Purpose

Medical students are learners. In no state are they given a license to practice medicine and therefore, they are never considered to be billing providers. Yet, an essential part of their education involves learning how to document patient care in the medical record. Without diminishing the educational value of medical student documentation, it also is important to understand the compliance risks that it may pose. The purpose of this Advisory is to:

- Provide an understanding of the Medicare rules related to medical students since Medicare may be the only payer that has explicit rules about medical students;
- Discuss the risks involved with medical student documentation in the medical record; and
- Offer suggestions about ways to mitigate the risks while not infringing upon medical students' education.

Background

The movement to Electronic Health Records (EHRs) represents opportunities to improve patient care, eliminate issues related to legibility, increase communication, offer potential automated warnings, and structure medical information. It also presents significant challenges regarding the controls for authorship and authentication.   The paper record shows trail of authorship in a tangible way, by ink, handwriting style and signature; creating a clear trail of authorship and authentication in an electronic record requires choices about the rules that will be used for anyone who adds information to a patient's record.

While Medicare does not pay for the services of medical students, it allows the limited use of the medical student's documentation to support a billable service. Medicare defines a medical student as an individual who participates in an accredited educational program (e.g., medical school) that is not an approved Graduate Medical Education Program and is not considered an intern or resident. Unlike residents, all of whom have at least a limited medical license or the equivalent, medical

students are unlicensed. Medicare does not pay for any services furnished by a medical or other student.[1]

Medicare has promulgated the following rules related to medical students:

1. Use of A Student's Contributions to a Service

Any contribution and participation of a student to the performance of a billable service **must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements** (other than the review of systems [ROS] and/or past/family and/or social history [PFSH], which are taken as part of an E/M service and are not separately billable).

2. Student Documentation

Students may document services in the medical record; however, the teaching physician may only refer to the student's documentation of an E/M service that is related to the ROS and /or PFSH. The teaching physician may not refer to a student's documentation of physical examination findings or medical decision making in his or her personal note. If the student documents E/M services, the teaching physician must verify and re-document the physical examination and the medical decision making activities of the services.[2]

Elements of medical student documentation that must be re-documented by a resident/provider include the history of the present illness, the physical exam, and medical decision making.

The Identified Risks in an Electronic Health Record

If the medical record does not clearly identify the original source of medical documentation it may allow inappropriate use of medical student documentation (inadvertently or intentionally) in support of a bill. Therefore, **the creation of an audit trail alone is not sufficient to address this risk.**

Intentional use of medical student documentation that is not "re-documented" by the teaching physician or resident (in accordance with Medicare rules) in support of a bill submitted to Medicare for Part B services may be considered by the Federal government to be fraud and abuse and may lead to allegations of False Claims Act violations.

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[1] **Guidelines for Teaching Physicians, Interns, and Residents,** July, 20008, Medicare Learning Network, Center for Medicare and Medicaid Services, Department of Health and Human Services.

[2] **Guidelines for Teaching Physicians, Interns, and Residents,** July, 20008, Medicare Learning Network, Center for Medicare and Medicaid Services, Department of Health and Human Services.

Common Challenges in Current Systems

- If the medical student's note is "hidden" in the medical record to discourage copy/paste and to ensure that inappropriate elements are not counted in support of a bill, how does one reliably retrieve this information when necessary?
- If the medical student's documentation is entered into structured fields (e.g., checklists of physical exam findings), how does the record indicate "re-documentation" by a resident or teaching physician?
- The inability of an EHR to create different rules for medical student documentation of ROS and PSFH, i.e., the inability of an EHR to allow cutting and pasting of only the ROS and PFSH from a medical student's note.

Policy Considerations for Institutions

Documentation

It is essential that medical students learn how to document patient encounters, but that educational experience must be clearly distinguished from documentation that is needed to support a billable service. A teaching physician must always include a personal attestation of his/her presence/participation in a service. If the service involves a medical student and a resident, then the Medicare teaching physician documentation rules must be met if the service is to be billed.

> *Recommendation*:
>
> - **The only parts of a medical student's note that should become part of the medical record are ROS and PFSH.**

Medical Students as Scribes

Whether medical students should be used as scribes—and if they are, how this activity is structured—is an institutional decision, involving issues largely outside the scope of the compliance office, including consideration of whether scribing is seen as a valuable educational experience. Any policy on the use of scribes should consider that scribes may create substantial compliance risks.

