Weill Cornell Medicine

Navigating Physician Compliance Challenges
Documentation, Billing, and Supervision

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Presenter Biographies



Maria Joseph currently serves as the Chief Compliance and Privacy Officer at Weill Cornell Medicine, where she's had more than 20 years of experience with the institution. A true driver of change, she has played a key role in the development, implementation, and ongoing maintenance of Weill Cornell's comprehensive compliance and privacy programs.

Maria also provides critical compliance oversight to ensure adherence to regulatory standards across the WCM campus and other covered entity units within Cornell University.

Previously, Maria served as Assistant Vice President and Corporate Compliance Officer at Northwell Health, where she led compliance and privacy programs for an extensive network of physician practices and the ACO programs.

Maria holds a Bachelor of Arts in Business Administration from Baruch College, an Executive MBA from Baruch-Zicklin School of Business, and multiple specialized certifications in compliance.



Chuck Mazer is the Clinical Compliance Officer for Weill Cornell Medicine. He is responsible for the design and implementation of clinical compliance and privacy functions within the compliance program, especially as they relate to compliance education, physician billing auditing and monitoring, compliance and privacy investigations, and reporting. He also oversees the WCM Conflicts Office. Chuck brings over 20 years of legal and compliance experience.

Prior to joining WCM, he was the Senior Director of Compliance at NewYork-Presbyterian, a 10-hospital health system, where he led the compliance governance function. Before working in the provider space, he was a litigator with Latham & Watkins LLP and Paul, Weiss, Rifkind, Wharton & Garrison LLP in New York.

Chuck hold a Bachelor of Arts from Tufts University and a Juris Doctor from Boston University School of Law. He is certified as a CCEP and CIPP.

Session Objectives



- Recognize high-risk areas in physician billing and supervision.
- Evaluate documentation practices for compliance with CMS guidelines.
- Develop monitoring and auditing approaches tailored to physician compliance.
- Apply lessons learned from enforcement trends to everyday operations.

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Why Physician Compliance Is Under the Microscope

- Physician billing remains a top DOJ and OIG enforcement priority
- Documentation deficiencies often drive False Claims Act exposure
- Complex care models create billing challenges
- EMR systems can introduce systemic documentation risks



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Enforcement Impact - DOJ

In 2025, the DOJ obtained **$6.8 Billion** in settlements and Judgments for False Claims.

- **$5.7 Billion** relate to matters involving the health care industry
- **$5.3 Billion** are from relator matters

Since the 1986 revisions to the FCA, more than **$85 Billion** has been collected in FCA settlements and judgments.

In 2026, the administration has indicated a focus on identifying health care fraud.

- Creation of the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative.
- Medicare program integrity savings increased from $26.3 billion in FY 2024 to $41.9 billion in FY 2025.



Press Releases Feb 25, 2026

Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud

DMEPOS suppliers Fraud, waste, & abuse Medicaid & CHIP

Share

Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud

Initiative Seeks Input on Strengthening Program Integrity to CRUSH Fraud

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Enforcement Impact - OIG

As part of the OIG Strategic Plan for 2025-2030, OIG has indicated a focus on “defrauded and misspent HSS funds” with their first goal to “Fight Fraud, Waste and Abuse”

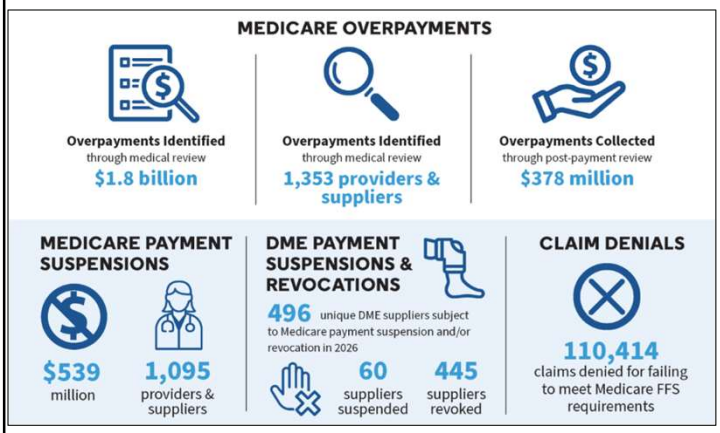
- “OIG uses advanced data analytics to spot potential fraud and outliers quickly so that they can be investigated.”
- “OIG’s enforcement ensures that bad actors are held accountable and that misspent and defrauded funds are recovered.”

