

Compliance Alert

SIU SOM Office of Compliance and Ethics

Scribe Guidelines

Guidelines for the Use of Scribes in Medical Record Documentation

“Scribe” situations are those in which the physician utilizes the services of his or her staff to document work performed by that physician, in either an office or a facility setting. In Evaluation and Management (E/M) services, surgical and other such encounters, the “scribe” does not act independently nor functions as a clinician, but simply records in real time the physician’s actions or words as they occur during the visit. The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply “scribed” by another person. **Scribes may not interject their own observations or impressions into the medical record.**

During a patient encounter, the scribe may additionally perform standard medical assistant functions, as long as the scribe remains available to the provider and free to document the provider’s verbal observations in real time. The act of scribing is intended to take place as the provider dictates his/her notes regarding the patient’s history, exam and plan of care. Physicians may rely on the review of systems (ROS) and past, family, social history (PFSH) obtained and recorded by ancillary personnel. The physician is ultimately responsible for all documentation and must verify that the scribe’s note accurately reflects the service provided.

Scribe documentation requirements:

- The name of the scribe and a legible signature.
- The name of the physician providing the service
- The date the service was provided
- The name of the patient for whom the service was provided.
- Sign the SIU “Scribe Agreement” provided in the SIU Guideline: Use of Scribes in a Medical Office
- Scribes are NOT permitted to record independent notes, but only those specifically dictated by the provider.
- Scribes MUST use their own log-in if using an electronic health record.

In a password protected and secure documentation system, i.e. electronic health record, etc., the scribe must create the medical note under their own user name and password. Once completed, the note is then forwarded to the attending clinician for final editing and approval. The scribe must not create the note under anyone’s user name or password other than their own.

Recommended Scribe Statements

If scribing the entire visit, the following statement should be entered by the person scribing:

“I, (XXXXXXXXXXXX) acted as a Scribe of the services personally performed by Clinician (XXXXXXXXXXXX) and the medical note documents those services and medical decisions by the Clinician and recorded by me as a scribe.” or

If scribing only a portion of the patient visit, the scribe should clarify which portion(s) they entered:

“The chief complaint, history, subjective, and exam portions of this note were entered by (XXXXXX), acting as a scribe for Dr. XXXXX.”

Physician documentation requirements when using a scribe:

- Affirmation of the physician's presence during the time the encounter was recorded
- Verification that he or she reviewed the information
- Verification of the accuracy of the information
- Any additional information needed
- Sign the SIU "Scribe Agreement" provided in the SIU Guideline: Use of Scribes in a Medical Office.
- Only 3rd year residents and beyond may use the services of a scribe.

Recommended Clinician Statements

ATTENDING: I have personally performed the services documented here and agree that the documentation accurately represents the services and the medical decisions I made. I have reviewed the documentation and made changes or additions as needed. The encounter was documented by the clinic staff acting as my scribe.

Signature requirements detailed in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1, (1 MB) as well as the specific documentation requirements for any service provided must be followed. Source: Important Information from National Government Services Regarding Documentation Requirements when Scribes are Utilized ngslistserve.com September 15, 2010.

Medical Students, Residents and Clinical Fellows as a Scribe

Medical students, Residents and Clinical Fellows are not eligible to act as a scribe while in their trainee role. A scribe is defined as an individual who is present during the attending clinician's performance of a clinical service and documents on behalf of the clinician everything performed and said during the course of the service.

Exception: A medical student may act as a scribe if their sole purpose is to record the service being rendered by the clinician and they are doing so while employed by or under contract with SIU SOM or SIU HC. For example, a first year medical student during summer break might act as a scribe during a summer employment.

Sources:

[Medicare Claims Processing Manual Chapter 12 Section 100.1.1](#)

SIU SOM Medical Student Scribe Policy

[WPS Guidelines for the Use of Scribes in Medical Record Documentation](#) [NGW Medicare Scribing Medical Record Documentation](#)

[NGS Scribing Medical Record Documentation](#)

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