Office of Integrity & Compliance

UR MEDICINE
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Student Documentation Guidelines

Applicable to APP Students and Medical Students

Documentation rule from CMS allows a precepting/teaching provider (physician or APP) to bill based on a medical **student/**APP **student** note after any edits, using **addend.**

This rule is applicable to:

- **Teaching Physician/Precepting (Teaching) APP:** Attending physician or APP who is **billing** for the encounter and supervising (precepting) a student.
- **Student:** This applies to medical students and APP students; any location where students rotate, who are currently, actively enrolled in an accredited educational program.

CMS Definition of Student

CMS defines a student as an individual who participates in an accredited educational program (for example, medical school).

For the purposes of this guidance medical residents are not considered students.

Applies only to provider types that will eventually be eligible to independently bill Evaluation & Management (E/M) services, (e.g., MD, DO, NP, DNP, PA).

Employees who have graduated from an accredited education program are no longer considered students. Providers who are hired as APP in a training capacity do not meet the definition of student for the purpose of this guidance.

New Documentation Rules

Teaching Physician or Preceptor APP may use **ANY** student documentation **but**:

1. Must verify in the record "***all*** student documentation or findings… of the E/M service being billed."
2. Must "***personally perform*** the exam and medical decision-making activities of the E/M service being billed"
3. **Teaching** physician, or **Preceptor** APP, must be ***physically present*** for "any contribution and participation of a student to the performance of a "billable service" other than the history.

What services are eligible?

Only Evaluation and Management (E&M) services. The student documentation rule does not apply to other diagnostic or therapeutic services.

Which payers accept student documentation?

- Medicare Part B
- Medicaid
- Other payers have not established their own Teaching Faculty/Student Documentation rules, so URMC will permit application of the new rules to all payers.

Who Can Use Student Documentation?

- Teaching (billing) **Physician** and Preceptor (billing) **APP** may use student documentation
- Residents may **not** use or incorporate (copy and paste) student documentation into their notes.
- The teaching physician (PATH) rule may not be applied to resident notes that incorporate student documentation.
- If a resident writes an addendum at the bottom of a medical student note, the teaching physician **must still** addend the student note.

Supervision Standards for Documentation

New Rule Includes APP Students with Preceptor

Teaching Physician (or resident for medical student) /APP Preceptor must be physically present (in the room) for the student contribution to the billable activities, other than the history.

Verification Standards for Documentation

- Teaching(billing)physician must verify medical student documentation
- APP (billing) preceptor must verify APP student documentation

All student documentation or findings that reflect the **E/M service being billed** must be **verified**

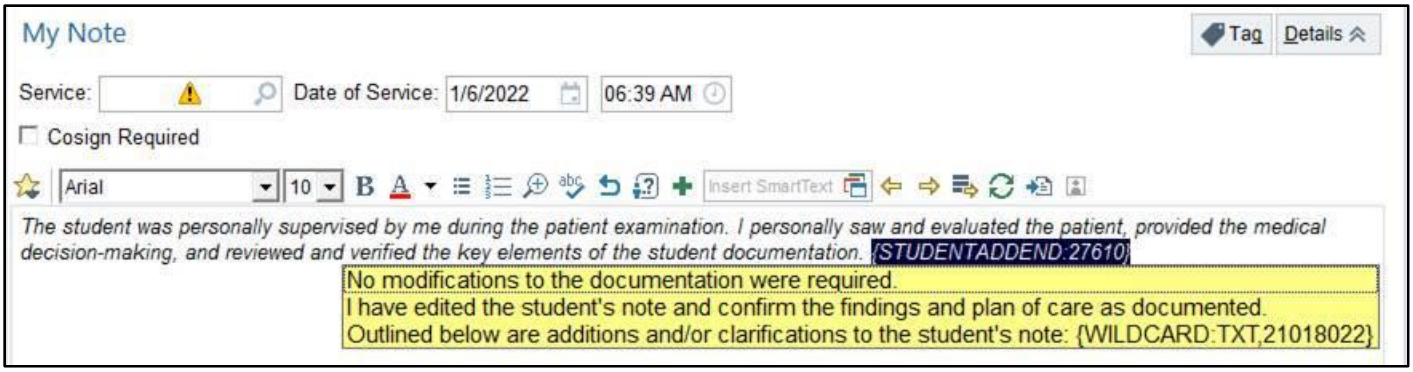
- Billing (LOS) should be based on the level of evaluation and medical decision making (MDM) necessary to address the patient's clinical presentation.
- Verify all portions of the documentation (HPI, Exam, Decision Making) being relied upon for the billable service.