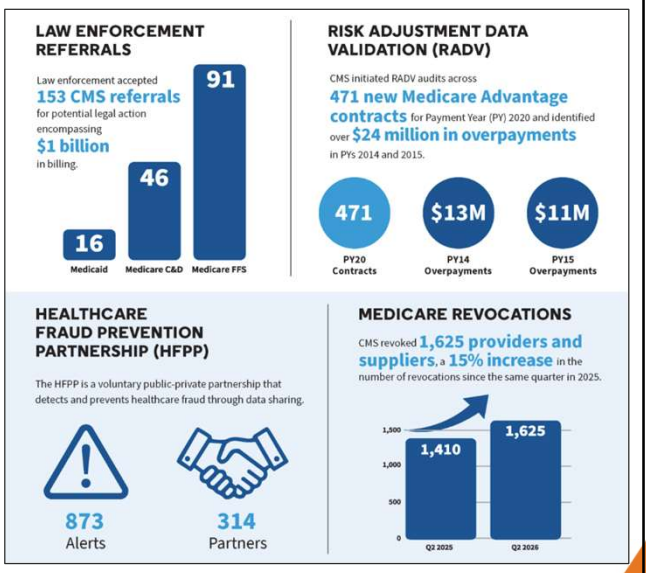


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Enforcement Impact - CMS

As part of the CMS's Crushing Fraud initiative, CMS issued the following results for January – June 2026



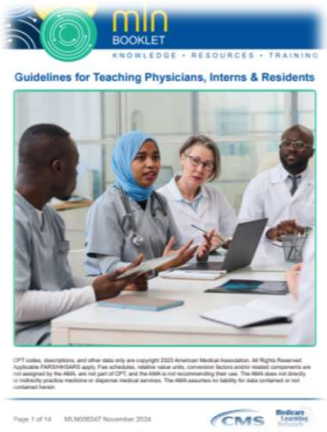


Major Physician Compliance Risk Areas

Physicians in teaching settings face additional scrutiny based on how they collaborate with peers and residents/fellows.

Key areas of heightened concern include:

1. Documentation Integrity
2. Supervision requirements
3. Teaching physician rules
   - Incident To
   - Split Shared
4. Overlapping Surgeries
5. Assistant-at-Surgery billing



With the increased use of AI, there is additional concerns to be considered.

Documentation Integrity

- Copy-and-paste or cloned documentation
  - Reliance on prior encounter documentation
- Overuse of templates or macros
- Notes that do not reflect services actually performed
  - Including multiple contributors to a note
- Inconsistent documentation across the record



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What Does Copy & Paste Mean

Cloned or Copy & Pasted notes include information copies or the entire content from prior notes. This practice raises compliance concerns:

- **Outdated or irrelevant information:** Copying a note may lead to outdated, conflicting, incomplete, or inaccurate information. Copied information may not accurately reflect the patient's current situation at the date of encounter if not updated properly and there is a risk of making assumptions about the patient's condition prior to evaluation on the date of encounter.
- **Coding and billing concerns:** Coding guidelines require that CPT, modifiers, and diagnoses are based on what is documented and must be a factual representation of what occurred or was confirmed on the date of service.
- **Note bloat:** Copying prior notes can cause notes to become lengthy and clutter the note with information that was not removed when irrelevant to the current visit.

