

Physician CONNECTION



“Take a Note”: The Role of Scribes in Medical Practices

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The word “scribe” comes from the Latin *scriba* and was first used, historically, to refer to persons who copy documents, especially during a time before printing was even invented. Fast forward to the modern medical era when paper records have been eclipsed by the computer. For all of its advantages, the electronic health record still seems to confound, complicate and challenge the efficient and enjoyable practice of medicine.

In this modern environment, the scribes of yore have become indispensable members of the medical team, enhancing physician productivity, clinical engagement and patient satisfaction. With careful selection and training, and being mindful of regulatory requirements, scribes can bring a level of efficiency and calming focus to even the busiest hospital department or physician office.

The Duties and Role of Medical Scribes

A scribe serves as the real-time transcriptionist for the healthcare provider, observing and recording

the provider’s conduct and actions, detailing the patient interaction, and helping to navigate and search for critical data in the electronic record. The scribe is not permitted to act independently but instead documents the provider’s dictation and/or activities during the visit.

Scribe duties typically include¹:

- Transcribing details of the physical exam and findings
- Recording the provider’s consultations with family members or other physicians
- Documenting procedures performed by members of the healthcare team including nurses and physician assistants
- Tracking results in the medical record such as pending lab results, X-ray interpretations and other patient data
- Recording physician-dictated diagnoses, prescriptions and instructions for planning and follow up

With the scribe serving as the documenter and transcriptionist, the provider is able to spend more time in direct face-to-face conversation and interaction with the patient. The



presence of the scribe means the computer is no longer a barrier between clinician and patient.

Working side by side in the exam room, the scribe can support the provider’s practice by accurately documenting the pertinent clinical details and recording the provider’s assessment and plan, which saves the provider valuable time as he/she moves from patient to patient in a busy practice.

Though unlicensed, a medical scribe is trained to accurately record medical information in the paper or electronic chart in real-time during medical encounters. At the present time, there are no training or certification requirements to become a scribe. Scribes may be employees of the hospital or practice group or contracted in from a staffing company.

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Most scribes come to the job with a background or exposure to medical terminology and anatomy. Scribes may be medical or nursing students, or have previously worked in the healthcare field. The successful scribe will demonstrate computer proficiency and the ability to quickly and efficiently navigate through the electronic health record (EHR). Medical practices and hospital units are fast-paced environments, so keen organizational skills, the ability to multitask, and a facility for tracking data and tasks will serve the scribe well.



Scribes are present alongside the provider in close proximity to patients during stressful and sometimes emotional encounters. The scribe must maintain a professional demeanor, observe strict confidentiality, and exert a calming and positive influence on patients and family members. Scribes cannot be shy, either. They must know when and how to speak up and ask for clarification, to be sure their documentation is accurate and complete.

Medical scribes can be found in the inpatient setting, most notably the

emergency room, as well as in physician offices. Scribes can be particularly helpful in an active pediatric office, for example. The American Academy of Pediatrics encourages “team-based care in the primary care pediatric office” and finds that a team-based approach provides integrative, comprehensive care for patients and their families. The team, led by the pediatrician, can include pediatric nurse practitioners, physician assistants, nurses, scribes, and many other trained and dedicated professionals. While clinicians and parents are focused on the needs of often rambunctious toddlers, the scribe is invaluable in watching, listening, and documenting all that occurs.

Benefits

Documentation

An attentive scribe can generate a more detailed and complete medical record than would a busy provider catching up on notes some hours, perhaps even days, after the patient visit.² The value and importance of accurate charting cannot be overstated. A risk manager at a major academic hospital in Cleveland has noted scribes are a positive addition to their emergency department that has over 100,000 patient visits per year. Among other benefits, charts can be completed and closed more quickly, making the details of the ER visit available to others and thereby improving continuity of care for the patient.

Support for Coding and Billing

By keeping detailed records, the scribe’s documentation will serve to verify that the physician actually performed the service at the level billed. Accurate documentation leads to correct coding, fewer denials and increased revenue for the practice.

Patient and Provider Satisfaction

In what has been described as the first randomized controlled trial evaluating the effects of medical scribes, researchers from the Stanford University School of Medicine examined the role of scribes in a family medicine clinic associated with a large academic medical center. The recently published study, which followed physician-scribe pairings over a 52-week period (one week the physician worked with a scribe, the next week without a scribe), found “scribes produced significant improvements in overall physician satisfaction, satisfaction with chart quality and accuracy, and charting efficiency without detracting from patient satisfaction.”³ Scribes appear to be a promising strategy to improve healthcare efficiency and reduce physician burnout.

Limitations & Challenges

To be successful, even an experienced scribe needs to be acclimated and oriented to the physician’s practice and preferences. The scribe will require training in office or unit protocols and policies. The scribe will need time to learn the clinical workflow and develop an effective provider-scribe routine. Patients, too, must adjust to the presence of an attentive “stranger” in the room. With adolescent patients, and those with sensitive or intimate concerns, some scribes may be asked to step out. Should that occur, patient privacy is preserved, but the scribe may then be limited in documenting events not witnessed.

