TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

PRIMARY CARE EXCEPTION (PCE) CLINIC ATTESTATION FORM - BCP EP 4.2(A)
Department: Internal Medicine - Transmountain
School of Medicine – Paul L. Foster

Process Reviewed	YES	NO	N/A
1. Has the department appropriately followed the CMS guidelines as described in the Claims Processing Manual, Chapter 12, Section 100? If NO, please explain:	☐	☐	☐
Process Reviewed	**YES**	**NO**	**N/A**
2. ALL PCE supervising physicians are aware of the requirements outlined in the CMS guidelines as described in the Claims Processing Manual, Chapter 12, Section 100? If NO, please explain:	☐	☐	☐
Process Reviewed	**YES**	**NO**	**N/A**
3. All residents participating in the PCE clinic have at least six (6) months in a GME approved residency program. If NO, please explain:	☐	☐	☐
Process Reviewed	**TRUE**	**FALSE**	**N/A**
1. The physician(s) providing oversight to the PCE clinics do not have any other responsibilities during the time they are supervising the PCE clinic; this includes seeing patients that are not PCE clinic patients? If FALSE, please explain:	☐	☐	☐
Process Reviewed	**TRUE**	**FALSE**	**N/A**
2. Teaching physicians submitting claims under this exception have the primary medical responsibility for patients cared for by the residents. If FALSE, please explain:	☐	☐	☐
Process Reviewed	**TRUE**	**FALSE**	**N/A**
3. Teaching physicians submitting claims under this exception ensure that the care provided was reasonable and necessary; If FALSE, please explain:	☐	☐	☐

Process Reviewed	TRUE	FALSE	N/A
4. Teaching physicians submitting claims under this exception review the care provided by the residents during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) If FALSE, please explain:	☐	☐	☐
Process Reviewed	TRUE	FALSE	N/A
5. Patients under this exception should consider the center to be their primary location for health care services. If FALSE, please explain:	☐	☐	☐
Process Reviewed	TRUE	FALSE	N/A
6. The residents must be expected to generally provide care to the same group of established patients during their residency training. If FALSE, please explain:	☐	☐	☐
Process Reviewed	TRUE	FALSE	N/A
7. The types of services furnished by residents under this exception include: • Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness; • Coordination of care furnished by other physicians and providers; and, • Comprehensive care not limited by organ system or diagnosis. If FALSE, please explain:	☐	☐	☐
Process Reviewed	TRUE	FALSE	N/A
8. The physician(s) providing oversight to the PCE clinics review the care provided by the residents during or immediately after each visit. The review includes the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies)? If FALSE, please explain:	☐	☐	☐
Process Reviewed	TRUE	FALSE	N/A

9. The physician(s) providing oversight to the PCE clinics do not supervise more than four (4) residents at any one time during the PCE session? If FALSE, please explain:	☐	☐	☐

Process Reviewed	TRUE	FALSE	N/A
10. The residents understand that they must call the PCE supervising physician and ask them to evaluate any patient that will receive services other than the below listed services?	☐	☐	☐

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

HCPCS Code	Descriptor
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

If FALSE, please explain:

To the best of my/our knowledge, the information as reported, does not contain any material misstatements or omissions and fairly represents, in all material respects, the operations of the primary care exception clinic(s). I/We understand the information provided from our clinic or division will be provider to CMS upon their request and will become part of the annual compliance report to the President of the TTUHSC EP.

_____	_____	_____
Signature, Department Chair	Printed Name	Date
_____	_____	_____
Signature, Department Administrator	Printed Name	Date
_____	_____	_____
Signature, Program Director	Printed Name	Date