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Monitoring Copy & Paste Documentation

How Compliance Detect Copy & Paste Risk

MR Audit Tools— Use system functionality to validate authorship:

- "Hover for details" (Epic) to identify who entered content
- Audit trails to confirm when documentation was created or modified

Documentation Review— Evaluate whether documentation is:

- Date-specific and encounter-specific
- Updated to reflect the current visit
- Consistent with clinical findings and orders

Red Flags for Auditors— Identify patterns such as:

- Repeated language across multiple encounters
- Notes carried forward without updates
- Identical assessments despite changing conditions

Link to Billing Risk
Focus on copied content used to support:

1. Medical Decision Making
2. Time-based billing attestation
3. Level of service billed

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Teaching Physician Supervision

Medicare pays for services in a teaching setting only when:

- Physicians personally provide the service (42 CFR 415.170(a)).
- Residents provide the service when teaching physicians are physically present during **critical or key** service parts (42 CFR 415.172(a)).
- Teaching physicians providing evaluation and management (E/M) services under the primary care exception may bill for lower- and mid-level E/M services provided by residents (42 CFR 415.174).
    - Teaching physician must discuss and attest to the documentation by the resident.

Physicians should attest to supervision requirements based on their actual presence during the services provided.

- Examples of Attestations:
    - *"I supervised Dr. XX and was physically present for the critical and key portions of the visit."*
    - *For Primary Care Exception: "I discussed the findings with Dr. XX and agree with the plan of care for the patient."*

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How to Monitor Teaching Physician Supervision

Targeted Audits	Data Review - Schedule
Documentation review to confirm presence during key/critical portions Documentation of Physician participation	Compare schedules to EMR timestamps Review operative notes Identify potential concurrent/overlapping services
EMR Pattern Analysis	**Education and Remediation**
Review templated attestations Identify identical physician language across encounters Attestations must be entered after the encounter	Provide targeted education for: - Teaching physician documentation requirements - CMS presence standards - Appropriate attestation language

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Incident-To Services Overview

"Incident-to" services are services furnished by NPPs or ancillary staff **as part of a physician's plan of care and under direct supervision**

Key Elements

- Must be **integral to the physician's professional service**
- Typically performed by **NPPs or ancillary staff**
- Physician must provide **direct supervision (on-site, immediately available)**

Eligible Providers

- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Clinical Nurse Specialists (CNS)
- Certified Nurse Midwives (CNM)
- Clinical Psychologists (CP)

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Incident-To Billing Requirements

To bill "incident-to," all of the following MUST be met:

1. Setting: Office/noninstitutional setting; not a hospital inpatient or SNF service.

2. Direct supervision: Supervising practitioner must be immediately available. For eligible services in 2026, real-time two-way audio/video supervision may qualify (not audio-only).

3. Plan of care: Physician/practitioner initiates treatment and remains actively involved.

4. Billing relationship: Confirm applicable employment/contractual, expense and Medicare billing requirements; not simply shared group membership.

5. New or changed problems: Determine whether care remains within an established plan or requires a new evaluation/plan.

Verify payer-specific rules and any exceptions.

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Incident-To Documentation Requirements

- Documentation must support evidence that a supervising physician was present and available.
- While the co-signature of the supervising physician is not required, it is a means of verifying the physician's availability for oversight.
- The NPP or ancillary staff performing the service may include entry in the note of the identity and credentials of the supervising physician who was available during the visit.
- Documentation by the attending provider from prior dates of service should clearly establish the intent for the incident-to services to be performed.
- Physician's schedule should be kept on file for auditing purposes.

- Examples of Attestation:
  - *Dr. [XX] was in the office today when I saw her patient in follow up for CHF and CKD. Patient will see Dr. [XX] for annual physical in March.*
  - *I discussed the treatment plan with Dr. [XX], she saw the patient briefly and agreed to continue the current plan described in the assessment.*

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Overview of Split/Shared Services

- A split/shared E/M visit is furnished jointly by a physician and an NPP in the same group in a facility setting.

The billing practitioner must perform the substantive portion, established by either more than half of the combined distinct time or a substantive part of the medical decision making (MDM), as permitted for that service.

History/examination alone do not establish the substantive portion.

Report modifier FS when required; apply special rules for critical care and prolonged services.

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Criteria for Split/Shared Services

- For eligible facility E/M visits, identify the practitioner who performed the substantive portion: either more than half of the combined distinct time or the substantive part of MDM.

At least one practitioner must have a face-to-face encounter, as applicable.

