Student/Trainee Documentation in the Electronic Health Record Policies

The ability to effectively and accurately enter information into electronic health records (EHRs) is an important skill for students/trainees to develop in order to provide safe, high quality patient care and to effectively communicate with other members of the healthcare team. Medicare (and other health insurance providers that emulate Medicare guidelines), while recognizing the importance of students/trainees learning this skill, has explicit rules about which student/trainee documentation can be used for billing purposes. Memorial Healthcare requires all students/trainees and their Staff Member preceptors to comply with Medicare rules when documenting in all patient EHRs.

Use of Medical Student Notes

Medicare does not pay for any services furnished by a medical or other student, but does allow the use of specific portions of the medical student's documentation to support a billable service. The Centers for Medicare and Medicaid Services (CMS) does not allow any documentation by any other type of student to be used to support a billable service.

Medicare requirements related to medical students and the use of their documentation to support a billable service:

1) A Teaching Physician or Resident Physician must be present.

   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. Exceptions to this requirement are review of systems (ROS) and/or past, family, and/or social history (PFSH), which are taken as part of an Evaluation and Management (E/M) service and are not separately billable.

2) A Teaching Physician may use only the ROS and PFSH when documented by a medical student. All other portions of the encounter must be redocumented by the Teaching Physician.

   The student 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 their personal note. If the student documents E/M services, the teaching physician must

verify and redocument the history of present illness, and perform and redocument the physical examination and medical decision-making activities of the service.[1] The Association of American Medical Colleges (AAMC) in a 2014 Compliance Advisory noted that Teaching Physicians must not use EHR functions that allow copying/pasting, copy forwarding, or changing of authorship from a medical student note to their own note. These actions do not meet Medicare requirements for redocumentation and could be considered fraudulent if used in support of a bill submitted to Medicare for services. Medicare requires personal documentation by the Teaching Physician to demonstrate their personal performance of the service.[2]

Documentation by Resident Physicians

Medicare allows both resident physicians and their teaching physicians to document physician services in a patient's medical record. Entries may be dictated/transcribed, typed, hand-written, or computer generated. All entries by resident and teaching physicians must be dated and have a legible signature (either manual or by electronic means). Physicians may use macros (computer generated templates with predetermined text), but they must also provide customized information that is sufficient to support a medical necessity. The use of only macros/templated notes is not considered by Medicare to be sufficient documentation.[1]

When a teaching physician bills E/M services, they must personally document at least all of the following:

1) That they performed the service or were physically present during the critical or key portions of the service furnished by the resident physician

2) Their participation in the management of the patient

On medical review, the combined entries in the medical record by the teaching physician and the resident physician constitute the documentation for the service and together must support the medical necessity of the service. Documentation by the resident physician of the teaching physician's presence and participation is not sufficient to establish such presence and participation.[1]

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[1] Centers for Medicare and Medicaid Services. *"Guidelines for Teaching Physicians, Interns, and Residents."* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf. (Accessed June 6, 2017).

[2] Association of American Medical Colleges. *"Compliance Advisory: Electronic Health Records (EHRs) in Academic Health Centers."* https://www.aamc.org/download/316610/data/advisory3achallengefortheelectronichealthrecordsofacademicinsti.pdf (Accessed June 6, 2017)