Departments
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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, but simply documents the physician's dictation and/or activities 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.

Physicians using the services of a "scribe" must adhere to the following:

- E/M guidelines for the place of service of that visit. According to the Centers for Medicare & Medicaid Services (CMS) Internet-only Manual, (IOM), Publication 100-04, Chapter 12, Section 30.6.1.
- Documentation supports both the medical necessity of the level of service billed *and* the level of the Key Components required of the service in the 1995 E/M Guidelines or the 1997 E/M Guidelines (whichever is applicable).
- Documentation meets the Current Procedural Terminology (CPT) definition of the level of E/M billed.
- Record entry notes the name of the person "acting as a scribe for Dr. X."
- Physician co-signs the note indicating the note is an accurate record of both his/her words and actions during that visit.

Hospital or nursing facility E/M services documented by a Non-Physician Practitioner (NPP) for work that is independently performed by that NPP, with the physician later making rounds and reviewing and/or co-signing the notes, is ***not*** an example of a "scribe" situation. Such a service cannot be billed under the physician's National Provider Identifier (NPI), since it would not qualify as a split/shared visit. Neither would it qualify as "incident to," which is not applicable in a facility setting. In this case, the service should be billed under the NPP's name and NPI.

In the office setting, the physician's staff member may independently record the Past, Family and Social History (PFSH) and the Review of Systems (ROS), and may act as the physician's "scribe," simply documenting the physician's words and activities during the visit. The physician may count that work toward the final level of service billed. *However*, in the same setting, an NPP accomplishing not only the PFSH and ROS, *but the entire visit*, should report those services *under his or her own PTAN*, unless "incident to" guidelines have been met (see IOM 100-02, Chapter 15, Section 60.2). Only when the "incident to" guidelines have been met, should the physician's name and NPI be used to bill Medicare for that service.

Under the above circumstances, "scribe" situations are appropriate and can be a part of the physician's billing of services to Medicare. It is important, however, to be certain that the "scribe's" services are used and documented appropriately, and that the documentation is present in the medical record to support that the *physician* actually performed the E/M service at the level billed.

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