The Proper Use of Scribes in Documentation

Medical scribes have become common in recent years, as practices and facilities search for ways to streamline the documentation process for providers and improve their overall productivity. Medical scribes are not medical providers (although some may have medical backgrounds), and they never treat patients. A scribe’s main task is to document in the patient medical record. The Joint Commission, which accredits and certifies healthcare organizations and programs, released guidelines for scribes in July 2012 setting limits for the role. A scribe is an unlicensed person hired to enter information into electronic medical records (EMRs) or charts at the direction of a physician or practitioner. Scribes do not and may not act independently but they can document a physician’s or practitioner’s dictation and/or activities. The scribe’s services must be documented appropriately, and their documentation must be present in the medical record to verify that the physician actually performed the service at the level billed.

It is important for a practice to include the use of a scribe in the organization’s overall compliance program. Scribes must be closely monitored for accuracy and adherence to applicable guidelines. This can be done through the development of policies and procedures specifically addressing the scribe’s duties, training, and overall management. Scribe documentation must be managed and maintained with the same quality assurance and compliance expectations as other patient care documentation. Policies and procedures identify the responsibilities and outline the requirements for scribes and, at the same time, set the tone and define expectations and accountability for them. Undoubtedly, we will begin to see more frequent use of scribes so that providers can make the best use of the time spent with the patient. The use of scribes can increase patient satisfaction, more accurately reflect the services performed, allow for more appropriate coding, and improve documentation, all of which help minimize risk.

Example: A scribe’s note should include a statement such as:

“Entered by ____, acting as scribe for Dr./PA/NP _____.” Signature______, Date______, Time______.

Example: The provider also completes a statement to attest that they personally performed the service(s) documented such as:

“The documentation recorded by the scribe accurately reflects the service(s) I personally performed and the decisions I made.” Signature____, Date____, Time____.

Know the Scribe’s Role

Electronic health records (EHRs) have increased the use of scribes in medical practices. Medical and nursing students make good scribes because of their knowledge of anatomy and medical terminology, but there are no training or certification requirements to become a scribe. The Joint Commission, which accredits and certifies healthcare organizations and programs, released the following guidelines in July 2012:

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 practitioner. It is the Joint Commission’s stand that the scribe does not and may not act independently but can document a physician’s or a practitioner’s dictation and/or activities. Carrier guidelines consistently define the intent of a scribe as “one who documents what the physician communicates.”

Example: When a person visited the emergency room, a scribe accompanied the physician during her examination. The scribe’s computer was worn like a mobile desk around her neck, and she typed as the physician talked. This was an appropriate use of a scribe.
Some policies go farther when describing the scribe’s role, as shown in these excerpts from various Medicare Administrative Contractors’ (MAC) policies:

**Cahaba GBA:** Documentation of scribed services must include:

- Name of the person that performed the service
- Name of the person that recorded the service
- The qualifications of each person
- The document must be signed and dated by both the physician and the scribe

**Source:** [Cahaba GBA](https://www.kmcuniversity.com)

**WPS Medicare:**

“Hospital or nursing facility E/M services documented by a Non-Physician Practitioner (NPP) for work performed independently by that NPP, with the physician reviewing and/or co-signing the notes, is not an example of a ‘scribe’ situation. ... In the office setting, the physician’s staff member may independently record the Past, Family and Social History (PFSH) and the Review of Systems (ROS), and may act as the physician’s ‘scribe,’ simply documenting the physician’s words and activities during the visit” [emphasis in the original].

**Source:** [WPS Medicare](https://www.kmcuniversity.com)

**Palmetto GBA:**

“If ancillary staff is present while the physician is gathering further information related to the HPI or any of the three key components, he/she may document (scribe) what is dictated and performed by the physician or NPP. The physician needs to review the information as it is written, documented, recorded or scribed and write a notation that he/she reviewed it for accuracy, add to it if supplemental information is needed and sign his/her name. The name of the scribe must be identified in the medical records.”

**Source:** [Palmetto GBA](https://www.kmcuniversity.com)

**Frequently Asked Questions**，“What specific information can ancillary staff (e.g., RN, LPN, CNA) document during an evaluation and management (E/M) encounter? Can ancillary staff act as a scribe for a provider?”

**Novitas:** “While the physician or NPP must perform the medical service, the scribe may document the dictation and what was performed in the medical record.” Novitas provide examples of how the provider and scribe should document their participation in the medical record.

**Source:** [ACEP](https://www.kmcuniversity.com)

**CGS:** “The scribe is functioning as a ‘living recorder,’ documenting in real time ... This individual should not act independently, and there is no payment for this activity.”

**Source:** [CGS Medicare](https://www.kmcuniversity.com)

**What Scribes Can’t Do**

In contrast to the above guidelines, scribes should not:

- Independently document details of an encounter outside the exam room; the person may have been present in the room at the time of service, but if content is added to the record after the fact it is not the work of a scribe.
- Populate template exams before the provider’s interaction with the patient (this would be documenting exam details not yet performed).
Cut and paste documentation from a prior patient visit that is irrelevant to the current encounter. The provider may review the information, but the scribe is not allowed to act independently. Pre-population is always inappropriate.

Create procedure or surgery dictation. The provider must dictate the note while the scribe records or documents it. Any action falling outside the definition of “human transcriptionist” is not appropriate for a scribe.

Evidence of inappropriate use of scribes is everywhere. One telling example can be found in, “The Disturbing Confessions of a Medical Scribe,” in which an anonymous scribe tells of a provider asking him to document smoking cessation services that were not performed, along with other abuses. A scribe may remind providers if they forget a needed element (e.g., failing to meet Meaningful Use requirements) but the scribe cannot document anything unless the physician performs the element and dictates the action to the scribe.

**Bottom Line**

To ensure your practice is using scribes in a compliant manner, consult the MAC guidelines for your jurisdiction. Most policies include specific signature requirements, as outlined above. Policies also may prohibit an individual from performing clinical duties while acting as a scribe — even if he or she is a qualified provider. Educate your staff on compliant use of scribes. Follow up by auditing chart documentation recorded by scribes and the process that resulted in those records.