Compliance Advisory 3
A Challenge for the Electronic Health Records of Academic Institutions:
Physicians combining documentation or using information documented by others when billing for a professional service

Purpose
In academic medical institutions, it is common for information to be entered into the medical record by a variety of individuals including teaching physicians, residents, Advanced Practice Clinicians (APCs), pharmacists, nurses, technicians, medical assistants, medical students and other learners. Some of these individuals may have access to formal note structures while others may be limited to only entering specific information such as patient history. This advisory focuses on ways in which academic medical centers and teaching hospitals can ensure the best use of electronic health records (EHRs) given the myriad of individuals who contribute to the medical record. The goal in doing so is to improve patient care and provide a meaningful educational experience while meeting regulatory requirements and restrictions related to the use of documentation written by someone other than the billing physician, or combining such information with a physician’s note.

Background
It is important that the EHR contains appropriate clinical documentation to support quality patient care, facilitates the optimal and efficient use of available documentation, and simultaneously provides controls to ensure compliant data usage in support of billing. Specific federal and state regulatory requirements, including limitations and prohibitions on the use of information generated by someone other than the billing provider also come into play. These rules apply to both paper and electronic documentation. Therefore, there is a need to easily identify the provenance of the note. Unlike a written note in which it is possible to distinguish authorship via visible differences in handwriting style, EHRs must be equipped to provide attribution. Clear identification of the originator of note content and all individuals who added, deleted, or changed information is critical. For example, the use of medical
student documentation is limited to the review of systems and past family social history in support of a bill submitted to Medicare\textsuperscript{1}. An electronic health record should provide functionality that makes it difficult, if not impossible, to include the history of the present illness, the exam, or medical decision making generated by a medical student in a note intended to support a bill.

**Identified Risks**

1. The inability to accurately identify each author may bring into question the credibility of medical entries and has the potential to have a negative impact on patient care.
2. Documentation that does not meet federal regulatory requirements may expose the institution to fraudulent billing allegations. A particular risk is documentation by individuals in certain roles that cannot be used to support a bill. Examples include notes by an individual whose expense or salary is not incurred by the provider’s clinical practice [medical residents not included]; notes by a medical student other than the permitted sections of history; or notes in areas of documentation not allowed to be captured by certain ancillary personnel [e.g., MAs].

**Common Challenges in Current EHR Systems**

**Teaching Physicians Combining Notes with Residents**

Medicare Carrier’s Manual Subsection 15016 and 42 CFR Section 415, Subpart D\textsuperscript{2} establishes requirements for documentation of and billing for services involving residents (defined as interns, residents, and clinical fellows in approved graduate medical education program). This manual section should be thoroughly reviewed. Any institution that trains residents should incorporate its requirements into the EHR functionality, documentation requirements, and policies.

In brief, Medicare requires the teaching physician to personally document his or her participation in Evaluation and Management (E/M) services, and their presence or participation in surgical and diagnostic procedures. Many academic physician practices adopt the Medicare documentation requirements as the standard for all documentation regardless of third party payer. The required language for procedures and ancillary services is different, making selection via dropdown menu or similar choices helpful. Each option should as provide appropriate language as required by federal and state rules. Institutions should check with their local Medicare contractor for specific guidance regarding E/M documentation requirements.

\textsuperscript{1} See AAMC Advisory One: Medical Student documentation. 


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\textsuperscript{2} IOM, Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician practitioners, section 100- Teaching Physician Services.
An identifiable field would assist in auditing for appropriate authorship, while providing the ability to exclude the language from correspondence when it is not necessary. The EMR should not add the teaching physician template as a default, or include it in every note as the teaching physician electronically signs and closes the note as the statement should only be added when a resident is involved in the service. ³

When the original authors of every note are visible the result is improved patient care, better learning experiences, and efficiencies in documentation review. Functionality that only supports confirmation of authorship by comparing prior versions of a note, or audit trail functionality that is only available to selected users, lacks full transparency and may be problematic in demonstrating the complete authorship history to third parties, including payors and regulatory agents.

