Revise CMS Teaching Physician Claims Processing Transmittal Instructions Related to Use of Student Documentation of Evaluation/Management (E/M) Services

Recommendation:
Revise the "Medicare Claims Processing instructions regarding E/M Documentation Provided by Students" to allow a student's clinical work to be included as part of the teaching physician's E/M documentation, to improve medical education and reduce inefficiencies and administrative burdens. The teaching physician should be authorized to refer to all parts of student documented clinical work for billing purposes, without repeating the documentation, as long as the teaching physician documents that he or she has performed a history and physical exam, has verified the accuracy of the student documentation and is personally responsible for the medical decision making.

Background:
Students' performance and documentation of their own findings on history and physical examination had been an essential task for students throughout most of the 20th century. Not only was this an essential part of their path toward independent medical decision making, but it was one of the principle ways that faculty made a judgment about whether a student could be trusted to advance. Before electronic health records (EHRs), teaching physicians typically corrected students' hand written notes in the paper record by crossing out errors and entering correct findings.

Current guidance for claims processing[1] by Medicare and Medicaid Services (CMS) has inadvertently hampered medical education and increased the administrative and regulatory burden on the teaching physician. These guidelines limit the student documentation role to review of systems and/or past family/social history, and prohibit teaching physicians from referring to a student's documentation of other parts of the history, physical exam findings, or decision-making. While these guidelines do not prohibit students from writing in the medical records, many health care systems have prohibited student access based on their interpretation of these guidelines.

As a result, the extra administrative burden on the teaching clinician is high. The effect of this additional burden is that it has negative implications for physicians deciding whether to oversee students. The responsibility for overseeing the care team can be much more efficient if they have the ability to use student notes to relieve the administrative burden, while still keeping the clinical judgment (for which billing is related) with the physician, not the student. In addition, limitations on student use of EHRs threaten the development of competencies needed for clinical care, licensure, and the lifelong practice of medicine; interfere with the teaching physician's ability to assess a student's progress toward independent medical judgment; create safety risks when students transition to clinical care and are expected to document as an intrinsic part of providing safe and effective care; and prevent students from serving an active role in team-based care through documentation.

The revisions requested can be made while ensuring that teaching physicians continue to appropriately assume responsibility for care documented in the medical record for which they submit claims.

Rationale for CMS to Change Documentation Policies:

- **Redocumentation places an unnecessary administrative and regulatory burden on teaching physicians, and inappropriately underutilizes students.**

Current CMS documentation policies which limit student involvement are an unnecessary administrative burden on the teaching physician. Medical practices and healthcare systems can clearly identify and track the history of authorship of all notes and edits in the EHRs. The teaching physician's involvement in the billable portion of medical services can be assessed to ensure appropriate oversight

[1] CMS Manual System: Pub 100-04 Medicare Claims Processing

of students and personal involvement in patient care services. Redocumenting all portions of the medical note is unnecessary, burdensome, and redundant.

- **Students must experience and learn the role(s) they will assume as members of a clinical care team.**

Given the movement toward inter-professional team care and value-based payment, clinical practices should have the ability to allow adequate experiences for students to have the patient care experience and fully use electronic health records to develop skills needed for clinical care. CMS instructions should operationalize and optimize the ability of the care team to function, rather than hinder them. Without these changes, the efficiencies both in quality of care and maximizing the input of members of the care team are undermined.

Current CMS language with proposed changes (tracked):

Code of Federal Regulations: 42 CFR §415.172 (b):
…the medical records must document the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures may be demonstrated by the note in the medical records made by a physician, resident, or nurse. In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records.

CMS Manual System: Pub 100-04 Medicare Claims Processing
B. E/M Service Documentation Provided By Students
Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document their performance of E/M services in the medical record. ~~However, t~~The documentation of an E/M service by a student ~~that~~ may be referred to by the teaching physician. ~~is limited to documentation related to the review of systems and/or past family/social history.~~ The teaching physician may ~~not~~ refer to a student's documentation of the history, ~~the~~ physical exam findings and~~or~~ medical decision making in his or her personal note. If the medical student performs and documents E/M services, the teaching physician must verify the accuracy of ~~and redocument~~ the history ~~of present illness~~ as well as perform ~~and redocument~~ the physical exam and medical decision making activities of the service.