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Health Information Compliance Alert

EMR Compliance: Using Scribes In The ED: What Documentation Can Be Counted By The Attending Doctor?

Take note of these rules when considering what the scribe can scribble.

If your ED has moved to electronic health records, you may be considering using a scribe -- a person who accompanies the doctor on each patient encounter -- to transcribe the doctor's History and Physical Exam into the medical record and expedite what can be a time-consuming documentation process.

Before implementing scribes in your ED, be aware that many payers have specific rules about how the scribe process should work, and not knowing those rules can derail your claims.

Todd Thomas, CPC, CCS-P, President of ERcoder, Inc. in Edmond, OK, offers the following tips for structuring a scribe program the right way:

1. The scribe's documentation should begin by identifying the scribe and the physician.

2. A scribe must document verbatim what is being said by the physician.

3. When using an electronic medical record, the scribe must have his or her own username and password to access the system. Entries in the EMR must be identified as having been made by the scribe.

4. The physician must review and verify the scribe documentation and attest to its accuracy in addition to also signing the chart.

While it helps if the scribe has knowledge of medical terminology and a familiarity with typical emergency department encounters, there are no training or qualification requirements since they basically function as a human tape recorder, says Thomas. The scribe should not independently document anything other than perhaps the review of systems and past medical, family and social history, which Medicare documentation guidelines allow to be recorded by any ancillary staff, he adds.

Know What Medicare Says About Scribes

Before billing Medicare, be sure you're up to speed on these scribe basics, summarized by Thomas:

- Medicare auditors have noted some physicians having individuals writing notes in the medical record for them, and then merely signing the note. This may be inappropriate.»
- It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed.
- The physician is ultimately accountable for the documentation, and should sign and note after the scribe's entry confirmation that the note accurately reflects work done by the physician.
- 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. This requirement is no different from any other encounter documentation requirement.

Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to deliver the services and create the record. There is no "incident to" billing in the hospital setting (in-patient or out-patient); thus, the scribe should be merely that, a person who writes what the physician dictates, advises Thomas. This individual should not act independently; there is no additional payment for the use of scribes, he notes.

Another Licensed Practitioner Acting As A Scribe? Beware

If a nurse or non-physician practitioner (NPP) such as a PA or NP acts as a scribe, the chart should clearly indicate that their documentation is entered in the record on behalf of the physician, Thomas warns.

The individual writing the note (or history or discharge summary, or any entry in the record) should note "written by Xxxx, acting as scribe for Dr. Yyyy." Then, Dr. Yyyy should co-sign and, indicate that the note accurately reflects work and decisions made by him/her.

E/M services documented by a NPP for work that is independently performed in the absence of the physician, with the physician later making rounds and reviewing and/or co-signing the notes, is not an example of a "scribe" situation.

In this case, the visit would have to be reviewed in the context of meeting the shared service requirements espoused in MCM Transmittal 1776, says Thomas. Such a service could be considered a shared service and billed under the physician's National Provider Identifier (NPI), provided the performance and documentation requirements for split/shared visits are met, including a face-to-face encounter with the patient, he adds.

Bottom line: The physician is ultimately accountable for the documentation, and should not only sign the chart, but also indicate that the scribe's documentation accurately reflects the work done by the physician, says Thomas.