**Recommendations for EHR Design**

- Only teaching physicians can append a teaching physician attestation and only if they participated in the service. EHR should allow for “Resident Only” services in cases in which the teaching physician did not participate in the service.
- The personally entered statement of the teaching physician regarding his/her involvement in the care of the patient should appear above his/her dated and timed electronic signature. The EHR should indicate date and time of the attestation and signature were appended as well as the date of service. Check with your Medicare contractor for additional guidance.
- Provide a function that allows exclusion of the teaching physician statements on documents where it is not required.
- Support a menu of options for teaching physician statements to provide a selection by type of service. The menu might include statements for E/M services, procedures, ancillary services, and critical care. It is important to provide the ability to add more notes, append patient-specific information related to his/her personal participation in the service, and make multiple selections, as appropriate.
- Whenever an entire note is copied from elsewhere in the medical record—whether by the original or by a different author- the name and title of the original author and date of the original note should be retained. The original authorship/participation of the resident or others in the service should remain clear to all users of the medical record.
- Append the teaching physician statement to the resident’s note, or link the two notes so that they are accessed and printed as a pair. Alternatively, the two notes should be immediately

³ See The Joint Commission Edition Comprehensive Accreditation Manual - Effective July 1, 2012, Record of Care, Treatment and Services (RC), RC.01.02.01, Entries in the medical record are authenticated.
identifiable as linked in the medical record. Check with your Medicare contractor for additional guidance.

- Include a prompt or reminder to the teaching physician to append his or her teaching statement prior to adding the e-signature. For billing purposes a resident’s note can only be used by one teaching physician. The ability to identify resident notes that have already been reviewed and used by a teaching physician for billing purposes would be useful.

**Medical Students**

Medicare limits the use of medical student documentation in support of Part B billed-services to the Review of Systems (ROS) and Past/Family/Social (PFSH) history. The remainder of the medical student’s note cannot be used to support professional fee billing. It is an important attribution of the medical student note to always be readily identified to all users and that there be functionality to discourage inappropriate copying by a resident, non-physician practitioner, or teaching physician.

*Recommendations:*

- Consider specific functionality (may be called a “note type” by some EHR vendors) designed for medical student use and review by either a teaching physician and a resident or both. This will promote the educational/learner model by permitting the use of ROS and PFSH and can be structured to prevent or strongly discourage inappropriate use. Consider engaging appropriate technical expertise to determine if this functionality is available in your organization’s EHR.

- As stated previously, consider functionality that is specifically designed to help ensure notes authored by medical students are easily identifiable, and that the portions of the history permitted by CMS Evaluation and Management guidelines (review of systems and past/family/social histories) may be accessible to be used in documentation in support of a billable service to federal payors.

**Combining notes with Non-Physician Practitioners/Advanced Practice Clinicians [APCs]**

The use of notes generated by APCs as well as a host of ancillary providers is determined by multiple factors such as state scope of practice laws, contractual provisions, facility policy, and medical staff by-laws. To add further complexity, rules can vary by site of service. Consistent with state scope of practice laws, Medicare allows certain APCs to bill for services under their own billing number when the services are provided independently. The payment for their services is 85% of the Medicare physician fee schedule (or less for Certified Nurse Midwives). Alternatively, when certain requirements (such as “incident to”) are met, Medicare allows the services to be billed in the name the supervising physician.

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4 See AAMC Advisory 1: Medical Student Documentation


at 100% of the physician fee schedule. Medicare requires that services that do not meet “incident to” rules be billed under the APC’s billing number. EHR functionality enabling the ancillary personnel to identify the services that meet “incident to” would greatly enhance the accuracy of billing in accordance with varying payor requirements.

For provider-based clinics and inpatient services billed to Medicare Part B, when appropriate conditions are met, split/shared documentation is permitted so that a physician and an APC can combine their respective notes in support of a single billable service. The EHR must identify both the APC’s note and that of the physician, and each individual must document his or her involvement in the service. Each note must be signed by its respective author.

Supervision and documentation requirements for APC services can vary significantly based on differences in State licensure requirements and on State Medicaid and non-federal payor rules. Some payers permit billing in the physician’s name and billing number, which may require documentation to be co-signed by the supervising physician. The EHR functionality should allow for supervising physician co-signature of notes by specific provider types.

