Policy /Procedure Document	
Manual:	N/A
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Policy Owner:	Medical Staff
Required Approvals:	
Committee:	Medical Executive Committee
Leadership/Board:	Board of Trustees

TITLE:	**Guidelines for Practitioners Supervising Medical, NP or PA Students in the Acute Care Setting**
SCOPE:	These guidelines are intended for Medical Staff Privilege Holders who are supervising students and not intended nor applicable to Privilege Holders who are teaching and supervising Residents.
DOCUMENT TYPE:	Reference document: CMS Transmittal 4068 dated May31, 2018; MLN Matters Number MM10412 released 06/01/2018; Guidelines for Teaching Physicians, Interns and Residents, Dec. 2011
PURPOSE:	To ensure that CMS guidelines are followed with regards to supervision of medical, NP and PA students.
PHILOSOPHY:	N/A
DEFINITIONS:	N/A
PROCEDURE:	

General Information:

- CMS limits the part of a student's documentation that can be used to support the professional billing of the supervising Practitioner when the information contained in that documentation was obtained independently by the student (limited to ROS and PFSH).
- Students are not "scribes" and cannot act as a scribe unless employed in that capacity by the facility.
- A medical student is never considered to be an intern or resident in a documentation capacity.

Requirements:

1. Medical, NP, and PA students are expected to document in the medical record as part of their training.
2. Medical student clinical activity requirements are delineated in the Rules and Regulations of the Memorial Medical Staff.
3. The supervising/teaching Practitioner may attest to a student's documentation, but the supervising/teaching Practitioner must personally perform a physical exam and the medical decision making activities.

Per CMS: Evaluation and Management Documentation Provided by Students:

Students may document services in the medical record, however, the teaching Practitioner must verify in the medical record all student documentation or findings, including history, physical exam, and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify

any student documentation of them in the medical record, rather than re-documenting this work. From the CMS guidelines: 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 not separately billable and may be performed independently by a student).

Junior/Senior Medical Students (Medical Staff Rules and Regulations: Medical Records)

Junior and senior medical students may write or dictate H&Ps, Progress Notes, and Discharge Summaries. They may also write orders after first conferring with a Resident, the Admitting Practitioner or a consultant. All orders written by students require a verbal or written approval by the Admitting Practitioner, consultant or resident before the order may be carried out. Special procedures by students such as a spinal tap, paracentesis, etc. will be supervised by a resident, Admitting Practitioner or consultant.

Consultations:

A Practitioner may request consultation on a patient from another Practitioner. A consultation request requires that a written report on the consultation be sent back or communicated to the Practitioner who requested the consultation. Consultation reports may not be documented by students.

Supervising Practitioner Documentation:

Unacceptable Documentation: The following are examples of "unacceptable" documentation by the supervising Practitioner when referencing student documentation.

- "Agree with above." Followed by countersignature.
- "Discussed with student and agree with above documentation."
- "Patient seen and evaluated with the student and agree with their documentation."

Acceptable Documentation: May refer to the student's documentation of history, physical exam and medical decision making process.

"I attest that I have reviewed and verified the student note and that the physical exam and the assessment and plan documented were performed by me."

"I attest that I was physically present with the student, verified all student documentation, and performed (or re-performed) the physical exam and medical decision making.

Alternate Acceptable Documentation: Refers only to student's documentation of ROS and PFSH.

"I saw, examined, and evaluated the patient. I discussed with the student and reviewed with the student the documentation of the ROS and past medical, family and social history. The following is my full documentation." The Practitioner then must additionally document in their own note:
History of Present Illness
Physical Exam
Medical Decision Making/Diagnostic Impression/Treatment Plan

Document Revision History:		
Revision Date:	Revised By:	Summary of Changes:
7/24/2014		Original Document
08/2018	Michael Blakesley, MD	Revised per new CMS guidelines