Introducing a scribe into the medical practice or hospital environment does call for an adjustment of workloads and routines among all personnel. The provider, scribe and staff need to become comfortable with the rhythm, routines and lingo of the practice.

defined and poorly understood within the practice. It is now clear that scribes cannot function or document independently. Scribes are not authorized to make independent patient assessments let alone initiate care. While scribes take on the laboring oar of documentation, by law the physician must still review and sign the documentation. Their documentation must take place inside the exam room. Scribes act in real time; they cannot add to the record after the fact.

Likewise, scribes cannot prepopulate the exam note in anticipation of the patient encounter. The scribe's documentation must be authentic and real. They cannot cut and paste from a prior note. Nor can they anticipate procedure or surgery dictation in advance.

To successfully integrate scribes into your medical practice, the following practice tips are recommended:

- When introducing the role of scribe for the first time in your practice, be sure to achieve full support from all members of your team: providers, NPPs, and all ancillary and office staff. A fully functioning and trusting team is essential for patient satisfaction, physician engagement, and enhanced productivity.
- Have a written job description for the scribe to use as a benchmark for performance reviews and guide process improvement.
- Utilize scribes in accordance with medical staff rules, hospital bylaws, and the organization's documentation, medical record, coding and billing policies.
- Follow the MAC guidelines for your jurisdiction of practice.

- Always remember that while the scribe's documentation may be more voluminous than the physician's, the physician remains ultimately responsible and accountable for the content of the note. The physician must review the documentation for accuracy and completeness and sign off on it at the conclusion of the patient visit.
- Scribes should be well-trained at the outset when they join your practice, but will still need ongoing training, support and education throughout their career. They should be well versed in office and hospital policies and practices, including HIPAA, HITECH and be cognizant of the basic rules and requirements for proper documentation, coding, and billing.
- It is advisable to carefully audit the scribe's documentation and practices. Be sure that notes are being properly authenticated and that orders are not acted upon without prior authentication. Take action to reinforce practice expectations, offer additional

training and mentorship, and facilitate the seamless integration and support for the scribe in practice.

Conclusion

Modern medical practice is challenging; technological advances are welcome but can also be disruptive. The demands on a physician's time often seem endless. Introducing a medical scribe into the practice setting can provide real benefits, to patients, practitioners and staff. When managed carefully the provider/scribe collaboration can be quite satisfying and rewarding.

References

- ¹ Lewis M. Scribes Can Help Document Care, Boost Efficiency at Medical Practices. *Medical Economics*, (Oct. 10, 2013), available at <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/billing/scribes-can-help-document-care-boost-efficiency-medical-pract>
- ² Misra-Hebert AD, Amah L, Rabovsky A, et al. Medical Scribes: How Do Their Notes Stack Up? *J Fam Pract*. 2016;65(3):155-159



The new signature requirements are applicable to MACs, CERT, SMRC, and ZPICs.

Further guidance and FAQs about the role of scribes can be found on the websites of the Medicare Administrative Contractors.

Novitas⁸ states that documentation of scribe services must be signed and dated by the physician/NPP and clearly indicate:

- Who performed the service
- Who recorded the service

But when an NPP acts as a scribe for the physician, which can sometimes happen though is not advisable, the medical record should clearly indicate the NPP is acting as a scribe and not as a provider of the services.

CGS Medicare⁹ instructs that “Record entries made by a scribe should be made upon dictation by the physician and should document clearly the level of service provided at that encounter. It is inappropriate for the scribe to see the patient separately from the physician and make entries in the record unless the employee is a licensed, certified NPP billing Medicare for services under the NPP name and number.”

In short, “the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity. The physician is ultimately accountable for the documentation, and should sign and note after the scribe’s entry, that the note accurately reflects the work done by the physician, which is reflected in the affirmation above.”

Palmetto GBA¹⁰ in addressing the role and authority of ancillary staff (e.g. RN, LPN, CNA) has stated that a scribe can be an NPP, nurse, or other appropriate personnel designated by the physician/NPP to document or dictate on their behalf. A scribe does not have to be an employee of the physician/NPP.

NGS Medicare¹¹ addressed scribe practices by offering the following guidance:

- For all scribed encounters, whether scribing was performed by licensed clinical staff or other ancillary staff, the billing provider’s note should state “[individual name], acted as scribe for this encounter.”



- If the provider wishes to addend or change what the scribe wrote, if the EMR system allows, the provider can amend the scribe’s entry before the provider signs and enters the note into the record. On a paper medical record, the provider should add and sign an addendum to the scribe’s note rather than cross out or alter what the scribe has written.
- The scribe may also perform standard medical assistant functions, such as holding the patient’s head, for example, or handing instruments to the provider, as long as the scribe remains available to the provider and free to document the provider’s verbal observations in real time during the visit. The act of scribing is intended to take place as the physician dictates the patient’s history, exam, plan of care, etc. As the physician moves through the encounter, the scribe must be ready to dictate those notes and comments as they occur. The scribe is not

permitted to record his or her own summary or notes regarding the patient encounter after the fact.

