Policy /Procedure Document	
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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 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:

- When supervising medical, NP, or PA students, CMS limits what parts of the student's documentation can be used to support the professional billing of the supervising Practitioner.
- 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 a student's documentation, but the supervising/teaching Practitioner must personally document their own services per CMS guidelines below:

Per CMS: Evaluation and Management Documentation Provided by Students:

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). 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 the student's

documentation of the history of present illness, physical examination findings or medical decision making in his or her personal note. If the student documents E/M services, the teaching physician must verify and redocument the physical examination and medical decision making activities of the service. (CMS 12/2011 Guidelines for Teaching Physicians)

Therefore, supervising Practitioners may NOT refer to a medical, NP, or PA student's documentation of present illness, physical exam findings or medical decision making to support documentation for billing purposes. The teaching Practitioner must repeat the exam, even if the medical student performed the exam in the teaching Practitioner's presence, except for those elements that the teaching Practitioner can assess by observing the student's performance of the element, for example: gait. Intentional use of other student documentation that is not independently confirmed and documented by the teaching Practitioner in accordance with Medicare rules in support of a bill submitted to Medicare for Part B services may be considered by the Federal government to be fraud and abuse and may lead to allegations of False Claims Act Violations.

		Student Documentation	**Physician Performance and Documentation Responsibilities**
History	History of Present Illness: (HPI) Elements	CANNOT BE USED to support supervising physician billing	Verify; Document
	Hx: Past Medical, Social, Family	Acceptable	Verify, Reference and Note Additions/Changes
	Review of Systems	Acceptable	Verify, Reference and Note Additions/Changes
Exam	Exam – body areas, organ systems	CANNOT BE USED to support professional billing	Perform and Personally observe; document
Medical Decision Making	Complexity	CANNOT BE USED to support professional billing	Document

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 cannot 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 review of systems and past family/social history.

"I saw 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 Examination
Medical Decision Making
Diagnostic Impression/Treatment Plan

Document Revision History:		
Revision Date:	Revised By:	Summary of Changes:
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