CU Medicine

CU Medicine Scribe Guidelines

Revised on Date 07/01/2016

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 medical scribe. For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service and documents (on behalf of the provider) everything said during the course of the service. Any individual serving as a scribe **must not** be attending to the patient in any clinical capacity and must not interject their own observations or impressions.

POLICY: 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 provider is ultimately responsible for all documentation and must verify that the scribed note accurately reflects the service provided. The use of Medical students, Residents, or Fellows may **not** act as a "scribe" for another provider.

PROCEDURE:

1. Any individual that desires to serve as a scribe must review the policy on the use of scribes and sign a policy agreement.
2. A scribed note must accurately reflect the service provided on a specific date of service.
3. A scribe's entry can be hand-written, dictated, or created/typed in an electronic health record (EHR). Documentation of a scribed service must include the following elements:
    - The name of the scribe and a legible signature
    - The name of the provider rendering the service
    - The date and time the service was provided
    - The name of the patient for whom the service was provided
    - Authentication of the scribe
4. The provider is ultimately responsible for the contents of the documentation. The provider note should indicate:
    - Affirmation that the provider was present during the time the encounter was recorded
    - Verification that the information was reviewed
    - Verification of the accuracy of the information
    - Any additional information needed
    - Authentication including date and time
5. Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
6. Scribes are required to notify the provider of any alerts. Alerts must be addressed by the provider.
7. Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
8. Failure to comply with this policy may result in corrective action and/or billing suspension.

Scribed services may be performed in any setting; excluding operating cases and sedation procedures.

When a nurse, NPP or other ancillary personnel acts as a scribe for a physician, the medical record must clearly reflect who performed the service, who recorded the service and the qualifications (i.e., professional degree, medical title, etc.) of each individual. The documentation must be **signed by both** the "scribe" and the rendering provider. Please see the example of a scribed service below*:*

> Leslie Smith, a registered nurse, accompanies Dr. Jones during his hospital rounds. Both the physician and the nurse are at the patient's bedside, where the physician takes the history, performs the examination, makes medical decisions and provides necessary patient education.
>
> The nurse documents the progress note and physician's orders as stated by the physician. When documentation of the service above includes a statement such as "I, Leslie Smith, RN, am scribing for, and in the presence of Jay B. Jones, MD"

The provider documents: "I, Dr. Jones, personally performed the services described in this documentation, as scribed by Leslie Smith, RN in my presence, and it is both accurate and complete.

The document is signed by both Nurse Smith and Dr. Jones, the record demonstrates a properly annotated scribed service.

In *the above* scenario, the service is clearly being performed by the physician, although the progress note was not documented by the performing provider.

Novitas Solutions' expects the use of a scribe to be clinically appropriate for each situation and in accordance with applicable state and federal laws governing the relevant professional practice, hospital bylaws and any other relevant regulations.

Scribes must contact their hospital HIM department to ensure all hospital standards are met when performing this role.

**** It is the department's Director of Finance & Administration decision to direct the use of scribes in their designated area.**

References: Novitas Scribe Services Last reviewed date July 10, 2012 http://www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad78b265_6797_4ed0_a02f_81627913bc78/Page49.jspx?wc.contextURL=%2Fspaces%2FMedicareJH&wc.originURL=%2Fspaces%2FMedicareJH%2Fpage%2Fpagebyid&contentId=00003295&_afrLoop=359328201567000#%40%3F_afrLoop%3D359328201567000%26wc.contextURL%3D%252Fspaces%252FMedicareJH%26wc.originURL%3D%252Fspaces%252FMedicareJH%252Fpage%252Fpagebyid%26contentId%3D00003295%26_adf.ctrl-state%3Dsvopumyj7_144

AHIMA http://bok.ahima.org/doc?oid=106220#.V5J_rK2V_RY
Joint Commission https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1208&ProgramId=46