

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Next

ALLOWING MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD

One example of the transformation of the U.S. health system is the expanding presence of the electronic health record in teaching hospitals. To be prepared for residency, every medical student needs to learn how to incorporate this technology into patient care. To better serve their patients in the future, students need to be able to enter data, write a note, and find information. While Medicare billing rules present some challenges to making this a reality, the AAMC is working with CMS, members, and vendors to achieve the goal of using the electronic health record to improve education, patient care, and research.

Darrell G. Kirch, M.D.
President and CEO, AAMC

Background and Purpose

Electronic health records (EHRs) provide opportunities to improve patient care and increase the accuracy of communication. For the full potential of EHRs to be realized, they must become part of the educational experience from the beginning. Medical students need to have hands-on experience—including entering and retrieving information in the medical record—as a first step toward preparation for residency and beyond. The AAMC has developed *Core Entrustable Professional Activities (EPAs)¹ for Entering Residency*—guidelines intended to help bridge the gap between patient care activities that new physicians should be able to perform on day one of residency training and those they feel ready to perform without direct supervision—that are now being pilot tested by 10 medical schools. It is apparent throughout the guidelines that the ability to work in an electronic health record is an important tool to achieving the desired skills for each of the EPAs. Two of the EPAs speak directly to the student's ability to interact with the EHR: "Enter and discuss orders and prescriptions" and "document a clinical encounter in the medical record".

Medical students are learners. Thus, states do not give licenses to them and therefore, they are never considered to be billing providers and their notes should not become part of the medical-legal record. Medicare is explicit that "students may document services in the medical record,"² but has strict rules about which student documentation can be used for billing purposes. Therefore, it is incumbent upon institutions to understand the compliance risks associated with billing when medical students document in an EHR and recognize that appropriate management—including design choices in the EHR, education, and monitoring—can significantly reduce the risks and allow for essential educational opportunities.

¹ The Core Entrustable Professional Activities for Entering Residency publication can be downloaded here: www.aamc.org/cepaer

² CMS Manual, Transmittal 2303. Teaching Physician Services. September 14, 2011. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2303CP.pdf>

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Next

Previous

The purpose of this advisory is to:

- Provide an understanding of the rules related to the use of medical student documentation when a claim is submitted to Medicare. Because Medicare may be the only payer that has explicit rules about the use of medical student documentation and billing, that will be the focus of this advisory.
- Offer suggestions about ways to enable medical students to learn how to use the EHR, while mitigating the compliance risks when submitting a bill to Medicare or any other payer.

Medicare Rules Concerning the Use of Medical Student Notes

While Medicare does not pay for any services furnished by a medical or other student,² it allows the limited use of specific portions 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. The documentation rules apply only to medical students. 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.

The electronic health record offers great potential to enhance the quality of patient care in many ways, including better documentation of care, elevating the standard of care through point of care education for providers, easy sharing of patient care information to all members of the care team and to the patient, and opportunities to monitor the public's health, to conduct population-based research, to ensure accurate coding and billing, and others. It is important for medical students to begin learning how to use this tool so that as they progress through their careers they will be able to take full advantage of its potential.

R. J. Canterbury, M.D., M.S., DLFAPA
Wilford W. Spradlin Professor
Senior Associate Dean for Education
UVA School of Medicine

Medicare has promulgated the following requirements related to medical students:

1. A Teaching Physician or Resident Must Be Present

Any student contribution to and/or participation in 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 considered to be part of an evaluation and management [E/M] service and are not separately billable).

2. A Teaching Physician May Use ROS and PFSH When Documented by a Medical Student; Everything Else Must Be Re-documented

Students may document services in the medical record; however, the teaching physician only may refer to the student's documentation of an E/M service that is related to the ROS and/or PFSH. The teaching physician personally must perform and document the examination, history of present illness, and his/her medical decision making.

² Guidelines for Teaching Physicians, Interns, and Residents. July 2008. Medicare Learning Network, Center for Medicare and Medicaid Services, Department of Health and Human Services.

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Next

Previous

At University of Florida College of Medicine we consider communication with and within the EHR to be a key clinical competence. We integrate EHR into the educational program from the first semester of medical school with a structured program on how to effectively communicate using the EHR. We have developed an educational version of the EHR that allows students to learn not only how to use EHR, but also to learn critical thinking skills, interdisciplinary objectives and meaningful use. We are actively working on improving each of these and how to assess our learners.

Maureen Novak, M.D.
Associate Dean for Medical Education
Vice Chair of Pediatric Education

Although Medicare does not address documentation in the EHR, it is recommended that meeting this requirement will mean that the teaching physician cannot copy and paste a medical student's note for any documentation that must be done personally. Additional information about the risks of allowing copying and pasting of any note can be found in the COF EHR Advisory.

Risks to Be Mitigated

It is essential that medical students learn how to document patient encounters in the EHR; however, that educational experience must be clearly distinguished from documentation that is used to support a billable service.

Risk: Copying disallowed sections of a medical student's note in support of a bill

Inappropriate use of medical student documentation by a teaching physician or resident (in accordance with Medicare rules) in support of a bill submitted to Medicare for Part B services may be considered fraudulent by the federal government and may lead to allegations of violating the False Claims Act. Using functions that allow copying/pasting, copy forwarding, or changing of authorship from a medical student note to a resident or teaching physician note does not constitute "re-documentation." Medicare requires personal documentation by the teaching physician or resident to demonstrate personal performance of the service.