For time-based attribution, document each practitioner's distinct time and do not double-count jointly performed time.

For MDM-based attribution, the billing practitioner must document the substantive part of MDM.

Emergency department visit levels are selected by MDM, not time.

Prolonged services and critical care have separate time-based rules.

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Documentation Requirements for Split/Share Services

To support split/shared billing, documentation must include the following:

- A clear attribution of who performed the MDM or majority of face-to-face time.
- Total time must be documented by **each** practitioner (If using time as the substantive portion).
- There must be a description of the services provided by each practitioner.
- Example of acceptable attestations:
  - *"I saw and evaluated the patient. Agree with PA [XX]'s note however, lower extremities are weaker today. Referral to PT."*
  - *"I performed a history and examination of the patient today. I reviewed NP [XX]'s note and agree with the documented findings. Patient with HTN, BP today 207/96. Start Losartan 100mg BID."*
- Examples of unacceptable attestations:
  - Seen and agree, followed by signature.
  - Agree with above, followed by signature.
  - Signature only.

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Split/Shared – Monitoring

- If time is used to determine the substantive provider, ensure the provider with the higher amount of time spent should be the billing provider.
- If medical decision making (MDM) is used to determine the substantive provider, ensure that the note supports the MDM.

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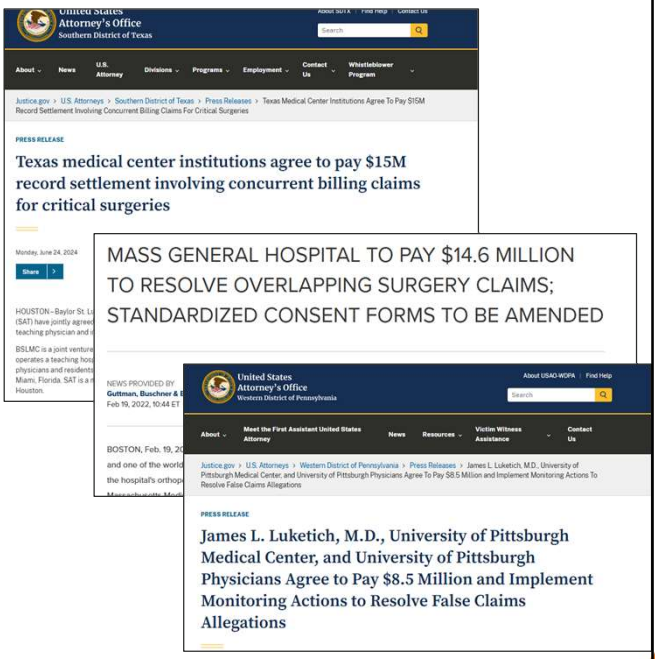
Overlapping Surgeries

- The teaching surgeon must be present for the critical/key portions of each operation; those portions may not overlap in time.

When absent for noncritical portions, the teaching surgeon must remain immediately available or arrange an appropriately qualified covering surgeon, consistent with applicable requirements.

Document critical/key participation, availability or coverage, and timing.

Distinguish overlapping procedures from concurrent critical/key portions; review consent and payer requirements.



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Overlapping Surgeries – Documentation

Surgical consent should include disclosure for overlapping surgeries

- Americal College of Surgeons' Statement on Principals- https://www.facs.org/about-acs/statements/statements-on-principles/

Using templated language can assist in ensuring documentary support for the procedure

- Example of Attestations:
  "I was physically present for the key portions of the procedure, and Dr. [xx] was the covering surgeon for the non-key portions of the procedure."