> *Recommendations*:
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> - **If scribing is allowed, the compliance office should contact the Medicare contractor to determine whether it has a definition of a "scribe."**

- **Scribing by a medical student is a distinct activity from allowing a medical student to write a note as part of his/her educational experience. If possible, the EHR should allow clear identification regarding whether a note is scribed or whether it has been written by a medical student as part of his/her educational experience. If this is not possible, then medical students themselves should be required to clearly indicate when they are acting as scribes rather as students.**

Sources of Information to Review Prior to Establishing a Policy

- ✓ **Medicare regulations and Carrier's Manual Instructions**
- ✓ **Medical staff by-laws**
- ✓ **Joint Commission requirements**
- ✓ **State requirements**
- ✓ **Private payers' requirements**
- ✓ **Your institution's Vice Dean for Education or Curriculum**

Audit/Review Considerations

- ✓ **Comparing the medical student note to the physician's note**
- ✓ **Data mining software to search for patterns/cloned notes**
- ✓ **Controls that hide the medical students note and discourage copying**
- ✓ **Controls that identify the origination and history of review of medical information**

Recommendations for EHR Architecture that Directly Addresses Billing Compliance

- o Regardless of who writes the note (medical student, resident, non-physician provider, or teaching physician) the EHR should allow for real time identification of the author in a way that is readily apparent to any user. Use color coding or different font style for medical student notes
- o Because the ability to readily identify a note's author for quality of care and other purposes, including the need to ensure correct documentation for billing, do not limit such identification to "audit trail" functions. Limit viewing of the note after the educational process is complete
- o Allow retrieval for medical/legal purposes
- o Provide ability to edit for educational purposes and patient safety

- ▪ **After review of medical student documentation (other than review of systems and past, family, social history) by the resident and/or teaching physician is complete, permanently block ability to copy the note.**

- o Autocopy/Smartlinks – prohibit features that function as macros from automatically pulling data from medical student notes (other than those that can be used in support of a bill) to field portions of frequently used statements or phrases.

- **Positive identification of services that have been repeated by the teaching physician and re-documented.**
  - o Do not allow a drop-down attestation of a medical student note

- **Allow use of ROS and PFSH that is documented by medical students by teaching physician in support of a bill.**

- **If possible, design a distinct security class for medical students**

  - Design a log-in for medical students which limits the use of their note by others to Review of Systems and Past Family and Social History.
  - Block functionality that allows copying of entire notes and change of authorship. Eliminate authorship issues in current and subsequent notes where other physicians may not be aware of note origins.
    - At a minimum, limit system features that facilitate copying of entire notes and changes of authorship as much as possible.
    - Educate physicians, residents, medical students, and all staff who enter information into the EHR.

  - **Allow tracking of the history of each person who has entered or reviewed information in these fields. This provides an audit trail but also is necessary for educational and legal reasons, and risk management/quality improvement activities.**
  - **It may not always be possible to adopt these controls. Regardless, it is preferable to design a system that contains safeguards such as the ability to audit patient records by running reports that will indicate the ways in which the student note has been used by residents and teaching physicians.**

  REMEMBER: Any field in an EHR that is automatically populated presents potential risks related to compliance as well as patient quality and safety. It always is essential that the documentation in a medical record relate only to actual services provided, clearly identifies the individual who provided them, and contains current and accurate findings about the patient.

Links to AAMC Members' Policies Related to Medical Student Documentation in an Electronic Health Record

The policies that you will find from the links below are intended to be a resource as you craft our own policy. Each institution must make its own determination about whether any specific interpretations or requirements contained in these policies accurately reflect their own views.

Oregon Health and Science:
http://www.ohsu.edu/xd/health/services/doernbecher/research-education/education/med-education/upload/Medical-Student-Documentation.pdf

University of Michigan
http://www.med.umich.edu/rce/student/BillingComplianceMedicalStudentDocumentationPolicy.pdf

University of Iowa
http://www.medicine.uiowa.edu/fppcompliance/policies/med_students.pdf

> **If you would like to have your medical student documentation policy added to this list, please send a link to Will Dardani, wdardani@aamc.org**.