Residents cannot verify student documentation (cannot be delegated to a resident)

New Smart Phrase *.STUDENTADDEND*

New Smart Phrase .STUDENTADDEND is **replacing** .MSATTEST and .MEDICALSTUDENTATTESTATION

Teaching physician and APP preceptor use the addendum function in eRecord, **not** attest, **not** co-sign. Therefore, this new Smartphrase was created with the word addend to reduce confusion and align with desired action.



eRecord Addendum .*STUDENTADDEND*

"The student was personally supervised by me during the patient examination. I personally saw and evaluated the patient, provided the medical decision-making, and reviewed and verified the key elements of the student documentation." {STUDENTADDEND:27610}

Smartlist: Teaching(billing)physician/APP preceptor selects one of the following:

- *No modifications to the documentation were required.*
- *I have edited the student's note and confirm the findings and plan of care as documented.*
- *Outlined below are additions and/or clarifications to the student's note: ****

Workflow Examples

Ambulatory Workflow

- Student independently performs interview and basic exam
- Student presents findings to preceptor (ideally in front of the patient)
- Preceptor clarifies, confirms key history, (re)performs exam and reviews assessment and plan (with student present)
- **Student writes note using a regular progress note (Do NOT use Provider Student Note type)**
- **Preceptor** addends student note, using **.STUDENTADDEND** and edits as needed, and submits billing (for medical and APP student)

Provider-Student-note type will not remain a part of the medical record

Inpatient Workflow Independent Student History and Exam, Not Directly Observed

- Medical or APP student obtains history and performs exam with patient independently
- During bedside rounds, medical/APP student presents the history and exam he/she obtained in presence of preceptor
- Teaching physician/preceptor verifies the key elements of the exam and confirm medical decision-making of the student/team

Inpatient Workflow Directly Observed by a Resident

- Resident supervises medical student obtaining physical exam
- Medical student presents the patient's history and physical exam to the teaching physician (outside room or at bedside)
- Teaching physician verifies history, physical exam, and reviews medical decision making ideally in the presence of the student

Inpatient Workflow Directly Observed, No Resident

- Teaching physician supervises medical/APP student or APP preceptor supervises APP student, performing physical exam, verifies key findings, and confirms medical decision making.

Confirming the Level of Service (LOS) Evaluation & Management (E&M) Elements

- All elements the student performs should be reviewed
- The teaching physician or APP preceptor should perform the history & physical exam elements to support optimal patient care and the level of service commensurate to the billing

To Which Students Do These Rules Apply?

Rule can be applied to any level medical and APP student

The Teacher/Preceptor's Responsibilities

1. Share documentation expectations with medical/APP student

   Type of note template:

   a) Student will use a **regular** note type, i.e. progress note, H&P note, if you want to use their note for billing

   b) Student should use the *'provider student note'* only if you ***do not*** want to use their note for billing

2. Review student documentation and **provide feedback!**
3. Use the Addendum function in eRecord with the **.STUDENTADDEND** smart-phrase
4. Ensure that physical presence rule is met:

   a) Student supervised obtaining exam by teaching physician, preceptor APP (can be a resident supervising for medical student)

   b) Student present for preceptor's verification and (re)performance of H&P and medical decision making

5. Select LOS (bill) based on elements of the history, exam, and medical decision making that have been personally verified or (re)performed:

   a) Does not have to be re-documented

6. Be prepared to explain your practices to the medical/APP student

   a) Why you choose to perform/not perform a particular exam component

   b) Your billing practice or a certain encounter

The Student's Responsibilities-Medical and APP

1. Confirm with attending/preceptor whether a billable note template or non-billable note template should be used, e.g. progress note *vs. the nonbillable provider-student-note type*
2. Assign attending/precepting APP to cosign each completed note
3. Ensure documentation accurately reflects the history and physical exam that you, the student, performed
4. Ensure documentation reflects the student's understanding of the medical decision making, formulated in collaboration with the attending/preceptor
5. **Do not copy** and paste text from other providers' notes within the EMR

Compliance Essentials for Use of Student Documentation

1. **Physical Presence–2 options**:

   Teaching Physician/APP preceptor (or Resident) was physically present in the room when the student examined the patient;

   Or

   Teaching Physician/APP preceptor verified the student documentation with the patient in the physical presence of the student.

2. **Verification**: Teaching Physician/APP preceptor personally verified the student documentation relied upon for the level of service billed.
3. **Examination**: Teaching Physician/APP preceptor performed the exam (if part of the billable service) and supplied the medical decision making.
4. **Use Smartphrase .STUDENTADDEND** *(Do not use .msattest* or *medicalstudentattestation)*

Key Take-Aways

- Any confirming exam relied upon for billing must be personally performed by the teaching physician, precepting APP
- Student presents findings to preceptor (ideally in front of the patient)
- Preceptor clarifies, confirms key history, (re)performs exam and reviews assessment and plan (with student present)
- Student writes note using a regular progress note (Do Not use provider student note type for billing)
- Understand when to use provider-student-note type (nonbillable note)
- *If student note type is used it will not remain as part of the medical record*
- Teaching/Preceptor addends student note, using *.STUDENTADDEND* and edits as needed, and submits billing (for medical and APP student)

2023 CPT E&M Inpatient & Outpatient Level of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low	**Low**
	• 2 or more self-limited or minor problems
	• 1 stable chronic illness
	• 1 acute, uncomplicated illness or injury
	• 1 stable, acute illness
	• 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high).
			Low risk of morbidity from additional diagnostic testing or treatment

Moderate	**Moderate**
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
	• 2 or more stable chronic illnesses
	• 1 undiagnosed new problem with uncertain prognosis
	• 1 acute illness with systemic symptoms
	• 1 acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported).
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	**High**
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*
		  • Review of the result(s) of each unique test*
		  • Ordering of each unique test*
		  • Assessment requiring an independent historian(s)
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported).
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).
			High risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances