Policy No: 2080
Effective Date: 03/15
Revision Dates:

Student Provider Documentation

1. Purpose

To educate clinical students regarding appropriate documentation as an integral component of their learning process, these guidelines are intended to ensure permissible student participation in care and documentation, not to replace the sound clinical judgment needed to ensure patient safety and an appropriate learning environment.

2. Scope:

This policy applies to Aurora Health Care, Inc. and any entity or facility owned or controlled by Aurora Health Care. Students working in a non-Aurora site, even if placed by AHC, must follow the policies of the preceptor’s institution. This policy is out of scope for physician residents or fellows or clinical students acting in a nonstudent role (e.g. NP student working as an RN).

3. Definitions:

**Student:** clinical provider students (MD, DO, PA, CNM, DPM, NP, DNP, MSN, CNS, CRNA) acting in the capacity as student in an ambulatory or inpatient setting.

**Scribing:** documenting the history, examination and medical decision making for the billing provider. The scribe can be either an employed person or a student acting in this capacity.

**Billing Provider (BP):** the licensed and credentialed clinician (MD, DO, PA, CNM, DPM, NP, DNP, MS, MSN, CNS, CRNA) whom is responsible for the care and under whose billing authority the encounter is taking place.

**Pend:** modify/edit active or previously entered orders. The Billing Provider or resident will then access, review and sign the pended orders; no action will be taken on an order while it is in pend status

4. Policy

4.1. Students must document under their own computer access; under no circumstances may a student log in to any Electronic Health / Medical Record system using the login or password of another student, staff member, or supervising clinician.

4.2. Each student must complete Aurora’s HIPAA and Compliance training thru the Learning Connection or the Nursing Clinical Placement website (www.aurora.org/students) annually and turn their documentation into the appropriate coordinator.
5. Procedures
5.1. Students doing approved rotations shall be given unique ‘n’ logins (Windows logins), EPIC login IDs and passwords. This student access will match their level of security to allow appropriate access and documentation, using established IT security templates.

5.2. Students may enter information into the patient database during or subsequent to the patient interview. This information includes problem, allergy and medication lists and past/family/social history. Review of systems (ROS) may also be completed by the student.

5.3. Medicare does not accept student dictation using an external transcription service for an encounter note unless the student indicates that they are “dictating as a scribe for Billing Provider”. Scribing requires that the student act as a dictation device for the Billing Provider (BP).

5.4. Using SmartChart:

a) Students can create notes through any of the available note-writing processes as determined by the BP, and discussed with the student.

b) The BP may cut and paste the permissible aspects (past, family, social histories and review of systems) of the student’s note, but must create their own History of Present Illness (HPI), Physical Examination (PE), and Medical Decision Making (MDM).

c) The student note must not be copied and used for billing unless the student documents that he/she is ‘dictating as a scribe for Billing Provider.’
   i. The note must contain the thought process, findings and medical decision making of the BP, and that the student is creating and reviewing the note in the physical presence of the BP. In this case, the BP should add a short attestation, such as “I have reviewed the information recorded by the scribe for accuracy and agree with its contents.” See Appendix A.

d) Students may enter orders, but must ‘pend’ all applicable, which need to be signed by a BP before the orders are valid. It is the student’s responsibility to alert the BP and obtain a signature.
   i. Students cannot pend certain orders, including restraints, DNR and seclusion orders, as outlined in the current AHC Hospital Cosignature Requirements document, located at: https://iconnect.aurora.org/DotNetNuke/LinkClick.aspx?fileticket=dhpPbOTi3I0%3d&tabid=1330

e) If a student is working with a resident or fellow:
   i. The resident/fellow may copy/paste or refer to the student’s past/family/social history and ROS, but must complete their own HPI, PE, and Assessment and Plan (A/P).
   ii. A student cannot scribe for a resident/fellow.
iii. The BP or resident must cosign the student’s note.

iv. The BP must attest supervision on the resident’s note. For example, the BP cannot refer to the student’s note for documentation of HPI, PE or A/P. See Appendix B.

Cross References:
• Information Security #118
• Medical Record Documentation Policy #162
• Medical Record Correction in SmartChart Policy #235

Owner: Medical Director, Undergraduate Medical Education, Academic Affairs, Aurora Health Care

References:

Review Dates:
Appendix A: Flowsheet: Student working directly with Billing Provider (BP)

Clinical Student accesses Chart
- Document problem list, history, meds, allergies

Student sees patient with BP

- Student documents “[Name, title] writing as a scribe for _________” and completes progress note. This note must be the thoughts, findings and MDM of the BP.
- BP reviews
- Student corrects & completes: ‘Sign upon closing encounter’

Student initially sees patient independently

Billable portions of service must be performed in presence of or repeated by BP

BP ‘dictates’ to Student

- Student completes progress note
- Reviews with BP & completes: ‘Sign upon closing encounter’

OR

Billing provider must write scribe attestation, e.g. I have reviewed the information recorded by the scribe for accuracy and agree with its contents

- Billing provider must write own progress note; may copy or refer to student’s Past/Family/Social histories and ROS
- Billing provider must create own HPI, PE and A/P (may use student note as framework but cannot simply cut and paste)

‘Billing Provider’ (BP) refers to the licensed and credentialed clinician (MD, DO, PA, CNM, DPM, NP, DNP, MS, MSN, CNS) whom is responsible for the care and under whose billing authority the encounter is taking place.; HPI’ refer to the History of the Present Illness; ‘PE’ refers to the Physical Examination; ‘MDM’ refers to Medical Decision Making, commonly denoted as the Assessment & Plan (‘A/P’). ‘P/F/S Hx’ refers to the Past/Family/Social Histories; ‘ROS’ refers to the Review of Systems. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/gdelinesteachgresfctsht.pdf
Appendix B: Flowsheet:  Student working with resident/fellow (R/F) and Billing Provider (BP)  

Workflow: Student working with resident/fellow (R/F) and Billing Provider (BP)*

- Clinical student accesses Chart
- Documents problem list, history, meds, allergies

Student sees patient with resident

OR

Student initially sees patient independently

- Student completes progress note
- Resident/Fellow reviews note with student
- Student corrects/completes: ‘Sign upon closing encounter’ (ambulatory) or checks ✅ cosign needed and signs (inpatient)
- Resident/Fellow must write own progress note; may copy or refer to student's P/F/S histories and ROS
- Resident/Fellow must create own HPI, PE and A/P (may use student note as framework but cannot simply cut and paste)
- Students cannot scribe for Resident/Fellow

- BP cosigns student note [Note that if BP simply co-signs, note will stay under student name as ‘medical student note’ but if BP edits or addends then note ownership will change to BP]
- BP writes supervising attestation on resident note, e.g. “I have seen and examined the patient and confirm the History, exam and decision-making as documented by Dr. X.” Must also “provide customized information that is sufficient to support a medical necessity determination;” e.g. ‘Heart failure, slowly improving, continue IV diuretics; Anemia, stable, asymptomatic; Hypertension, controlled. Physical Therapy assessment for mobility and home safety.’

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