Risk: Inadvertent use of inappropriate sections of a medical student's note by a teaching physician or resident

A teaching physician may inadvertently use ineligible sections of a medical student's documentation (i.e., anything other than PFSH or ROS) if a resident copied portions of a medical student's note and the EHR does not clearly identify the history of authorship. Therefore, it is important to develop the ability to identify, track, and monitor authorship in an electronic record environment and conduct robust education and monitoring.

Risk: Inappropriate use of access controls—requesting the medical student to enter data using passwords of others

Every individual who enters documentation into a medical record must do so logged in under his/her own password. Basic record integrity rests on the principle that each individual enters information into the EHR using his/her own password. Entering data as a person who already is logged in, or logging in under someone else's name, even at their request, misstates authorship, and cannot be detected electronically. This principle applies to all system users, but is mentioned in this advisory because medical students may be more vulnerable to these situations than others. The risk can be managed with robust education for medical students, residents, and teaching physicians. Educate all system users, including medical students, about what to do in the event that they are asked to use another individual's login information.

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Next

Previous

Mitigation Strategies

Risk mitigation must be a multipronged strategy, involving the adoption of policies, education of all individuals who will be affected by those policies, and monitoring to ensure compliance. There also are design choices that can make the EHR an educational tool, a patient-care tool, and a billing compliance tool. It may not always be possible or desirable to adopt all of these controls into your EHR, but consideration should be given to those that will best meet the needs of your institution.

Each of these EHR design strategies involve:

- (1) Working with your EHR vendor to develop functionalities to accommodate learners
- (2) Educating medical students, residents, and teaching physicians on the correct use of medical student documentation
- (3) Developing ways to effectively and efficiently monitor compliance

Easy identification of note authorship is a key element of “documentation integrity.”

According to the American Health Information Management Association (AHIMA), an authoritative source of information about EHRs, “documentation integrity involves the accuracy of the complete health record. It encompasses information governance, patient identification, authorship validation, amendments, and record corrections as well as record auditing for documentation validity when submitting reimbursement claims.”³ The EHR should allow for real-time identification of the author of a note (medical student, resident, nonphysician provider, or teaching physician) so that the author/history of authorship and review is readily apparent to all users in the final note. Use of color coding or different font style for medical student notes may be helpful strategies.

Because of the need to readily identify the author of a note for quality of care and other purposes, including the need to ensure correct documentation for billing and to support educational goals, we encourage development of EHRs that attribute the content of each note to the actual author(s).

Suggested mitigation strategies for accurate author identification include:

- Assigning separate access controls/security class for medical students to make their entries readily and permanently identifiable
- Blocking inappropriate copying of the exam and medical decision portions of a note when entered by a medical student for evaluation and management services

³ AHIMA. Integrity of the Healthcare Record: Best Practices for EHR Documentation. *Journal of AHIMA*. August 2013;84(8):58-62. Available at:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050286.hcsp?dDocName=bok1_050286

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Next

Previous

- Blocking EHR system functionality that allows:
(1) copying of entire medical student notes
(2) changing or removal of medical student authorship
- Prohibiting features (macros) that automatically pull data other than ROS and PFSH from medical student notes into the notes indicated to be authored by others
- Automatic indication within a note that it has been copied in whole or in part and, if possible, the source of the note
- Identifying when a note is edited, if the EHR has the capability, to ensure that the note is identified as having been edited and indicates the identity of both the original author (as a medical student) and the editor
- Limiting viewing of the medical student note once the educational process is complete, but allowing retrieval for medical-legal purposes.
- Blocking ability to simply append a teaching physician statement to a medical student note, where only the teaching physician is identified as the author.

The JAMA Viewpoint—“Refocusing Medical Education in the EMR Era”

There is increasing recognition that medical education should be adapted to address the integration of the electronic medical record (EMR) into medical practice, but how this should occur and the specific educational goals have not been well-defined. In this Viewpoint, we offer suggestions for updating the Accreditation Council for Graduate Medical Education (ACGME) competencies to promote optimal integration of the EMR into clinical practice, guidance for using data available within the EMR to support and evaluate the achievement of ACGME milestones, and specific steps that individual institutions can take to support this evolution in medical education. Nathalie M. Pageles, M.D., M.Ed.

<http://jama.jamanetwork.com/article.aspx?articleid=1787416>

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

Medical Students as Scribes

Scribes do not interact directly with patients; they document the activities of a provider, as verbally instructed. Whether medical students should be used as scribes—and if they are, how this activity is structured—is an institutional decision that includes consideration of whether scribing is seen as a valuable educational experience. Any policy on the use of medical students as scribes should consider whether they should be assigned two passwords, one when they are acting as a scribe, and

the other to identify information they gather directly from the patient. We recommend you review your Medicare contractor’s specific guidance on scribes and incorporate the requirements into your policy and training.

[Background and Purpose](#)

[Medicare Rules
Concerning the Use of
Medical Student Notes](#)

[Risks to Be Mitigated](#)

[Mitigation Strategies](#)

Previous

Sources of Information to Review Prior to Establishing a Policy

- Medicare regulations and CMS instructions manual
- Medical staff bylaws
- 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 either by hand or electronically
- Data mining software to search for inappropriate use of medical student documentation
- An EHR design that hides the medical student note after review to provide clear designation and discourage copying
- Controls that identify the origin and review history of medical information