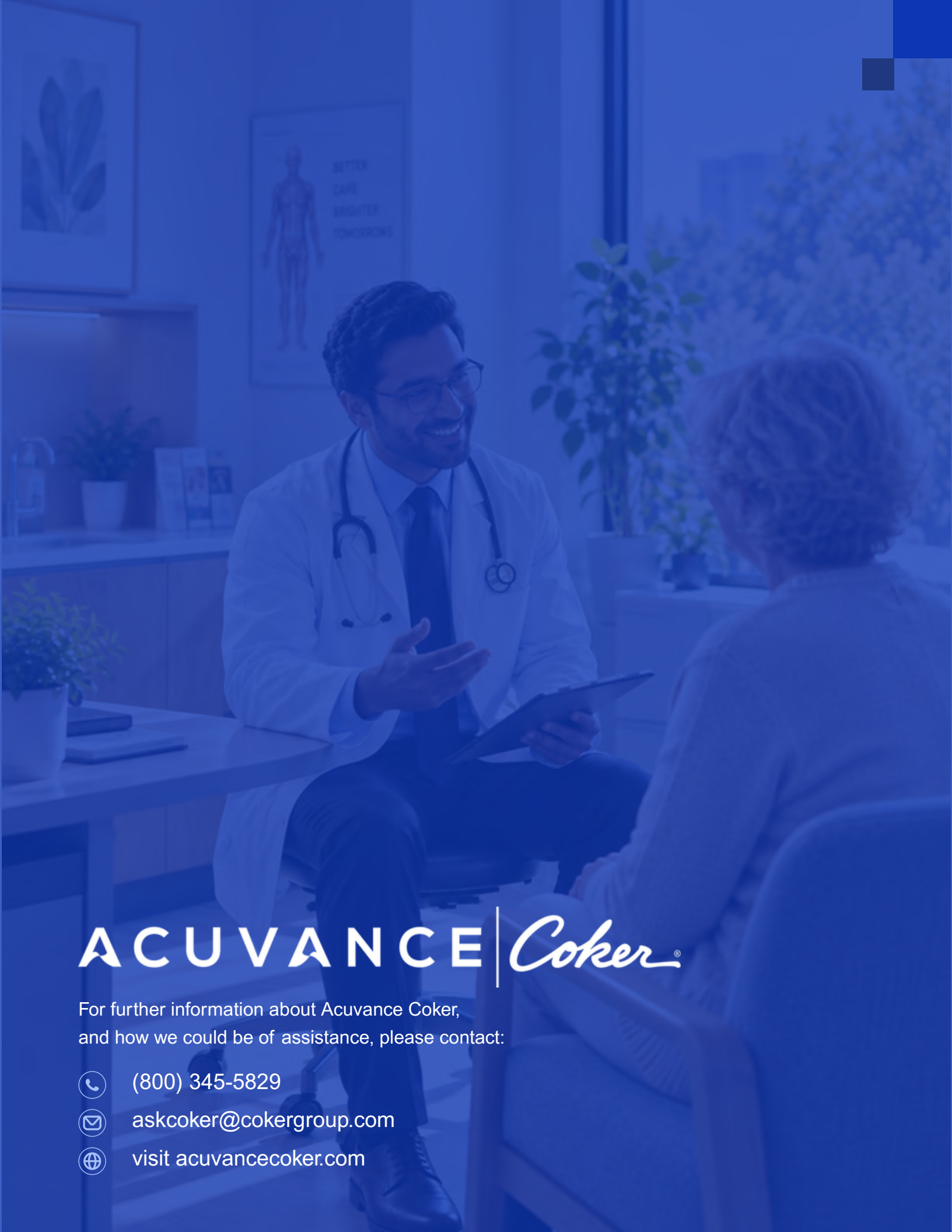
Conclusion and Recommendations

Implementing a residency program that equips new physicians with strong coding and billing knowledge—and prepares them to be a financial asset to any organization—requires a team-based approach. The most successful programs are built through collaboration between attending physicians and coding or provider education departments.

All participants benefit from a solid grounding in coding and billing principles. Because residents learn from faculty physicians daily, every attending who interacts with residents should model correct coding practices from the start.

Building this knowledge requires ongoing investment in education, structured audit processes, and a genuine commitment to documentation standards, not just when auditors are looking, but as a matter of program culture. Ongoing education and evaluation help cement these concepts in the minds of residents.

Organizations that commit to this approach produce better outcomes across the board: residents who are clinically prepared for independent practice, programs that hold up under audits, and institutions positioned as centers of excellence that attract top talent.
Acuvance Coker's auditors have deep expertise in coding and billing education for residency programs and provide coding and compliance audit services that set teaching hospitals up for long-term success.



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