CHILDREN'S HOSPITAL LOS ANGELES MEDICAL GROUP

COMPLIANCE POLICY MANUAL

POLICY	Use of Scribes Policy and Procedure
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Purpose

The purpose of this policy is to ensure proper documentation of clinical services when the billing physician has elected to utilize the services of a scribe. This policy defines a scribe as an individual who is present during the physician's performance of a clinical service and documents on behalf of the physician, all pertinent medical information said during the course of the service. Any individual serving as a scribe cannot see the patient in any clinical capacity and cannot interject his or her own observations or impressions.

Procedure

Any individual desiring to serve as a scribe must review this CHLAMG policy on the use of scribes and sign an agreement that states that the scribe will adhere to the policy. Each division is responsible for maintaining a copy of the agreement in the outpatient clinic, and providing a signed copy of the Scribe Agreement to the CHLAMG Compliance Department.

I. Scribes must accurately reflect the service the attending physician provides on a specific date of service in scribed notes. The attending physician is ultimately responsible for the content of a scribed note.

II. Scribes may handwrite (Scan), dictate, or enter notes into the electronic medical record (EMR). Scribes must include a personal, dated note from the scribe that:
    a. Identifies them as the scriber of the service;
    b. Attests that the notes are created from information obtained directly from the attending physician
    c. Identifies the name of the attending physician
    d. Contains the signature of the scribe
    e. Contains the co-signature of the billing physician

    Example of a compliant scribe statement:

    "I (scribe's name) am personally scribing the note in the presence of the attending physician, Dr. (physician's name)."

III. Individuals can only create a scribed note in an EMR, or dictate a scribed note if they have their own unique password and access to the EMR or transcription service. Scribes must clearly identify their identity and authorship of documents they scribe in the EMR– in both the document and the audit trail.

IV. Physicians are required to document in compliance with all federal, state, and local laws as well as with CHLAMG policy.

Frequently Asked Questions:

Can medical students or residents serve as scribes?

No, medical students or residents cannot act as scribes. Medi-Cal does not allow this activity because it may be difficult for others to differentiate a scribe note, or note for billing purposes, from a student note demonstrating the medical student/resident's ability to individually document information for teaching purposes.

Medi-Cal prohibits the use of any medical student documentation to support the billing of an attending physician.

Can you provide some examples of what is not appropriate under this policy?

Inappropriate utilization of a scribe:

A medical student or resident evaluates the patient with the attending physician and the medical student documents the service. The physician edits, corrects and signs the note. *This does not represent a scribed service. (Note: This practice is also not allowed under the teaching physician rules per First and Second Written Warning of Improper Billing Practices – State of California, Department of Health Care Services – Medi-Cal Fraud and Integrity Unit).*

The scribe interviews and evaluates the patient prior to the physician visit and documents his/her personal findings. The attending physician reviews the scribe's note, makes corrections, and/or adds additional information and signs the note. *This does not represent a scribed service because the scribe is not permitted to provide or add any personal observations or clinical impressions of their own. The scribe only records what the physician states.*

Related Policies:

- CHLAMG 15-0027A Scribe Agreement
- CHLAMG 15-0028 Documentation and Charge Entry Guidelines for Scribes