- The physician’s note, as documented by the scribe, must clearly indicate the physician’s face-to-face presence with the patient throughout the service. The scribe note must be documented during the visit and not at a point thereafter.

Avoiding Legal Risk: Practice Pointers for the Successful Scribe

In 2006 a Florida jury returned a \$116 million verdict in a case involving delayed care and misdiagnosis of a 44-year-old man presenting to an emergency department with stroke symptoms.¹² The patient was first seen by an “expediter” who examined the patient on his own and recorded his findings in the medical record.

The ER physician admitted to having relied upon the examination done by the unlicensed expediter, believing him to be a licensed physician assistant, and discharged the patient to home. The patient worsened at home, returned to the ER early the next morning, where a different ER attending suspected a stroke, ordered a CT and found the patient was having a massive cerebellar infarct with swelling and mass effect. The evidence revealed the individual had failed the physician assistant examination four times, and the ER group had no written policies and procedures, job descriptions or protocols governing the conduct of the expediter. The ER attending’s reliance on the notes of this individual allegedly contributed to the delay in administering appropriate therapy.

This is instructive on multiple levels. In that case the role of the “expediter/scribes” was vaguely

With patience, the scribe will learn the provider's preferences and expectations, and improved productivity soon follows.

Regulatory Guidance and Legal Requirements: New Rules From Medicare

As scribes have become increasingly more common in the medical setting, the rules for their engagement are evolving. In July 2012, The Joint Commission issued guidelines for scribes and offered a rather stern description of their role:

An unlicensed person hired to enter information into the electronic medical record (EMR) or charts at the direction of a physician or practitioner [licensed independent practitioners, APRNs, or PAs]. It is The Joint Commission's stand that the scribe does not and may not act independently but can document the physician's or practitioner's dictation and/or activities.

In an FAQ from August 2016, asking if scribes could enter orders for physicians and practitioners, The Joint Commission replied, "No. The Joint Commission does not support scribes being utilized to enter orders for physicians or practitioners due to the additional risk added to the process."

The Joint Commission has stated that it does not endorse nor prohibit the use of scribes.⁴ However, if an organization chooses to allow the use of scribes, surveyors will look for compliance with applicable standards (Human Resources, Information management, Leadership, Rights and Responsibilities of the Individual, Record of Care and Provision of Care), including but not limited to⁵:

- A job description that recognizes the scribe's status and clearly defines the qualifications and extent of responsibilities
- Orientation and training specific to the organization and role
- Competency assessment and performance evaluations
- Scribes are no different than other hospital personnel and must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards
- Proper documentation and authentication practices by the physician or practitioner, (required for organizations that use The Joint Commission accreditation for deemed status purposes)
- A physician or practitioner signature stamp is not permitted for use in the authentication of "scribed" entries—the physician or practitioner must actually sign or authenticate the note through the clinical information system
- The authentication cannot be delegated to another physician or practitioner, and must take place before the physician or practitioner leaves the patient care area
- The organization implements a performance improvement process to insure that the scribe is not acting outside of

his/her job description, that authentication is occurring as required and that no orders are being entered into the medical record by scribes

But in light of new Medicare signature requirements effective June 2017, The Joint Commission scribe rules may change. On its website, The Joint Commission states that "the use of scribes in healthcare settings is currently under review." Any updates or changes will be published in future additions of the Perspectives Newsletters and/or via The Joint Commission Online newsletter.⁶

In June 2017, CMS issued revised guidance for Scribe Services Signature Requirements.⁷ CMS also added language to its Program Integrity Manual to address the review of medical claims when scribes are used. The new rules state:

Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/NPP's (non-physician provider) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/NPP on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

With this new rule, Medicare made it clear that it requires that the licensed professional who provides the services and makes the orders must also authenticate the entry.



- ³ Gidwani R, Nguyen C, Kofoed A. et al. Impact of Scribes on Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized Controlled Trial. *Ann Fam Med* 2017;15:427-433
- ⁴ https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqlD=1208&ProgramId=46
- ⁵ *Id.*
- ⁶ https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqlD=1577&ProgramId=46
- ⁷ CMS Scribe Services Signature Requirements; Transmittal 713; CR 10076 (Effective 06.06.2017), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R713PI.pdf>
- ⁸ Novitas Solutions, *Scribe Services* (last modified 09/07/2017) (available via web search: JHHome-Novitas Solutions Scribe Services)
- ⁹ Non-Physicians Acting as Scribes for Physicians, <https://cgsmedicare.com/partb/pubs/news/2012/0412/cope18560.html>
- ¹⁰ <https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM%20Part%20B~Browse%20by%20Topic~Frequently%20Asked%20Questions~EM~8EELQE6434?open&navmenu=%7C%7C>
- ¹¹ National Government Services, Policy Education Topics, *Scribes*, available at www.ngsmedicare.com (search keyword scribes)
- ¹² *Navarro etc. et al. v. Austin, et al*, Case No. 02-6154-G, 2006 WL 4530263 (Fla. Cir. Ct., Thirteenth Judicial Circuit, Hillsborough County)

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