December 1, 2017

Auditing The Use of a Scribe

A scribe is someone that can act as a walking transcriptionist on behalf of a medical provider.

Oxford Dictionary defines a scribe as: "A person who copies out documents, especially one employed to do this before printing was invented."

Merriam-Webster defines a scribe as: "An official or public secretary or clerk."

The Joint Commission defines a scribe as:

- "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 (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities.
- "Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding."

A scribe may be a staff member that accompanies a provider into the room when seeing a patient and

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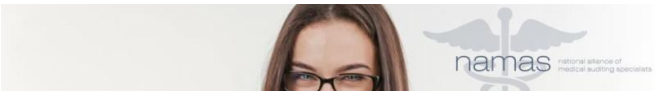

they document what they see, hear, and observe. A scribe should not add anything additional to the documentation and may not perform any of the work of the encounter, outside of the ROS and PFSH as permitted through 1995 and 1997 Documentation Guidelines.

Scribes may NOT:

- Independently document details of an encounter outside the exam room
- Populate exam elements prior to the provider interacting with the patient
- Cannot act independently to pre-populate information from a prior encounter
- Any action that falls outside the definition of a scribe as earlier defined

The scribe is required to indicate within the documentation that they were used to create the documentation. Furthermore, the provider is also required to provide an attestation statement indicating that they have reviewed the documentation for accuracy and if supplemental information was required, it has been added. For this, CMS indicates the provider's signature of the documentation is not enough, and a separate attestation statement is required.

Examples of approved scribe statements and provider attestations are as follows:

Identification of scribe:
'_____ scribing for Dr._____' or '_____ is scribing for me today'

Notation from physician/NPP that he/she reviewed for accuracy:
'I agree with the above documentation' or 'I agree the documentation is accurate and complete'

EMR/Dictated Note:
Identification of scribe:
'Dictated by _____'

Notation from physician/NPP that he/she reviewed for accuracy:
'I agree with the above documentation' or 'I agree the documentation is accurate and complete'

In May 2017, CMS updated the Medicare Program Integrity Manual with regards to Signature

Requirements for Scribes. It seems this was more of a clarification as the guidance is marked as a "Note." The manual now states specifically that "CMS does not require the scribe to sign/date the documentation." Again, this appears to be policy

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regarding the signature only and has no affect on the attestation statement.

However, there is one sentence in this note that creates yet another grey area.

"The treating physician/non-physician practitioner (NPP) signature on a note indicates that the physician/NPP affirms the note adequately documents to the care provided."

The seems to contradict the need for the physician attestation statement, however, all scribe rules still indicate the requirement for the attestation statement.

CGS Medicare has published Scribe Guidelines that supersede most MACs and due to the specific guidance, it provides- it is worth an honorable mention and review of those highlights. This document was published April 2012, and revised February 2017.

- "Scribes are not providers of items or services:" In the section of guidance on this from CGS- this sentence was rather "thrown in" and no further elaboration was made, but it is noteworthy. If they are stating that scribes cannot be providers of items of service, this could then indicate that the NPPs are not valid scribes.
- In this document, CGS also discuss JCAHO's position on scribes. JCAHO has guidance that if a scribe is used, then the scribe must meet certain Human Resource (HR) requirements. These include, but are not limited to:
- Competency assessment and performance evaluations
- Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards as do other hospital personnel
- Signing (including name and title), dating of all entries into the medical record-electronic or manual - note this directly contradicts the updated guidance by CMS
- The physician or practitioner must then authenticate the entry by signing, dating and timing (for deemed status purposes) it. The scribe cannot enter the date and time for the physician or practitioner.

Your MAC may not be CGS, but if you organization is a hospital owned practice(s) who are JCAHO accredited then you will be required to follow these rules, and this is a significant difference then CMS guidance.

Increasingly, CGS is seeing components of evaluation and management services completed or

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updated by nursing or other medical staff in the EMR. For example: In the Past Medical or Family/Social History sections, there is an electronic note stating "updated by Nancy Jones, Medical Technician" or an electronic statement of "medication list updated by Mary Smith RN." If the physician does not review and address these components as well; and the only documentation relating to these components is the entry from the nurse or a medical technician, then these components may not be used in determining the level of E&M service provided as they do not reflect the work of the physician.

Again, CGS is only one MAC, but this statement if used by other MACs could have a significant impact on audits as most EMRs hold who documented the information and not necessarily who reviewed it.

This Week's Audit Tip Written By:

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Shannon is a Partner with our parent organization, DoctorsManagement and is also the President of NAMAS

NAMAS 9th Annual Auditing & Compliance Conference Speaker Spotlight

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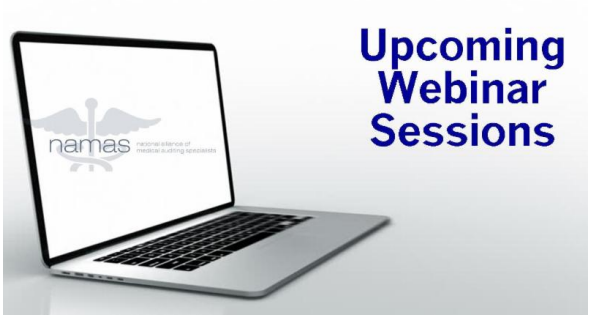

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Prolonged Physician Service Concerns in Your Audit Findings
(Auditing Webinar Series)
Speaker: J. Paul Spencer
December 12, 2017
2pm EST

Compliance Considerations for Practice Acquisitions
(Compliance Webinar Series)
Speaker: Jesse Overbay, JD
December 19, 2017
2pm EST

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