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Overlapping – Monitoring

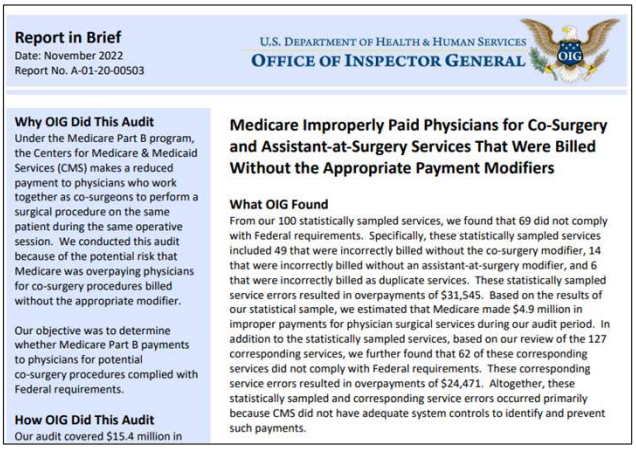
- Identifying cases based on Surgeon and OR schedule
  - Dependent on EMR and scheduling systems
- Helpful to have time in and time out documented in the OR record to determine when the provider was in the room
- Review Consent and Attestation for appropriate language and whether it was consistent with the schedule/OR Times

Assistant-at-Surgery

Modifier 80 (Physician as assistant), 81 (minimum assistance), 82 (no resident available in teaching facility), AS (Non-Physician as assistant)

An assistant at surgery is a provider who actively assists a surgeon in charge of a case in performing a surgical procedure.

- In teaching facilities, billing for an assistant is not allowed if there is a qualified resident available to assist
  - Unavailability may be due to involvement in other activities, complexity of the surgery, numbers of residents in program, or other valid reasons
- Documentation should explain the "exceptional medical circumstances" that require the assistant.
- CMS restricts assistants to be used in certain procedures.



Report in Brief
Date: November 2022
Report No. A-01-20-00503

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Audit
Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) makes a reduced payment to physicians who work together as co-surgeons to perform a surgical procedure on the same patient during the same operative session. We conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier.

Our objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

How OIG Did This Audit
Our audit covered $15.4 million in

Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers

What OIG Found
From our 100 statistically sampled services, we found that 69 did not comply with Federal requirements. Specifically, these statistically sampled services included 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. These statistically sampled service errors resulted in overpayments of $31,545. Based on the results of our statistical sample, we estimated that Medicare made $4.9 million in improper payments for physician surgical services during our audit period. In addition to the statistically sampled services, based on our review of the 127 corresponding services, we further found that 62 of these corresponding services did not comply with Federal requirements. These corresponding service errors resulted in overpayments of $24,471. Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to identify and prevent such payments.

Assistant-at-Surgery – Modifier 82

Appropriate use:

- When an attending physician is actively assisted in a surgical procedure(s).
- When the surgical procedure is performed at the teaching hospital, and no qualified resident is available to assist in the surgical procedure.

Inappropriate use:

- Do not use for a non-physician practitioner, such as a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).
  - Use Modifier AS, in teaching and non-teaching hospitals.
- Do not use when a resident is present.

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Assistant-at-Surgery – Scenario

Teaching Hospital Scenario:

Procedure: Emergency C-section for placenta previa.

Resident Status: No qualified OB residents due to scheduling overlap.

Assistant Surgeon Role: controlled uterine bleeding, assisted in fetal delivery, and closure of uterus and abdominal wall.

Medical Necessity: Required immediate and experienced assistant to stabilize for heavy intraoperative bleeding and rapid delivery.

Operative Note Documentation Example:

" Dr. OB Surgeon assisted with the fetal delivery, hemostasis, and closure. Her assistance was required due to active bleeding and the need for a rapid operative intervention."

Attestation Documentation Example:

A qualified resident was not available at the time of surgery.

Coding Example:

Primary Surgeon	CPT Code: 59514	Assistant Surgeon	CPT Code: 59514-82

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Assistant-at-Surgery – Monitoring

- Medical necessity must be documented
- Assistant role should be clearly described
- Confirm resident availability when applicable
- Modifier usage must be accurate

How to Audit

- Identifying cases based on modifier 82 use, and pull in both the Primary and Assistant Surgeons' claims
  - While the modifier is appended to the assistant surgeon's claim, the documentation is required of the primary surgeon.