**Recommendations are for functionality that allows:**

- The physician to combine his or her note with an APC’s note and allows each note to be electronically signed by both providers, while retaining the identity of who authored each portion.
- The ability to label services meeting “incident to” and to readily identify them for billing purposes.
- The ability to identify notes that were intended to be linked facilitates identification of a combined service.
- The ability to identify and conduct searches by both the date of service and the date the note was signed.

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6 CMS Transmittal, 1776, Oct 25, 2002 (Ibid)
Combining with Technicians’ Notes

Some specialties, such as ophthalmology, use technicians as well as residents and non-physician practitioners. There must be clear identification of the work performed, and confirmed, by each participant.

Recommendation:

- The ability to combine a note with three participants: a technician, a resident, and a (teaching) physician. Attribution must be clear within the note of respective authorship, as well as personal statement of the billing provider’s participation in the service.

Scribes

The use of scribes—individuals whose role is to document as the physician performs the service—has become more common in Emergency Medicine and other specialties. Scribes do not provide health care services or gather information independently. Typically, while the provider examines the patient or performs a procedure, a scribe contemporaneously enters data into the computer as directed by the provider. For example, as a series of lesions are removed, a dermatologist may dictate to the scribe rather than interrupt the service to input the data him/herself.

A scribe must have his/her own system security, sign-on, and EHR access that is appropriate for what he/she is doing. A scribe should never use the system login and password of the performing clinician/physician.

Requirements:

- Separate login/passwords. Scribes may not use the password of a physician or other provider or enter data while another individual is logged in, even with their consent.
- Append a statement identifying the scribe and the name of physician for whom he/she is scribing e.g. “I am (enter Scribe’s name) functioning as a scribe for (Provider’s name)...”
- A statement by the physician should be placed close to his/her electronic signature that indicates that the content of the note is recognized as scribed and has been reviewed and confirmed.

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Joint Commission FAQ, May 18, 2011 “A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or licensed independent practitioner (APRNs are considered licensed independent practitioners in some states. Physician Assistants are not considered licensed independent practitioners). It is the Joint Commission’s stand that the scribe does not and may not act independently but documents the physician’s or licensed independent practitioner’s dictation and/or activities.”

For example, “I have reviewed and verified the above scribed note of this patient’s visit as recorded by (enter Scribe’s name).”

Recommendations:
- Identification of information provided by an individual with dual roles – scribe and medical assistant. Some assistants may gather patient history before the physician enters the room. This is not scribing. The medical record must make distinctions between these two types of documentation.
- Scribes and individuals using scribes must receive specific training, including copies of institutional policies, about the use of scribes.
- Institutions may consider evaluating if it is appropriate to limit the scribe’s access to notes only.

Data in central repositories: Indicating when the Data was reviewed

Often EHR systems store patient histories (the review of systems and past/family/social histories) in central data repositories. Caution should be exercised when creating a note, as incorporating excessive amounts of information may lead to an overlong note that endangers patient care. In many cases it may be preferable simply to reference the data in the repository. The ability to identify when the information was entered, the items that were reviewed, and the name of the individual who reviewed them, is critical. Documentation in support of a specific service should identify only information pertinent to and medically necessary for the date of service. This allows it to be retrieved and incorporated into a note for review by other care providers and coders, as well as outside entities such as payers and regulatory agencies.

It is not sufficient to indicate that the entire history has been reviewed as this may overstate provider effort for a specific encounter. It is important that the health care provider have the ability to select specific items as reviewed, and not be limited to selecting all or nothing. Some elements in the history may not be pertinent/medically necessary to the current patient encounter and could potentially result in a pattern of over-coding of billed services.

Recommendation:
- The physician should be able to identify, select, and specify sections of the history that are reviewed indicating them to be medically necessary for the patient encounter.
Services provided by a team

Teaching institutions often deliver team-based care that includes providers with different roles: teaching physicians, residents, APC’s, technicians, nurses, pharmacists and counselors. The documentation must be clear as to original authors and to the multiple levels of review for those roles that require review. Federal regulations prohibit the use of documentation generated by individuals whose salaries are recovered under Part A (hospital) to be used in support of a Part B (physician) bill. Institutions should identify which individuals’ salaries are covered under Part A as a way to further ensure appropriate use of documentation.

Recommendations:

- Identify authors by name and role (e.g., resident, RN, Resident/MD, Teaching/MD, ARNP, PA); documentation should indicate the date last reviewed.
- Ability to combine documentation provided by three or more care providers and to identify and assign authorship to each separately authored portion of a note when a team encounter occurs.
- Ability for multiple teaching physicians to append their respective teaching physician statements when more than one physician is providing services to patient in one day (such as Emergency Medicine), or during a single surgical session. In allowing for this ability, it is important to remember that this must be consistent with the Medicare requirement that a resident’s note can be combined with the note of only one teaching physician.
- Ability to combine documentation of specialized multidisciplinary teams such as physical therapy, occupational therapy, and dietary social workers, while maintaining identification of authorship of each portion of the note.
- Ability to identify original authorship and all subsequent contributions.
- Ability to alert team members when an individual’s documentation may not be used in support of a Medicare Part B bill, such as a prompt when an individual is included on the hospital cost report.

Critical Care and Other Time-based Codes

Only the attending physician’s time can be used when selecting the proper time-based code for certain billable services such as critical care, discharge day service, counseling and coordination of care, and prolonged services.
**Recommendation:**

- Ability for the attending physician to append statement of time spent in critical care, exclusive of procedures, and explanation of why the patient requires critical care. This should not include resident or APC time.

**Combining documentation with individuals who may or may not have billing numbers**

Nutritionists, genetic counselors, pharmacists, and radiology assistants all provide professional services. For those who are employees of the billing provider group, the use of their documentation is governed by the same rules as documentation by medical students. When any of these licensed professionals are employed by the same entity as the physicians, the submission of a professional fee bill must be supported by documentation that demonstrates the requisite supervision requirements have been met.

**Policy and Audit Review Considerations**

This advisory focuses on access controls and authorship identification provided by EHR functionality. Policy and review considerations may include:

- Seek resources and recommendations from your electronic health record vendor, and determine the resources the vendor provides and recommends.
- Establish audit policies and procedures that are approved by the hospital, and/or the clinical practice, and conduct education as to the appropriate use of electronic health record features and functionality.
- Training and education on system design/functionality, including the reasons that circumvention of controls creates risk and may result in non-compliant documentation.
- Documentation reviews should include exploring the documentation trail, including viewing all note versions, if applicable, to identify authorship of entries.
- Consider making an inventory of the audit resources, including functionality, that permit viewing prior versions of a documentation/authorship, and any reports developed to facilitate search for inappropriate use of documentation, such as medical student notes, copying and deleting name of previous author.

**Summary Recommendations in EHR architecture to support professional fee billing compliance and effectively identify authorship in notes involving multiple caregivers:**

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8 Professional licensure requirements are state specific and vary by ancillary profession.
• Design EHR’s for ease of recognition of entries/data authored by each individual by all system users rather than functionality that permits only those individuals assigned special access to view prior note versions, or requiring printing prior versions of the note for those who cannot view the note on-line.

• Specific EHR functionality designed for shared services with specific roles including:
  o Teaching Physicians combining notes with residents, including ease in including appropriate statements as required by Medicare teaching physician rules.
  o Medical student notes, designed to discourage inappropriate use of documentation for billing purposes. (Limiting ability to copy to eligible portions of history and/or e.g., visual cues such as red print, or special font).

• Ability to combine and edit notes of services provided as a team (combinations of the roles), including identifying authorship, review, appending appropriate statements of participation and supervision with a valid electronic signature(s), including combining physicians documentation with the documentation of:
  o APCs
  o Technicians
  o Individuals acting as scribes

• Identification of individuals fully included on the hospital cost report.

• Ability to identify authorship of data entered/reviewed that resides in central repositories rather than a note.

• The ability to identify the original author documentation that has been reused, and ideally, the ability to count the number of times a note has been carried forward to generate the next note unchanged (particularly inpatient progress notes).

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1. CMS Transmittal 1530 contains rules about billing for critical care. One rule is that critical care services are not eligible for split/shared combining of notes. Therefore, when a physician is documenting critical care, the ARNP/PA note may not be referenced to explain why the patient was critical.


Department of Health and Human Services, Centers for Medicare & Medicaid Services, , Publication 100-04 Medicare Claims Processing, Transmittal 1530, June 6, 2008.