EMR Scribe Policy

Use of Scribes

Approved by WUSM Faculty Practice Plan: January 19, 2010

PURPOSE: The purpose of this policy is to ensure proper documentation of clinical services when the billing provider has elected to utilize the services of a scribe. For the purpose of this policy, a scribe is defined as an individual who is present during the physician’s performance of a clinical service and documents (on behalf of the physician) everything said during the course of the service. Any individual serving as a scribe must not be seeing the patient in any clinical capacity and must not interject their own observations or impressions.

POLICY: The use of scribes by Washington University teaching/attending physicians is acceptable. However, residents, interns and fellows may not act as scribes. Ancillary providers such as NPs, MA’s, RNs, secretaries and other staff may serve as scribes. Individuals serving as scribes must sign a scribe agreement prior to scribing. Scribed documentation must clearly support the name of the scribe, the role of the individual documenting the service (i.e. scribe) and the provider of the service. The physician is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided.

PROCEDURE:

1. Any individual desiring to serve as a scribe must review the University’s policy on the use of scribes and sign an agreement which states that the scribe will adhere to the policy. Each department is responsible for maintaining a copy of the agreement and providing a signed copy upon request.

2. A scribed note must accurately reflect the service provided on a specific date of service. The billing provider is ultimately responsible for the content of a scribed note.

3. A scribe’s entry can be hand-written, dictated or created/typed in an electronic medical record (EMR). Documentation of a scribed service must include the following elements:
   - A personal, dated note from the scribe that:
     - Identifies them as the scribe of the service
     - Attests that the notes are written/recorded contemporaneously in the presence of the physician performing the service
     - Identifies the physician
   - Signature of the scribe
   - Co-signature of the billing physician

Example of a compliant scribe statement – “I (scribe’s name) am personally taking down the notes in the presence of Dr. (physician’s name).”

1 CMS provides the following definition of a scribe - “A scribe is one who follows the doctor around and writes word for word, what the doctor says as he’s examining the patient – a sort of human tape recorder.” This definition makes it clear that the physician is providing the service while the scribe is recording only information cited by that provider.
4. Individuals can only create a scribe note in an EMR if they have a password/access to the EMR. Documents scribed in the EMR must clearly identify the scribe’s identity and authorship of the document – in both the document and the audit trail.

5. Providers are required to document in compliance with all federal, state and local laws as well as with University policy.

**Frequently Asked Questions:**

*Can medical students serve as scribes?*

Yes, medical students can also act as scribes. The medical student that is scribing is functioning as a “living recorder”, recording in real time the actions and words of the physician. The medical student scribe must not be seeing the patient in any clinical capacity and must not document or interject their own observations or impressions. This ability to scribe is sometimes confused with the medical student’s ability to individually document information for a billable service. There are strict rules regarding the manner in which the teaching physicians can reference medical student documentation. The Medicare Carriers Manual (MCM) Section 15016 of states:

**E/M Service Documentation Provided By Students.**—Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing. Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

While this policy does not prohibit utilizing medical students as scribes, it is important to distinguish between scribed services and utilizing medical student documentation to support the attending/teaching physician service.

*Can you provide some examples of what is and is not appropriate under this policy?*

**Appropriate utilization of scribes:**

- A medical student who only writes down what the physician says during the assessment, observing and learning, but not touching the patient, and not documenting his/her own findings.
- A staff member independently records the past family and social history(PFSH) and review of systems (ROS) , the physician reviews and confirms the PFSH and ROS and performs the entire service. During the performance of the service the physician dictates to the staff member his findings which are then recorded by the staff member.

**Inappropriate utilization of scribes:**

- A medical student evaluates the patient with the attending physician and the medical student documents the service. The physician edits, corrects and signs the note. This does not represent a scribed service. *(Note: this practice is also not allowed under the teaching physician rules, see MCM 15016 above.)*
Scribe Agreement

I hereby certify that I have reviewed the Washington University School of Medicine, Use of Scribes Policy. I understand that as a scribe I am:

- Required to be present during the physician’s performance of a clinical service and document (on behalf of the physician) everything said during the course of the service. I am not seeing the patient in any clinical capacity and must not interject my own observations or impressions.

- Documentation of my scribe service must include:
  - A personal, dated note that:
    i. Identifies me as the scribe of the service
    ii. Attests that the notes are written/recorded contemporaneously in the presence of the physician performing the service
    iii. Identifies the physician
  - Signature of the scribe

Example of a complaint scribe statement – “I (scribe’s name) am personally taking down the notes in the presence of Dr. (physician’s name).”

- I am aware that documenting in the EMR requires having a password/access to the EMR. Documenting under some else’s log in is prohibited.

Name: ____________________________________________

(Please Print)

Department: ____________________________________________

Signature: ____________________________________________

Date: ____________________________________________

\[1\] CMS provides the following definition of a scribe - “A scribe is one who follows the doctor around and writes word for word, what the doctor says as he’s examining the patient – a sort of human tape recorder.” This definition makes it clear that the physician is providing the service while the scribe is recording only information cited by that provider.