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Use of Artificial Intelligence

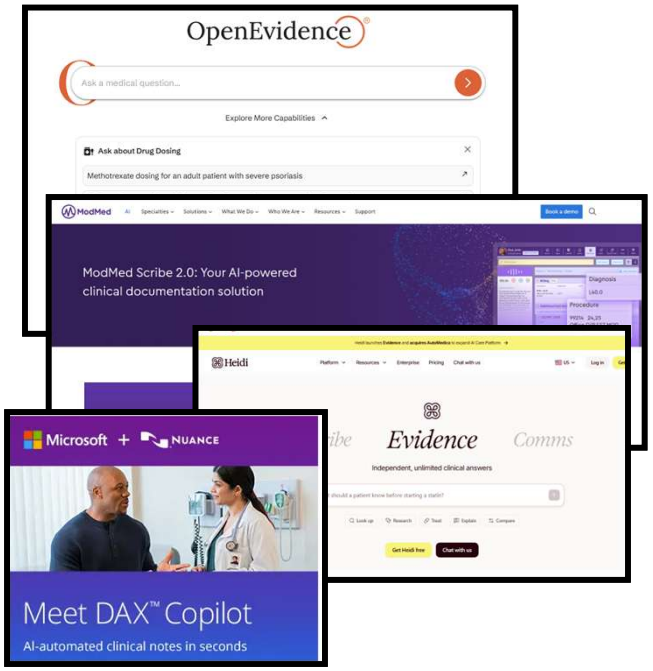
AI tools can assist with clinical decisions, notes, and coding, but require appropriate governance:

Clinical decisions: qualified clinicians remain accountable for patient care and review outputs.

Documentation & coding: validate note accuracy, authorship, service support, and coding before billing.

Privacy & security: assess PHI access, permitted use, security controls, and whether a business associate agreement is required.

Oversight: approve use cases, test performance, monitor errors, and reassess as tools change.



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Best Practices for Physician Compliance

Standardize Documentation Expectations

- Develop clear guidance for physician documentation and attestations
- Provide specialty-specific documentation examples

Implement Risk-Based Monitoring

- Conduct targeted audits in higher-risk specialties and services
- Review documentation supporting supervision and physician participation

Leverage Data Analytics

- Identify patterns such as cloned documentation or repeated attestations
- Compare scheduling, documentation, and billing data

Provide Ongoing Physician Education

- Train physicians on documentation requirements and supervision rules
- Use real audit findings to inform education

Collaborate with Clinical Leadership

- Engage department chairs and clinical leaders in compliance initiatives
- Promote a culture of accountability and documentation integrity



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Common Pitfalls That Create Compliance Risk

Templated or Cloned Documentation

- Notes that appear identical across encounters
- Overuse of smart phrases or copy-and-paste functionality

Generic Physician Attestations

- Statements that do not clearly describe physician participation
- Attestations that appear automatically generated

Insufficient Supervision Documentation

- Failure to document presence during key portions of procedures
- Unclear physician involvement in resident or APP services

Inconsistent Medical Record Information

- Documentation conflicting with procedure schedules or timestamps
- Billing not supported by clinical documentation

Limited Monitoring or Follow-Up

- Lack of targeted documentation audits
- Failure to address repeat compliance findings



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References

Centers for Medicare & Medicaid Services (CMS)
- Medicare Claims Processing Manual, Ch. 12 – Physicians/Nonphysician Practitioners
- Medicare Benefit Policy Manual, Ch. 15 – Covered Medical and Other Health Services
- CMS Guidelines for Teaching Physician Services (42 CFR §415)
- CMS Rules for Split/Shared Evaluation and Management Visits

Office of Inspector General (OIG)
- OIG, General Compliance Program Guidance (2023)
- OIG, Compliance Program Guidance for Hospitals
- OIG Work Plan – Physician billing and documentation oversight

U.S. Department of Justice (DOJ)
- False Claims Act enforcement related to physician billing and supervision
- DOJ press releases on physician documentation and teaching physician settlements

Additional Guidance
- American Medical Association (AMA), CPT Professional Edition
- Medicare Learning Network (MLN) – Teaching Physician & Billing Guidance
- Compliance resources from the Health Care Compliance Association (HCCA)
- CMS CY 2026 Physician Fee Schedule Final Rule (CMS-1832-F)
- CMS Evaluation & Management Services: Split/Shared Visits

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Questions?