USING MEDICAL STUDENT DOCUMENTATION FOR BILLING PURPOSES

Re: Use of Medical Student Documentation for E/M Billing

In an effort to decrease administrative burden, CMS recently ruled that providers may use medical student documentation for E/M billing. Beginning May 14, Epic will be updated to allow additional student documentation and billing from their notes.

<u>The rule has very specific requirements for using student documentation, which are different</u> <u>from resident documentation</u>. Please review the requirements below and the recommended workflows in Epic for the inpatient and ambulatory settings.

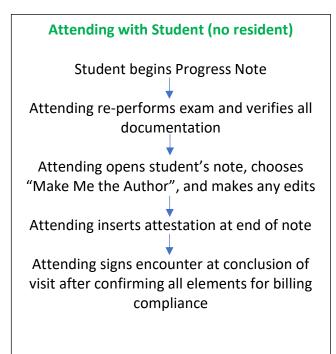
- The attending or resident must personally *verify, update, and/or edit* all of the student's documentation, including all history and medical decision making.
- In addition, the attending or resident must *personally perform or re-perform* the documented physical exam (may verify, but not required to re-document.)
- The attending physician or resident must be physically present to verify all student documentation and re-perform the exam.
- Residents may use student documentation, but the resident must supervise the student and adhere to the same requirements as noted above.
- Medical student documentation may be used for H&P, Progress Notes, Consults, and Discharge Summaries with appropriate attestation. Medical student documentation of Procedure/Op Notes may <u>not</u> be used for billing and will require re-documentation.

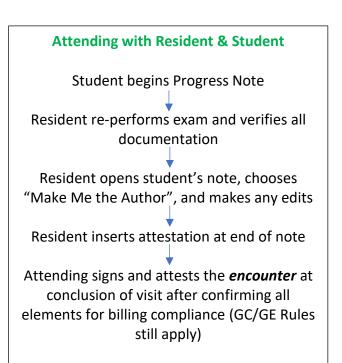
Only the approved attestation statement (.STUDENTATTEST) should be used in all clinical settings.

Note:

- Use of medical student documentation for billing purposes is optional. Attendings may continue to use their own note or attest a resident's note, and allow students to write a separate, independent note.
- This workflow does not apply to nurse practitioner students, physician assistant students, nurse practitioners, or physician assistance.

Ambulatory





Inpatient

